How is moral distress perceived and experienced in Northern Ghana? A study of neonatal intensive care and paediatric nurses

by

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Abstract

The experience of moral distress has been studied extensively in developed economies where it was originally conceptualized, however, there is a paucity of studies on moral distress in nurses in developing economies. The goal of this study was to understand the perception and experience of moral distress in nurses working in Neonatal Intensive Care Unit (NICU) and paediatric wards in Northern Ghana. A qualitative descriptive approach was used to collect data from 40 nurses and 14 nurse managers about their experience of moral distress and support measures nurse managers render to nurses who experience moral distress. Thematic analysis showed 7 themes: 1. nurses experienced morally distressing situations, 2. causes of morally distressing situations among nurses, 3. the impact of morally distressing situations on nurses, 4. coping mechanisms of nurses who experienced morally distressing situations, 5. recommendations by nurses to reduce the incidence of morally distressing situations, 6. inadequate support measures offered by nurse managers to address morally distressing situations in nurses and 7. moral distress experienced by nurse managers. The findings of the study were that Ghanaian nurses perceive and experience moral distress, that the contributing factors to moral distress are mainly organizational in origin, and that there are few support measures available to nurse managers to help nurses navigate morally distressing situations on the wards. The effects of moral distress were also highlighted in this study. Lessening the experience of moral distress is critical because of its detrimental effects on nurses and the health care system. Nurses and nurse managers who have been affected by moral distress may leave the nursing profession and this will ultimately add to the problem of a shortage of nurses and nurse managers in Ghana. In the light of these findings more resources are needed by healthcare institutions. Stakeholders in the Ghanaian health care industry should explore coping strategies for moral distress to retain nurses and nurse managers to ensure quality patient care.

DEDICATION

For my husband, Dr Akisibadek Alekz Afoko and our children, Petrina, Manuela and Alexander Jnr. for motivating me to attain a PhD in nursing.

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List of Acronyms

MD	Moral distress
NM	Nurse Managers
NHIS	National Health Insurance scheme
NICU	Neonatal Intensive care unit
ICN	International Council of Nurses
ICU	Intensive Care Unit
WHO	World Health Organization
GHS	Ghana Health Service
UN	United Nations
PHC	Primary Health Care
GDP	Gross Domestic Product
SNO	Senior Nursing Officers
PNO	Principal Nursing Officer
HRD	Human Resource Division

Definition of Terms

Moral agent: 'Someone who has the capacity to direct their actions to some moral end, for example, good outcomes for patients' (Canadian Nurses Association, 2017 page 6).

Moral sensitivity: '…the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical consequences of decision on behalf of the person' (Lützén et al., 2000 pg. 521).

Moral judgement: '…involves integrating numerous ethical considerations that count for or against a particular course of action in order to determine what ought to be done in a specific situation' (Corley, 2002 pg. 646).

Moral dilemma: '…when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action' (Jameton, 1984 pg. 6).

Moral conflict: '…is a situation involving a clash of moral values concerning what is the morally right action to take' (Corley, 2002 pg. 646).

Chapter 1: Introduction

1.1 Overview

Nurses and nurse managers play significant roles in the delivery of health care worldwide by promoting health, preventing illness, restoring health, and easing suffering (WHO, 2020). Delivery of care services often results in nurses being in constant direct contact with patients and family members through several hours of care giving in a continuous process of interaction. In providing care nurses communicate and advocate for patients and must make decisions in the best interest of these patients (Foley et al., 2000). Nurse turnover has become an urgent human resource challenge, affecting healthcare systems globally. A WHO report estimated a global shortage of 5.9 million nurses in 2018, as a result an additional 6 million nurses are required to achieve the Sustainable Development Goals (SDGs) by 2030 (WHO, 2020). The SDGs are 17 goals agreed by all member states of United Nations in 2015, calling for action through global cooperation to tackle health inequalities, poverty, education and to stimulate economic development (UN, 2015).

The shortage of nurses is compounded by the increased burden of illness globally. Both developed and developing economies battle with illnesses such as hypertension, diabetes, and cancers (WHO, 2019). Developing economies are comparatively more burdened and susceptible because of factors such as demographic challenges, geographical location, traditional, social, and economic challenges (Boutayeb, 2010). In addition, malaria, tuberculosis, acute respiratory infections, and diarrhoeal disease contribute to high mortality rates in developing economies (Schieber et al., 2006; WHO, 2019). These challenges have been magnified by the COVID-19 pandemic that has affected every country in the world (Chang et al., 2021). The burden of increasing diseases coupled with the shortage of nurses is likely to result in poor patient care outcomes and moral distress in nurses in clinical care practice.

Moral distress is defined by Morley et al., (2017 pg. 16) as 'a combination of (a) the experience of a moral event, (b) the experience of psychological distress and (c) a direct causal relationship between (a) and (b) which are necessary and sufficient conditions for nurses' to experience moral distress'. The phenomenon of moral distress is widely recognised in developed economies and has received considerable attention from nurses in the last decade. This is because of the need to improve patient care, safeguard the wellbeing of nurses and increase the retention of nurses by health institutions (Borhani et al., 2015).

This empirical study explored the perception and experience of moral distress in nurses in Neonatal Intensive Care Unit (NICU) and paediatric wards in Northern Ghana. The focus on NICU and paediatric wards was pragmatic because nurses within such environments are likely to encounter morally distressing situations because NICU and paediatric wards are settings where nurses face difficult and challenging situations in the care of patients and their families (Prentice et al., 2016).

Nurses working in NICU, and paediatric wards seem to be at higher risk of experiencing moral distress because of the direct involvement of family members and the very sensitive nature of care of critically ill children, especially end of life care, and debates about futile care (Prentice et al., 2016). For instance, when critically ill neonates and children are at risk of death or impaired functional recovery and receiving aggressive life sustaining treatment requested by family members of patients, nurses may feel the harm or burden outweighs the benefit of continuing such treatment. Another instance is when a nurse knows he/she must carry out a comprehensive physical assessment on a newly admitted patient on a paediatric ward to aid diagnosis and initiate treatment but is unable to carry out this task because of lack of basic instruments such as a thermometer, a glucometer and paediatric weighing scales. Lack of instruments and equipment not only affects quality of care of patients it may lead to delayed care and complications (Moyimane et al., 2017).

Moral distress is first and foremost a practical encounter in nursing (Corley, 2002) because nurses face morally difficult situations at some point in the care of patients. The purpose of nursing care is typically moral (Corley, 2002). Nurses have 'to provide care that prevents complications, and to maintain a healing environment for patients and families' (Corley, 2002 pg. 637). Nurses are required to be moral agents who ensure the welfare of their patients and patients' family members with concern, empathy, sympathy, advocacy for patients and family members (International Council of Nurses, 2012; Code of Professional Conduct, Nursing and Midwifery Council of Ghana, 2017). However, nurses with such attributes may have difficulty advocating for their patients because of factors that constrain them from caring leading to the experience of moral distress. Such factors are lack of nurses, lack of administrative support and inadequacies of colleagues (Corley, 2002; Hamric and Blackhall, 2007; Maluwa et al., 2012; Prentice et al., 2016). In addition, aggressive medical treatment of patients and inadequate communication in health teams have been identified as causal factors of moral distress in nurses (Trotochaud et al., 2015).

Nurses who experience moral distress may show signs of sadness, frustration, and anxiety (Corley, 2002; Wilkinson, 1987; Morley et al., 2017). Over time nurses may reach a state of job displeasure, burnout, and eventually leave the nursing profession (Corley et al., 2001; Epstein and Hamric 2009; Varcoe et al., 2012; Wilkinson, 1987; Whitehead et al., 2014; Oh and Gastmans, 2015). According to Prentice et al., (2016), moral distress was the reason given by nurses for leaving a previous position and thirteen percent of nurses had considered leaving their position because of the experience of moral distress. If the impact of moral distress is not addressed, nurses' ability to provide optimal patient care and attain quality outcomes for patients may be compromised (Schluter et al., 2008; Corley, 2002; McCarthy and Deady 2008; Pauly et al., 2012; Prentice et al., 2016). As well as the experience of moral distress being a

concern for the profession of nursing internationally, it was also an issue I had been interested in as a health professional and educator for many years in Ghana.

1.2 The researcher's background

After earning my undergraduate degree in nursing at the University of Ghana, Legon in June 2003, I worked as a clinical nurse at various hospitals in the country. My first post was at the NICU and paediatric wards of a hospital where I cared for neonates and children with various illnesses. While working at the children's hospital, I encountered different, anticipated, and unanticipated moral difficulties. These resulted from a combination of factors such as increased admissions 1,584 in 2003 to 3,237 in 2008 (Tette et al., 2016), lack of nurses (nurse-to-patient ratio of 2: 60 in 2008) (Princess Marie Louise Children's hospital, 2009) and lack of basic instruments and consumables to work with. Also, electricity outages at the hospitals made caring for critically ill patients difficult, for example, patients on oxygen concentrators did not receive the oxygen they needed for their care. In addition, family members frequently refused to give consent for essential procedures, all of which created moral difficulties. Although I recognized these moral difficulties, I was not aware of the term moral distress. I only became aware of the concept when I started teaching at a University in Ghana. These moral difficulties were also reported by colleagues in their accounts of working in similar environments.

Later in my career at the Regional Health Directorate in the Northern Region, I was involved in training various categories of health staff (especially nurses) from the Northern region about contemporary issues in health care including the development and use of case management protocols, quality assurance and staff safety. During facilitative supervision visits to nurses in their clinical care settings, they also shared their experiences of moral difficulties concerning patient care. They reported their inability to apply their skills and implement health protocols learnt from in-service training programmes because of work overload because of a shortage of

nurses, and lack of the instruments needed to provide patient care. This had a negative effect on the quality of care rendered to patients.

Currently as part of my responsibilities at the University I supervise undergraduate nursing students on clinical placement at various clinics and hospitals all over the country. During these supervisory visits to the student nurses, my interaction with staff nurses and nurse managers indicates nurses are fatigued and distressed in their quest to render optimal care to neonates, infants, and children. These nurses express a desire to provide quality care for patients, yet they are confronted with difficulties, often of a moral nature, that cause them anguish. This situation motivated me to investigate the experience of moral distress in nurses with a view to understanding the problems and contributing new knowledge in this field.

1. 3 Purpose and rationale of the study

The purpose of this qualitative study was to gain an in-depth understanding of the perceptions and experiences of moral distress in nurses in NICU and paediatric wards in Northern Ghana.

The rationale for conducting this research with nurses in NICU and paediatric wards in Northern Ghana was three-fold. Firstly, the study of moral distress and its impact on nurses in care settings is virtually absent in developing economies (Prompahakul and Epstein, 2020). Most studies have been conducted in developed economies such as the United States of America, Canada, and Europe. As a result, accounts of moral distress reflect the experience of nurses in developed economies (Prompahakul and Epstein, 2020; Morley et al., 2017). The findings of this study will add to the existing knowledge of moral distress.

Secondly, like other developing economies, the health care system in Ghana has budgetary constraints which adversely affect service delivery. Allocation of funds from the government to health institutions is inadequate. For example, health care spending accounted for 3.54% of Gross Domestic Product (GDP) in Ghanaian government expenditure in 2018 compared to 10% of GDP in 2018 in most European countries (Pett et al., 2020; The World Bank Group,

2021a). Further, resource availability to areas outside the capital city is inadequate which affects health care delivery in these regions, compelling nurses to work in difficult circumstances (Adua et al., 2017). Thus, I believed an examination of moral distress in nurses in the Ghanaian context was essential. Examining moral distress in nurses in different socio-economic contexts is central to increasing our understanding of it and identifying comprehensive coping strategies to help health care staff manage it (Varcoe et al., 2012).

Thirdly, the number of nurses is inadequate to meet the health care needs of the rapidly growing population in Ghana. There is a chronic shortage of nurses and disparities in the distribution of health workers (Ministry of Health, 2018; Ghana Health Service, 2017). This limits access to health services and impedes the realization of the national health goals (Association of Chartered Certified Accountants, 2013). The shortage is felt even more in the deprived regions of Ghana (Poku-Boansi and Amoako, 2015; Ghana Health Service, 2017; Aikins and Koram, 2017). However, there has been an increase in the number of nurses in recent years. For example, the ratio of nurses to total population was 1:1,084 in 2013 and 1:799 in 2017 (Ministry of Health, 2018) an improvement on previous years. However, in 2018, the ratio of nurses to total population increased to 1: 839 (Ghana web online, 2019), meaning equity of access to, and high-quality delivery of health care is not possible. The shortage of nurses has been attributed to migration of nurses, low incomes, lack of recruitment and lack of professional progression (Ghana Health Service, 2015). Lack of nurses can cause work pressures which may lead to psychological challenges for nurses such as moral difficulties which may contribute to the shortage of nurses in Ghana. Against this background I felt it was necessary to examine the experience of moral distress in nurses in Northern Ghana to determine how it affects nurses and if action was needed to mitigate its impact.

1.4 Guiding research questions

The development of the research questions was informed by the following: (a) an examination of the literature on moral distress in developing economies; (b) discussions with nurses working in NICU and paediatric care settings; and (c) my experience as a former clinical nurse in NICU and paediatric ward. The principal questions I set out to address in the study were:

1. Is moral distress experienced by nurses working in NICU and paediatric wards in Northern Ghana?
2. What kind of moral challenges related to moral distress do nurses encounter working in NICU and paediatric wards?
3. What are the principal factors contributing to moral distress among nurses in NICU and paediatric wards in Northern Ghana?
4. Does moral distress affect the work of nurses? If so in what way(s)?
5. What organizational and professional mechanisms if any do nurse managers use to address moral distress in Northern Ghana?
6. How do nurses working in NICU and paediatric wards in Northern Ghana cope with moral distress?

1.5 Structure of the thesis

Chapter 2 provides background information about Ghana, where the study was conducted to set the study in context. Chapter 3, offers a critical discussion of the definition of moral distress. An overview of Jameton's definition of moral distress that focuses on constraint is presented followed by a critical examination of the arguments for a broader definition of moral distress which focuses on elements other than constraint such as uncertainty and dilemmas. A justification is then given for the selection of Morley et al's., (2017) definition of moral distress as the definition used for my study.

Chapter 4 presents an integrated literature review of the experience of moral distress in nurses in health care settings in developing economies. A range of data bases was used to retrieve articles for the review. Sixteen articles reporting the experience of moral distress in nurses in developing economies published between 1984 and March 2019 were included. Analysis of the findings is provided in this chapter followed by a discussion of the findings.

Chapter 5 presents and justifies the selection of the qualitative methodology used to explore moral distress in nurses working in NICU and paediatric wards in Northern Ghana. This was based on the principles of interpretivism, grounded in the epistemological perspective of social constructionism which underpinned the thesis. The details of the methods and procedures used in the study are also presented in this chapter. The study was conducted in the context of a specific sector of health care (NICU and paediatric wards) in Ghana, a developing economy.

In Chapter 6, the results of the in-depth individual interviews conducted with 40 nurses and 14 nurse managers who worked in the NICU, and paediatric wards are presented. The findings offer insights into the experience of moral distress of nurses in Ghana and its association with clinical practice and the delivery of paediatric care.

Chapter 7 is a discussion of the findings. Relevant literature is used to support the essential points identified in the findings. Through the discussion, nurses', and nurse managers' experience of moral distress in NICU and paediatric is examined. The implications of the experience of moral distress for education, research, practice, and policy are also discussed. Recommendations for nursing students, nurses, nurse managers other health care professionals and policy makers are made. The limitations of the study are also discussed in this chapter.

Chapter 8 is the final chapter which includes reflections on my experience as I examined moral distress in nurses in Ghana and a conclusion of the study.

1. 6 Conclusion

The motivation for this study was my practical experience of and my academic curiosity about the experience of moral distress. There is a gap in the current body of knowledge regarding the experiences and perceptions of moral distress of nurses in Ghana. The experience of moral distress is a widespread challenge for nurses because it has detrimental effects on nurses, and so it is important to identify this distress and assist nurses to develop coping strategies to mitigate it. Supporting nurses psychologically when they experience moral distress is vital to enable them work effectively, maintain moral values and continuously improve standards of care. In short, recognizing moral distress is essential for strengthening service delivery to improve health outcomes. By using a qualitative descriptive approach this study adds to our understanding of nurses' and nurse managers' moral distress in the developing economy of Ghana.

Chapter 2: The Ghanaian context

2.1 Introduction

Chapter 2 provides information about the wider context of the study sites where moral distress was studied in nurses in Ghana. Since moral distress has not been examined in nurses in Ghana, the health care system is described to provide some background information about the nature of health care and nursing work in Ghana. A practical starting point is to present a brief description of Ghana as a country, followed by an overview of the health care system and how it is financed. In addition, a brief history of nursing in Ghana is presented followed by a summary of the challenges nurses and nurse managers face working in Ghana. This background material provides information about several factors that may contribute to the causes of moral distress in nurses and are important to consider given the study questions. The picture painted in this chapter also reflects my experience working within clinical settings in Ghana.

2.2 Brief overview of Ghana

Ghana is a middle-income economy, located in West Africa. Ghana gained its independence from Great Britain 64 years ago. Since independence, Ghana has experienced a series of political challenges, however, since 1992 the political climate has been stable. Currently its population is approximately 30 million (United Nations Population Division, 2019) with an annual growth rate of 2.16% in 2019 (O'Neill, 2021a). Ghana is a multilingual country with about eighty languages spoken although the country's official language is English.

As a developing economy Ghana faces several challenges. Agriculture contributes 19.7% of Ghana's current GDP, which accounts for 30% of export earnings. In 2019, 30% of the labour force in Ghana was employed in the agriculture sector (The World Bank Group, 2021b).

Although agriculture is the second largest employer in the economy it is the smallest sector in terms of income generation compared to services and industry.

In 2007, crude oil was discovered in commercial quantities, which was expected to increase the financial stability of the economy (Ghana National Petroleum Corporation, 2008) and by 2017 the Gross domestic product had increased to 8.4 percent and continued to rise as oil and gas production surged (Ghana Statistical Service, 2019). This made Ghana one of the highest GDP per capita countries in West Africa. However, the growth rate of GDP fell to 6.26 percent in 2018, increased to 6.48 percent in 2019 and fell by 0.88% in 2020 (O'Neill, 2021b). The substantial drop of the GDP growth rate affects the economic growth of a country and invariably affects its health care system (Raghupathi and Raghupathi, 2020). For instance, in Ghana the infant mortality was 33.9 deaths per 1,000 live births in 2019 and remained the same in 2020 (O'Neill, 2021c).

The country was made up of 10 administrative regions (Brong Ahafo Region, Northern region, Eastern region, Western region, Volta region, Greater Accra region, Ashanti region, Central region, Upper East region, Upper West region) until 2019 when, 6 more regions were created following a referendum (Van Gyampo, 2018). Historically, the Northern part (an area containing around 17% of the population and covering around 40% of Ghana's land mass) of Ghana lags in terms of access to education, health services, infrastructure development and donor support (Akrofi et al., 2018). Less than 50% of the people in the Northern part of Ghana have access to electricity compared with 72% nationally. Comparatively, the population of Northern Ghana has limited access to secondary healthcare facilities compared with people in the South but are better served with community health services (Association of Chartered Certified Accountants, 2013; Poku-Boansi and Amoako, 2015; Ministry of Health, 2018; Akrofi et al., 2018). Akrofi et al., (2018), reported there is a traditional North-South separation

in Ghana, parts of the South have good infrastructure, whereas regions of the North have poorer infrastructure with major inequalities. This seems to follow the way the colonial authorities purposely structured economic activities in the South whereas the Northern sector of the country served as a source of labour and was not the focus of economic development. This heightened inequalities between the South and the North (Akrofi et al., 2018).

2.3 The health care system in Ghana

The health care system is made up of five levels of providers: health centers, clinics, district hospitals, regional hospitals, and tertiary hospitals (Alhassan, 2017). Many of the hospitals provide out-patient consultation, paediatric health, adult health, surgeries, maternal health, laboratory, and pharmacy services. Urban centers such as Greater Accra and Kumasi are well served and contain most of the hospitals, clinics, and pharmacies in the country (Association of Chartered Certified Accountants, 2013; Poku-Boansi and Amoako, 2015; Ministry of Health, 2018; Akrofi et al., 2018). The mission statement of the Ghana Health Service (GHS) 'is to provide and prudently manage comprehensive and accessible quality health services with an emphasis on Primary Health Care in accordance with approved national policies' (Awoonor-Williams et al., 2018 pg. 7). There is no doubt that attaining this goal will be challenging. Some of the challenges identified are inequalities of health services between the northern part and southern parts of the country, cultural and religious beliefs of the people, poor physical infrastructure, and limited resources (Ministry of Health, 2018). These factors can impede the provision of equitable healthcare services in Ghana (Ministry of Health, 2018).

2.4 Health care financing in Ghana

Adequate public health care financing improves the efficiency of health care services and health outcomes (Nolte and McKee, 2004). Nevertheless, increasing health spending has been

challenging even among developed countries because of economic decline and rising healthcare costs (World Health Organization, 2013). This is even more pronounced in developing economies where public healthcare expenditure has been low despite the potential benefits in health outcomes that could be achieved. Public healthcare financing in less developed economies is derived from low tax revenues, premium collection, out-of-pocket payments by persons, and limited foreign grants (Schieber et al., 2006). The percentage of GDP allocated to health has ranged from 3 per cent in 2000 to 5.4 per cent in 2013 (Aikins and Koram, 2017). The main source of financing for health care institutions in Ghana is through public funds which are Government of Ghana (GOG) revenues, private funds from enterprises and households for both pre-paid voluntary premiums and out-of-pocket payments and international resources from donors and development partners (Aikins and Koram, 2017). For the past decade, the National Health Insurance Scheme (NHIS) has become a main contributor of health financing in Ghana (Aikins and Koram, 2017). However, the scheme only covered 40% of the Ghanaian population (National health insurance authority annual report, 2013). This is attributed to the voluntary nature of enrolling into the health insurance system where people must pay an annual fee to register (Kipo-Sunyehzi, 2020). This indicates that more of the population are yet to be enrolled and therefore pay out -of -pocket, however they may be unable to because of poverty, this is especially the case in the Northern region of Ghana (Kusi et al., 2015). In a national health insurance authority annual report (2011) it was stated that although 40% coverage had been achieved the introduction of the NHIS had contributed to increased pressure on health infrastructure and staff. This increased pressure resulted in longer waiting times for treatment, and non-adherence to standard professional practices by health workers (National health insurance authority annual report, 2011). Dzakpasu et al., (2012) reported low satisfaction among patients regarding the quality of health care in NHIS accredited health facilities. Another significant challenge with the NHIS is the late

reimbursement of hospitals (Akortsu and Abor, 2011) which hampers the efficient administration of hospitals (Ghana Health Service, 2017).

Further, the commitment to increase health infrastructure in Ghana is low, the number of hospital beds in Ghana is limited, for instance the paediatric ward of site 1 (Chapter 5: 5.5), has a hospital bed occupancy of 100 % with a turnover per bed of 3.5 and an average length of hospital stay of 7 days according to the ward records. The supply of medical instruments is not sufficient to treat the large number of patients who seek medical care (Adua et al., 2017). As a result, there is increased demand for the few existing instruments and pieces of equipment in the hospitals especially in the rural parts of Ghana (Ghana Health Service, 2017).

Public health financial mismanagement has been identified as a crucial hindrance for achieving improved health care outcomes. According to Pillinger (2011) about 36% of health costs are wasted because of ineptitude and financial embezzlement. Further compounding the challenges associated with limited funds available to public health institutions to execute their core mandate of caring for patients. These financial challenges seep down to the nurses and nurse managers who struggle to provide safe and appropriate health care to their patients in the face of resource constraints.

2.5 National health insurance scheme coverage

The National Health Insurance Scheme (NHIS) was established in Ghana in 2003 and became operational in 2005 (Schieber et al., 2012). The NHIS is financed by a central National Health Insurance Fund (NHIF) obtained from the National Health Insurance Levy (NHIL) of a 2.5% tax on selected goods and services, a 2.5% of Social Security and National Insurance Trust (SSNIT) contributions from formal sector workers and donor funds (Alhassan et al., 2017). It operates as a health insurance scheme and has an annual renewable premium. The NHIS has

offered many benefits to the populace and presently covers over 80% of all health-care costs in Ghana (National Health Insurance Authority, 2013). When the NHIS was introduced, its aim was to eliminate inequalities of health service delivery between rich and poor people; however, this goal has not yet been attained (Kotoh and Van der Geest, 2016). For instance, enrolment into the scheme is lowest in the Northern region compared with the Southern region of the country (Kusi et al., 2015). Schieber et al., (2012) found that the neediest (poorer) members of the population were more likely to treat themselves at home rather than visit a hospital to access health care because of a lack of funds.

2.6 Traditional and religious beliefs

There are many deep rooted traditional and religious practices undertaken by some Ghanaian Ethnic groups that have an unfavourable effect on physical health which are of concern to nurses (Nyinah, 1997). These include female genital mutilation (ActionAid Ghana, 2014). For instance, in a study among a section of the population in Bawku, Northern Ghana, 50% of the respondents had undergone genital mutilation. Genital mutilation is described as a dangerous procedure whereby unsterilized instruments are used to disfigure the female genitals, which may lead to pelvic diseases (ActionAid Ghana, 2014). Cultural and religious beliefs influence the practice of female genital mutilation. In a systematic literature review, Berg, and Denison (2013) reported that participants considered the practice a significant tradition, which served as a method of societal deterrent for girls and women in lessening prenuptial sex, teenage pregnancy and lessening the chance of extramarital affairs. This is because of the high societal value placed on safeguarding the need to stay a virgin until marriage (Berg and Denison, 2013).

Herbal medicines also called traditional medicines are usually favoured over orthodox medicine in Africa (Abdullahi, 2011). It is estimated that 80 % of patients in Africa use traditional medicine (Payyappallimana, 2010), and about 70 % of patients in Ghana (Tabi et

al., 2006). Herbal medicines are easier to access, low in price, and presumed to be harmless, give quick results and bring positive results (Abdullahi, 2011). Preference to herbal medicine is a cause of people's personal beliefs and values. The foregoing discussion indicates how the health care system can produce moral difficulties for nurses in Ghana.

2. 7 Context: nurses and nurse managers

2.7.1 Contextual details from the history of nursing in Ghana

In the study of moral distress in nurses in Ghana, it is useful to gain a historical perspective of nursing practice and training in the pre- and post-independence era and its link to nurses' experience of moral distress. The traditional practice of Ghanaians before colonialism was that traditional healers, herbalists and spiritualists cared for the health needs of the people (Twumasi, 1979). These traditional beliefs have not changed even with the introduction of modern medical and nursing practice (Krah et al., 2018; Tabi et al., 2006).

In 1878 the first two European nurses arrived in Ghana, known at the time as the 'Gold Coast', to care for the European officials. More female nurses (number of nurses not documented in the literature) had arrived in Ghana from Britain by 1899 which encouraged several (estimated number of 20) Ghanaian women to be educated as nurses (Kisseih, 1962). The training of nurses by the colonial nurses was mainly practical in nature and they were nurse assistants (Kisseih, 1962). At that time any local nurse who wished to become a registered or qualified nurse had to travel abroad for further training (Kisseih, 1962). The British colonial nurses in Ghana, served as nurse educators, and held senior nursing positions in many hospitals up until 1945 (Donkor and Andrews, 2011). In 1944, it had become essential to train professional nurses locally to ensure standardization of nursing training in Ghana (Kisseih, 1962), as a result the General Nurses Training program was established. Nurses in Ghana were trained using the

curriculum of the General Nursing Council of England and Wales during the colonial period and the post-independence era from 1925 – 1962 (Opare and Mill, 2000).

After independence the Ghana Registered Nurses Association was created in 1960 to offer central direction and organization for all registered nurses in the country (Kisseih, 1962). Training of nurses for a long period focused on work in hospital-based health care systems. This brief historical summary paints a picture of the inception of nursing care in Ghana.

2.7.2 The challenges of the Ghanaian nurse in the health care system

Nurses are a key group of health care professionals, who play a vital role in the contemporary health care delivery system in Ghana. The nature of the nursing profession in Ghana is ethical: to protect the patient from harm, to provide care that prevents complications, and to maintain a healing environment for patients and families (Code of Professional Conduct, Nursing and Midwifery Council of Ghana, 2017). Because of the moral nature of their work, they encounter several moral difficulties regarding patient care.

Hospitals in Ghana face challenges of inadequate material resources arising mainly from limited availability of funds to purchase equipment and supplies for patient care (Akortsu and Abor, 2011). This means nurses work under difficult circumstances as they must care for patients without the necessary instruments and medicines (Donkor and Andrews, 2011; Adu-Gyamfi and Brenya, 2016; Ghana Health Service, 2017). Adu-Gyamfi and Brenya (2016) reported that nurses complained of a lack of consumables to work with in hospitals in Kumasi. Clinical settings such as NICU and paediatric wards are challenging environments where vulnerable patients need specialist care and attention (Lauraine, 2012).

Another challenge for nurses in Ghana is the interplay of cultural practices, beliefs of patient relatives and the need for the practice of evidence-based medicine. For instance, a paediatric

unit in Ghana, developed a strong family centered care approach. There is a hospital policy for parents to remain with their hospitalized child as much as they wish and participate in the child's care and treatment planning. Parents and family members of ill children sometimes withhold consent for recommended evidence-based hospital treatment of critically ill patients and seek discharge against medical advice for traditional home management. The difficulty here is that the child may die on the way home or at home because of lack of the necessary health support. These are some of the difficult challenges' nurses must deal with in their work (Nsiah et al., 2020).

The shortage of nurses hampers the achievement of the national health goals. For instance, in a typical NICU in Ghana, 2 nurses may be on duty to care for 60 neonates. Adu-Gyamfi and Brenya, (2016) reported a gross shortage of nurses in Kumasi and as a result, each nurse cared for 11-20 patients daily in similar settings. In these situations, nurses are overstretched since they have more responsibilities in the care of patients. Complaints have been made by nurses to nurse managers about increased workload, however, the challenge remains (Adatara et al., 2016).

2.7.3 Nurse managers

In Ghana nurse managers, also referred to as 'nurse in charge', are mainly senior nurses appointed as leaders to manage wards and departments and are a crucial part of the healthcare management system. Nurse managers do not have formal training in management (Ofei Ansah et al., 2014; Adatara et al., 2016) and appointments are generally made based on experience (Azaare and Gross, 2011; Adatara et al., 2016). Thus, nurse managers are not always adequately prepared to undertake their role (Ofei Ansah et al., 2014; Adatara et al., 2016). Just like their subordinate nurses, nurse managers face difficult challenges such as lack of nurses, inadequate training in management and leadership skills and lack of support from hospital

management in clinical care settings (Adatara et al., 2016). They sometimes work as nurses on the wards during periods of shortage of nurses thus the managerial day-to-day running of the wards is compromised.

2.8 Anticipated COVID-19 challenges

The unemployment rate in Ghana in 2020 was 4.51%**,** an increase from 4.33% in 2019 (O'Neill, 2021d). Like many other economies globally, Ghana has suffered from the effects of the COVID-19 pandemic. There is a heavy reliance on international trade, for instance, GDP has exports forming about 33.6% and importation of goods and services representing 34.7%, suggesting that international trade comprises of 68.3% of the total GDP of Ghana. The two main exporters of goods to Ghana are China and the United States which have been affected by the COVID-19 pandemic. China which was the first to record the outbreak of this pandemic contributes about US$5.3 billion, forming approximately 8% of Ghana's GDP (Amponsah and Frimpong, 2020). The effects of the pandemic caused a decrease in demand for local and imported goods and services. Further, the lockdowns instituted in Ghana and many of its trading partner countries led to a reduction in trade, leading to vast economic losses for the countries involved (Ayittey et al., 2020). This resulted in a rapid contraction of domestic economic activity. Economic growth is likely to remain low even after the COVID-19 disaster (Aduhene and Osei-Assibey, 2021). The impact of the pandemic on the health care delivery system is significant and hospitals in Ghana have seen an increased number of patients with COVID-19 with limited number of nurses and other workers to care for them (Fenny and Otieku, 2020).

2.9 Conclusion

This chapter highlights the difficulties nurses encounter in a developing economy and the limitations on their roles and responsibilities as clinical nurses. Limitations such as budgetary

constraints, lack of nurses, religious and traditional beliefs and poverty affect service delivery. Identifying the factors that influence the health care system is helpful in building understanding of the difficulties that might be created for nurses in clinical care settings. It has not been established yet whether these factors contribute to the experience of moral distress in nurses in Ghana, thus the need for this current study. The next chapter (3) presents a critical discussion of the definition of moral distress.

Chapter 3: A critical discussion of the concept of moral distress

3.1 The need for a definition

As I sought to study the experience of moral distress in nurses in Northern Ghana a practical starting point was an exploration of the literature which examines moral distress as a concept. A critical discussion of the definitions of moral distress is presented in this chapter. This is to enable an increased understanding of moral distress generally and its applicability to my study. I start with a review of Jameton's definition of moral distress that focuses on constraint and then proceed to examine 8 definitions in the literature which focus on elements of constraints, uncertainty, and dilemmas. I then present my rationale for the use of a broad definition of moral distress in my study.

Since the introduction of the term 'moral distress' in 1984 by Jameton, the number of studies of moral distress in nurses has increased globally. Many of these studies have been conducted in developed economies including the United States of America, Canada, the United Kingdom, and Belgium (Morley et al., 2017). These studies have documented the factors that contribute to the experience of moral distress in nurses in clinical care settings such as adult care, paediatric care, psychiatry, gerontology, oncology, and haematology (Lützen et al., 2010; Hamric, 2012; Wolf et al., 2016; Thorne et al., 2018; Morley et al., 2019). The consensus is that the experience of moral distress has significant adverse effects on nurses making this phenomenon one of great interest in nursing (Whitehead, et al., 2014; Lamiani et al., 2017). Although many studies of moral distress in nurses have been conducted, there is no agreement on a single definition of moral distress resulting in wide variation in how moral distress is understood and defined in research (McCarthy, 2013; Barlem and Ramos, 2015; Fourie, 2015; Campbell et al., 2016; Morley et al., 2017). Consequently, a range of terms and meanings have been applied to moral distress in nursing studies (Morley et al., 2017). Concerns have been

expressed that Jameton's (1984) definition is too 'narrow' because it focuses only on constraints and so a broader definition of moral distress is needed to capture its other antecedents (Fourie, 2015; Barlem and Ramos, 2015; Campbell et al., 2016). Further, proponents of a broader definition contend that the use of Corley's measurement tool (Corley et al., 2001), which was developed based on Jameton's 'narrow' definition, is restrictive in measuring moral distress. This measurement tool has been adapted by researchers from various countries with different cultural contexts (Browning 2013; Shoorideh et al., 2015). A review of Jameton's definition of moral distress is presented below to provide a background to the discussion.

3.2 A review of Jameton's definition of moral distress

The term moral distress was first introduced in nursing by Andrew Jameton in his work on *Nursing Practice: The Ethical Issues* published in 1984. Jameton defined moral distress as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (1984 pg. 6). Jameton places emphasis on institutional constraints as the main cause of moral distress in nurses. His original definition of moral distress emphasized the way institutional challenges prevent nurses acting in ways they believed were in the best interest of their patients. This definition presupposes that, moral distress arises under certain conditions:

1. A belief in what morally should be done regarding patient care.
2. A constraint or inability to act in the best interest of patients.

Jameton's definition, outlines institutional constraints (lack of nurses, nurse - physician disagreements and institutional policies) as the main conditions in the occurrence of moral distress. When nurses are prevented from executing their moral obligations or taking moral

action in ethical situations involving the care of patients, because of these constraints, it results in moral distress. Internal (personal) constraints as causes of moral distress were not explicitly articulated in Jameton's account of moral distress.

He also made a distinction between moral uncertainty, and moral dilemma. Moral uncertainty arises when one is unsure what moral principles or values to apply, or even what the moral challenge is. A moral dilemma arises 'when two or more moral principles apply to the same thing, nevertheless they support mutually inconsistent courses of action' (Jameton, 1984 pg. 6). For instance, in a dilemma about a nurse not knowing who to use the last oxygen for; patient A who has severe anaemia and awaiting blood transfusion or patient B who has just been brought in with an asthmatic attack and needs oxygen. Moral dilemma and uncertainty were not identified as part of the definition of moral distress, because Jameton, (1984) argued that nurses experienced moral distress only when they were morally constrained from carrying out actions, not when they were uncertain or in a dilemma regarding patient care.

He subsequently added initial distress and reactive distress to his original definition (Jameton, 1993). Initial distress arises from the frustration and anger experienced when a nurse is confronted with institutional challenges and/or with co-workers leading to a conflict of values. Reactive moral distress occurs when the nurse feels he/she is unable to act on his/her initial distress. He concludes that both initial distress and reactive distress are elements of moral distress that occur when a nurse is constrained from acting (Jameton, 1993).

3.3 Summary of the section on definitions of moral distress that use constraint as the defining term

Whilst acknowledging the importance of institutional constraints, Wilkinson (1987) was the first to incorporate the psychological and physiological effects of moral distress into her

definition after carrying out a study of 24 nurses. She added an affective component to Jameton's original definition, defining moral distress as 'the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision' (Wilkinson 1987 pg. 16).

Similarly, Corley, (1995 pg. 280) defines moral distress as 'painful feelings and/ or psychological disequilibrium caused by a situation in which (1) one believes one knows the moral action to take and (2) that one cannot carry out that action because of (3) institutionalized obstacles such as lack of time, lack of supervisory support, medical power, institutional policy, or legal limits'. Corley acknowledges that when institutional constraints prevent the desired moral action from being executed the experience of moral distress leads to psychological effects, although this was implied in Jameton's definition of moral distress, he could have been more explicit on this point. The common ground that Jameton, Wilkinson and Corley share is that moral distress occurs when institutional constraints prevent a person acting in a moral way despite him/her knowing the right thing to do. Both definitions identify constraints as contributory factors to the occurrence of moral distress. Constraints such as lack of time, lack of supervision, organizational policies, power structures, and legal considerations are the main causes of moral distress in nurses (Corley, 1995).

Epstein and Hamric (2009) agree with Jameton that moral distress 'is the presence of constraints, either internal (personal) or external (institutional) that prevent one from taking actions that one perceives to be morally right' (p. 330). In essence moral distress occurs as a result of some form of constraint of one's actions. In a review of literature to assess the way moral distress has been defined McCarthy and Gastmans (2015), found that several researchers drew on Jameton's definition and explanation that the experience of moral distress is connected to some form of constraint on nurses' moral action. Jameton's definition has shaped research,

however it is limited. Practically the experience of moral distress can be caused by factors (dilemma and uncertainty) other than institutional constraints signifying a limitation in Jameton's definition of moral distress. The challenges with Jameton's definition are discussed in the forthcoming section. Further, lack of attention to the nature of the experience of moral distress may have occurred because of the limitations of the definition.

3.4 Argument for a broad definition of moral distress: dilemma and uncertainty

Jameton's definition of moral distress, has been criticised for being 'narrow'. For example, a major challenge with Jameton's definition is its focus on institutional constraints as the major cause of moral distress, the belief that nurses usually know the right action to take for a patient yet are unable to carry out the right thing because of external constraints (Hanna, 2004; McCarthy and Deady, 2008; Fourie, 2015; Campbell et al., 2016). This has led to multiple redefinitions to include morally challenging circumstances that give rise to moral distress that may or may not necessarily relate to nurses feeling constrained (Hanna, 2004; McCarthy and Deady, 2008; Barlem and Ramos, 2015; Fourie, 2015; Campbell et al., 2016; Morley et al., 2017). If moral distress is experienced in circumstances where 'morality pulls a person in one direction, but constraints pull her in another, moral dilemmas are cases in which morality itself pulls a person in competing directions' and causes moral distress (Campbell et al., 2016 pg. 5). As argued by Campbell et al., (2016) the definition of moral distress should encompass moral dilemmas, for a nurse may be morally distressed in a state of moral dilemma. Hanna (2004) also advocates for a broader definition or a cluster concept (not a single thing) that refers to a wide range of phenomena and causes, and not solely institutional constraints (Table 1). The broad definition involves, psychological, emotional, and physiological suffering that may be experienced when one acts in ways that are inconsistent with deeply held ethical values and principles.

In a similar vein, Fourie (2015 pg. 97) argued for an expansion of the concept of moral distress as a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both. Fourie (2015) suggests her proposed definition is only a starting point though it is an adequate response to the problems of the limitations of Jameton's (1984) definition. Identifying the specific cause of moral distress in a definition presupposes that Jameton's definition is limited, since there could be a wide range of causes or conditions for the experience of moral distress among nurses (Fourie, 2015). Further, Fourie (2015 pg. 92) suggests that Jameton used the terms moral dilemma and moral distress in a 'mutually exclusive' manner implying a simple understanding of moral dilemma. For Jameton, when a nurse is faced with a difficult moral belief with enough thought, it is possible to identify the morally correct action hence that will not be moral distress. If the experience of moral distress is caused by knowing the right course of action but feeling unable to take it, as described by Jameton's definition leaves out a whole host of times when nurses feel distressed when not knowing the morally right thing to do.

Campbell et al., (2016 pg. 6) also advocated for a broader definition of moral distress as 'one or more negative self-directed emotions or attitudes that arise in response to a person's perceived involvement in a situation that is perceived to be morally undesirable'. This suggests that moral distress occurs when nurses experience adverse emotions because of a seemingly morally unfavorable encounter. The involvement of one's perceived involvement is left vague to allow for a wide range of ways in which individuals may be related to a morally problematic situation (Campbell et al., 2016). The use of involvement in this definition may be a matter of having acted or failed to act in a certain way or having felt or failed to feel certain effects. Furthermore, moral uncertainty may be present because of a lack of relevant practical evidence concerning a particular circumstance, because the nurse may not know all potential activities that are available to them therefore may not know what best action to take for the patient at a

particular time (Campbell et al., 2016). For Campbell et al., (2016), though circumstances of dilemma and uncertainty do not prevent the nurse from acting, it makes it difficult for the nurse to act in the best interest of the patient. The point is whether nurses do and perhaps should experience moral distress in these circumstances.

Table 1: Summary of definitions of moral distress

Author and year of publication	Definition of moral distress	Description of definitions	Critique
Andrew Jameton (1984 pg. 6)	Moral distress is "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action"	Jameton's definition highlighted - institutional constraints (hospital policies, organizational structure, inadequate resources) - moral judgement Jameton distinguished between moral distress, dilemma, and uncertainty	The challenge here is that the definition of dilemma is unclear as described by Jameton, for a nurse can be in dilemma and still experience some form of moral distress. With the limited nature of Jameton's definition its usage for my study may not elucidate the experience of moral distress in nurses in Ghana. Further, the exact cause of moral distress is in-built in the definition given by Jameton this makes it problematic as there can be other causes of moral distress for nurses.
Andrew Jameton (1993 pg. 544)	Initial distress 'involves the feeling of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is 'the distress that people feel when they do not act upon their initial distress'	Jameton explained reactive moral distress and initial moral distress to clarify his definition of moral distress	Jameton's discussion of reactive and initial moral distress throws more light on the impact of moral distress on nurses, in that appropriate support measures can be identified to assist nurses build moral resilience in any of the forms of moral distress.
Wilkinson (1987 pg. 16)	Moral distress is a "negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision".	Wilkinson agrees with Jameton's definition of constraints and was the first to include the psychological effects of moral distress experienced by nurses in a definition	Although implicated in Jameton's definition, emotional feelings of the nurse were not stated in Jameton's definition, making Wilkinson, the first to integrate the psychological effects of moral distress into a definition. This brought further clarity to how nurses feel when they experience moral distress. However, Wilkinson also suggested that moral distress cannot include a state of uncertainty.
Corley (1995 pg. 280)	Moral distress is a painful feeling and/ or psychological disequilibrium caused by a situation in which (1) one believes one	Corley acknowledges Jameton's version of moral distress as a psychological effect experienced when one believes in a moral	Stating the specific causes of moral distress in the definition makes it problematic to examine moral distress. The critique here

	knows the moral action to take and (2) that one cannot carry out that action because of (3) institutionalized obstacles such as lack of time, lack of supervisory support, medical power, institutional policy, or legal limits'.	issue, but institutional constraints prevent the desired moral action from being executed.	is that moral distress can be experienced from factors inherent in the nurse or the patient and family members.
Hanna (2004)	Moral distress is an act of interior aversion in response to a perceived harm to a known good (moral end) and involving a perceived violation of the person.	Hanna argues for a broader definition of moral distress to encompass harm to a known good understood as a moral end and violation of the person	This definition is complex and might make the study of moral distress in Ghana where the concept was not originally conceptualised impractical because of contextual difference.
McCarthy (2013 pg. 1)	Moral distress is an umbrella concept that describes the psychological, emotional and physiological suffering that may be experienced when we act in ways that are inconsistent with deeply held ethical values, principles or moral commitments'	McCarthy describes moral distress as a broad term that comprises of a wide range of difficulties that prevents nurses from caring for patients	McCarthy's definition is in practical in a Ghanaian setting where moral distress was not conceptualized. However, its use for future studies is encouraged because of the inclusiveness of the definition.
Fourie (2015 pg. 92)	'Moral distress is a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both'.	For Fourie, moral distress is a psychological effect experienced by nurses in response to a wide range of moral challenges.	Although Fourie, includes moral constraints and moral conflict as causing moral distress, nurses may encounter other moral events that may led to moral distress which are not necessarily because of conflict nor constraints
Campbell et al (2015 pg. 2-9)	Moral distress is 'One or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable'.	Campbell et al., (2015) argued moral distress is experienced in numerous morally challenging situations. For distress is seen in uncertainty and in situations of dilemma	Like Fourie's definition, Campbell et al argue that moral dilemma and uncertainty can lead to moral distress.
Morley et al., (2017 pg. 16)	Moral distress is the combination of (1) the experience of a moral event, (2) the experience of 'psychological distress' and (3) a direct causal relation between (1) and (2) which are necessary and sufficient conditions for moral distress.	Finally, for the broadest definition of moral distress, Morley et al., argue that a combination of factors needs to be present for the experience of moral distress to occur.	This broad definition may support the study of moral distress in context where moral distress was not originally conceptualized such as Ghana because of the inclusive nature of the definition. For Morley et al, nurses may experience moral distress when they encounter any moral event (moral dilemma, moral conflict, moral difficulty, moral challenge) that makes them distressed.

3.5 The broadest definition of moral distress

Morley et al., (2017) provide the broadest definition of moral distress based on necessary and sufficient conditions for moral distress. In a narrative synthesis, Morley et al., (2017 pg. 16) defined moral distress as a combination of (a) the experience of a moral event, (b) the experience of psychological distress and (c) a direct causal relationship between (a) and (b). For Morley et al., (2019 pg. 187) a moral event could be 'moral tension, moral conflict, moral dilemma, moral uncertainty or moral constraint', the experience of psychological distress such as frustration, anger, blame, shame, misery, helplessness linked with distress and a link between a moral event and emotional experience. Morley et al., (2017 pg. 16) suggest a common sense understanding of the term 'moral distress', 'it seems obvious that any distress causally associated with a 'moral event', such as a moral dilemma or moral uncertainty is, ipso facto, moral distress'. A broader definition seems more inclusive and focused on the individual rather than 'only constraints' and so more useful in studying moral distress in nurses in Ghana. Even though factors such as traditional beliefs, lack of financial resources and lack of nurses have been discussed as contributing to the challenges facing the health care system in Ghana (chapters 1 and 2), it is not known if nurses' experience of moral distress is caused solely by these constraints. Therefore, Morley's definition is more inclusive and practical making it appropriate for exploring moral distress in nurses in Ghana.

3.6 The definition of moral distress in the context of this study

There have been difficulties encountered in arriving at the choice of an appropriate definition of moral distress for my study. This is because of the numerous definitions offered by nursing scholars and theorists. Jameton (1984) was the first to define the term moral distress, and many theorists and researchers have subsequently contributed to its conceptual development, however it still seemed limited as a definition to explore moral distress in nurses in Ghana because of its limited focus on institutional constraints. As a result, Morley et al's., (2017)

definition of moral distress was used in the current study. This decision was based on several factors.

Nurses in developing economies feel frustrated, angry, hopeless, and helpless when they encounter moral challenges regarding patient care (Fournier et al., 2007; Harrowing and Mill, 2010; Maluwa et al., 2012). According to Morley et al., (2017) the psychological or emotional distress nurses experience when unable to carry-out what is deemed best for the patients is a necessary circumstance of moral distress, and so Morley et al., definition may be more useful in a Ghanaian context.

Morley et al.,'s (2017) definition is more inclusive in the sense that, for a nurse to experience moral distress it must be linked to a moral incident which seems to resonate with nursing practice as a moral act (Wilkinson, 1987; Corley, 2002). Clinical nurses often make and carry out moral decisions in the management of patients because of their involvement with the care of these patients (Wilkinson, 1987). As illustrated by Wilkinson, (1987), the nursing care process by itself is guided by making various decisions regarding care interventions needed for patients. Nurses practice comprehensive nursing meaning the physical, the physiological and social aspects of patients are managed by nurses requiring that they make moral decisions (Wilkinson, 1987). This means a variety of moral difficulties may be encountered by nurses in Ghana, predisposing them to the experience of moral distress in NICU and paediatric wards.

Since the experience of moral distress has not been explored in nurses in Northern Ghana, a practical starting point is to utilize a broad definition of moral distress that encompasses a wide range of antecedents that may capture the type and kind of moral distress that might be experienced by nurses in Ghana. The definition is sufficient for research purposes, grounded in nurses' professional roles and concerns nurses psychological state and flexible to numerous viewpoints on given morally difficult circumstances.

3.7 Conclusion

Eight definitions of moral distress have been discussed, however there is no consensus among them as to its precise meaning. If we are to understand and investigate moral distress in nurses in developing economies, it is important to explore it in context to gain an in-depth perspective of it. Also, if moral distress is not clearly defined it may be misunderstood and go unrecognised by nurses despite its impact on health care delivery (Hanna, 2004). The practical application of the chosen definition of moral distress has been used to investigate the experience of moral distress in nurses in clinical practice (Morley et al., 2019). To study moral difficulties in nurses in developing economies, it is imperative to use a broad definition which encompasses a variety of moral events encountered by nurses working in NICU and paediatric wards. This approach is likely to capture many moral encounters of nurses as it relates to developing economies.

The next chapter, Chapter 4, describes an integrated literature review of studies of moral distress in nurses in developing economies.

Chapter 4: Integrative literature review on moral distress in developing economies

4.1 Introduction

Chapter 4 presents an integrative literature review which examines the evidence and identifies gaps in the current knowledge base about the experience of moral distress in nurses in developing economies. This chapter is made up of five sections. The first section gives an overview of developing economies to set the review in context, followed by the formulation of the review question. Next, the review method is described, and a report of the results is presented in themes. The findings are then discussed, and a conclusion presented.

4. 2 Overview of developing economies

Since the concept of moral distress was introduced in 1984, most studies in nurses have been carried out in developed economies such as North America, the United Kingdom, Canada, Europe, and Australia (Hanna, 2004; Prentice et al., 2016; Prompahakul and Epstein, 2020). As a result, the nature of the experience of moral distress has been reported from the perspective of nurses in developed economies (Prompahakul and Epstein, 2020). The findings of these studies may be limited in representing the experience of moral distress of nurses in developing economies. A practical concern is that moral distress is a 'western concept' and may not be prevalent in nurses in developing economies. In view of my intention to study moral distress in nurses in Ghana, a developing economy, a useful starting point was to shed more light on the experience of moral distress in nurses in the cultural and economic context of developing economies as reported in the literature. As a result, an integrative literature review was carried out to ascertain whether nurses experience moral distress, what causes it, its impact on nurses and whether nurses in developing economies employ coping mechanisms to deal with the effects of moral distress. An agreed definition of a developing economy has been difficult to identify, and so the United Nations World Economic Situation report on classification of

economies was used (United Nations, 2020). This report categorizes economies in the world into three general classes. These are developed economies, economies in transition and developing economies. The categorization is based on critical analysis of a number of criteria such as the per capita gross national income (GNI), geographical region and gross domestic product (GDP) of each economy.

Developing economies are countries where citizens have a lower standard of living and industries are less developed compared to other countries (United Nations, 2020). Generally, developing economies have low per capita income, high population growth rates, high rates of unemployment among their citizens, mainly depend on the agricultural sector and rely mainly on exports of primary products (goods that are obtainable from exporting raw materials without manufacturing) for income, (United Nations, 2020). Table 2 shows developing economies by geographical region.

Table 2: List of developing economies by region (United Nations, 2020).

North Africa	Southern Africa	East Africa	West Africa	Central Africa	East Asia	South Asia	Western Asia	Caribbean	Mexico and Central America	South America
Algeria Egypt Libya Mauritania Morocco Sudan Tunisia	Angola Botswana Lesotho Malawi Mauritius Mozambique Namibia South Africa Zambia Zimbabwe	Burundi Comoros Democratic Republic of the Congo Djibouti Eritrea Ethiopia Kenya Madagascar Rwanda Somalia Uganda United Republic of Tanzania	Benin Burkina Faso Cabo Verde Côte d'Ivoire Gambia **Ghana** Guinea Guinea-Bissau Liberia Mali Niger Nigeria Senegal Sierra Leone Togo	Cameroon Central African Republic Chad Congo Equatorial Guinea Gabon Sao Tome and Principe	Brunei Darussalam China Hong Kong Indonesia Malaysia Myanmar Papua New Guinea Philippines Republic of Korea Singapore Taiwan Province of China Thailand Viet Nam	Bangladesh India Iran (Islamic Republic of) Nepal Pakistan Sri Lanka	Bahrain Iraq Israel Jordan Kuwait Lebanon Oman Qatar Saudi Arabia Syrian Arab Republic Turkey United Arab Emirates Yemen	Barbados Cuba Dominican Republic Guyana Haiti Jamaica Trinidad and Tobago	Costa Rica El Salvador Guatemala Honduras Mexico Nicaragua Panama	Argentina Bolivia (Pluri-national State of Bolivia) Brazil Chile Colombia Ecuador Paraguay Peru Uruguay Venezuela (Bolivarian Republic of)

These characteristics can influence the experiences of moral distress in nurses in developing economies (Fournier et al, 2007; Maluwa et al., 2012). Healthcare systems in these types of economies face financial difficulties and lack the human resources needed to meet the health care needs of their citizens (Haghighinezhad et al., 2019). The number of nurses per 10,000 of the population in developed economies is significantly higher than the number of nurses in developing economies such as Iran, Malawi, South Africa, Israel, Uganda, and Ghana (WHO, 2016). This can have an impact on the health care system and influence the experience of moral distress in nurses in such economies (Prompahakul and Epstein, 2020).

The studies reviewed were carried out before Morley et al.,'s article was published. However, the breadth of Morley et al., definition meant this did not affect the inclusiveness of the review, indeed it helped ensure a suitably wide range of literature which was included in the integrative literature review of the experience of moral distress.

4. 3 Review question

The review question was formulated using the Sample, Phenomenon of Interest, Design, Evaluation and Research type (SPIDER) criteria. The SPIDER framework is a mnemonic used in evidence-based medicine to frame and answer clinical or health care related questions (Cooke et al., 2012; Methley et al., 2014). The SPIDER framework is also used to develop literature search questions in systematic and integrative reviews (Cooke et al., 2012; Methley et al., 2014). The SPIDER framework was used for this review because it provided a clear and systematic procedure for identifying relevant articles for this review.

Because the SPIDER tool was used mainly to search for qualitative and mixed method studies, I searched the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (Medline), Cochrane and Psych INFO using key words (quantitative studies, nurses, effects of moral distress). Table 3 below shows the development of the review question using the SPIDER criteria.

Table 3: Development of review question using the SPIDER criteria

Framework item	Review question
Sample	Nurses
Phenomenon of Interest (PI)	Moral distress in nurses in developing economies
Design	Surveys
Evaluation	Perception, experiences, sources, outcomes of moral distress
Research Type	Qualitative, mixed methods

The integrative literature review question was: In what ways do nurses in developing economies perceive and experience moral distress in clinical care settings?

4.4 Methods

4. 4. 1 Design

A review of literature allows for a summary and synthesis of concepts of current knowledge in specific areas to be produced. Grant and Booth (2009) examined 14 types of review commonly used in health and health related research: literature review, critical review, mapping, meta-analysis, mixed studies, overview, qualitative systematic review, scoping review, rapid review, state of the art review, systematic review, systematized review, and umbrella review. They found the type of review selected depended on the nature of the study being conducted and availability of the literature (Grant and Booth, 2009).

A literature review, offers an analysis of up-to-date evidence, allowing for a varied number of issues to be reviewed to ensure inclusion of the current evidence (National Centre for Biotechnology Information, 2005). The literature review approach allows for strengthening earlier studies, avoiding repetition and for recognising gaps in the literature (Grant and Booth, 2009). As a result, an integrative literature review was conducted to identify case studies, observational studies, and practice applications to determine the state of the experience of moral distress in nurses in developing economies.

Whittemore and Knafl's (2005) integrative literature review method was used to organise and conduct this literature review. An integrative literature review is an approach that involves examination of a broad range of empirical, theoretical, and other related literature to generate a complete understanding of a phenomenon (Whittemore and Knafl, 2005). This method was chosen because of the precise description of the integrative review process and appropriateness of this process to the phenomenon under study. The experience of moral distress in nurses in developing economies is relatively under researched and so the evidence base was likely to be limited, therefore a more inclusive and broad-based approach was needed. Moreover, compared to systematic reviews, this approach allows for a combination of varied study methodologies to be included which contributes to the rigour of a review (Whittemore and Knafl, 2005; Baxter et al., 2018; Knafl and Whittemore, 2017). Although a scoping review could have been used for this review, there are concerns about its rigour and potential for bias (Grant and Booth, 2009). For instance, quality appraisal is not generally a feature of scoping reviews (Grant and Booth, 2009). An integrative approach was selected because it was more likely to produce a comprehensive review of the experience of moral distress in nurses in developing economies. Although the Whittemore and Knafl (2005) framework allows for concurrent inclusion of varied methods such as commentaries, opinion pieces and letters, for this review only primary and secondary papers were included. Primary research papers generally report first-hand data and information from participants and are usually peer reviewed and secondary research papers provide already used data (primary data) as their basis of information such as reviews, these were included. Although the literature on the experience of moral distress was limited, 16 articles were identified. Opinion pieces, commentaries, and letters were not utilized because of the need to evaluate empirical evidence on the current state of moral distress in developing economies, that may portray the true picture of the experience

in nurses. However, opinion pieces, commentaries, and letters may be used to provide another view on moral distress in a different study.

In this review, the five-stage integrative review process developed by Whittemore and Knafl (2005) was followed. This involved the articulation of the problem, completion of a well-defined literature search, evaluation of the quality of papers, analysis of the data, and presentation of conclusions (Whittemore and Knafl 2005). This was necessary because it allowed for a detailed narrative approach to synthesis of the evidence which was most suitable for the objective of the review.

4.4.2 Literature search process

Inclusion criteria were primary and secondary research, qualitative, quantitative, and mixed method empirical studies that explored nurses' experiences of moral distress, sources of moral distress and outcomes associated with moral distress in nurses in developing economies. Secondary studies were used because an initial scoping of the literature on moral distress in nurses in developing economies revealed a limited number of empirical studies hence its inclusion in the review. With the limited evidence of moral distress in nurses in developing economies no date range was set for the search. Studies of moral distress in health care professionals that included nurses were included, however only data from registered nurses were analysed. Studies had to be written in English.

The following were excluded from the review, published and unpublished studies conducted in developed economies such as the United Kingdom, the United States, Belgium, Canada, New Zealand, and other European economies. Articles not written in English. Papers that did not contain empirical data such as editorials, commentaries, letters, and opinion pieces were excluded.

Four academic electronic databases were searched, CINAHL, Medical Literature Analysis and Retrieval System Online (Medline), Cochrane and Psych INFO to identify existing studies. These data bases were chosen because they were the most appropriate for studies related to biomedicine and nursing (Bahaadinbeigy et al., 2010).

Search terms included associated MeSH terms (Medline), and Boolean operators were used. An information specialist was consulted to ensure the search was comprehensive. Since the aim of the review was to identify and review empirical studies of the experience of moral distress in nurses in developing economies, the key words, nurses* ethic* moral * health care professionals* AND (moral distress OR moral stress) AND less developed countries* developing countries* developing economies were used based on the review question. Reference lists of papers were scanned for additional studies that were not captured using the data bases. Truncation symbols were varied as "nurs*" and "ethic*" depending on the data base used.

4.4.3 Critical appraisal method

Hawker et al., (2002), produced an instrument for appraisal of methodologically heterogeneous studies which was used to assess the selected papers for methodological rigour consistent with integrative literature reviews. This tool was used because of its detailed methods and modes of critical analysis of extracted articles needed for the review. It has nine elements that are scored for methodological rigour. The scoring elements are abstract and title, introduction and aims, method, sampling, data analysis, ethics and bias, results, transferability or generalizability, implications, and usefulness of the articles. The rating for each of the nine elements are 'good' - 4 points, 'fair' - 3 'poor' - 2 and 'very poor' - 1 point, permitting a possible maximum score of 36.

The selected articles were scored for methodological rigour so that they could be graded according to the reliability of the results (Hawker et al., 2002). Articles that met the criteria for inclusion at the assessment stage were included in the review. The figure for inclusion of papers were 24 - 36. Table 5 below shows the methodological rigour of the included articles.

4.4.4 Data abstraction and synthesis

Data extracted were location of the study (country), objectives, methodology/design, participants, sample size, measurement variables, data analysis criteria and main results (Table 6). The findings reported in the papers were analysed using Braun and Clarke's, (2006) thematic analysis framework. This analysis process was utilized because it provided a theoretically precise method for examining the results of the studies included in the review. A narrative synthesis of the reviewed articles is presented in the findings and discussion section of this chapter.

4.5 Results

4.5.1 Literature search outcome

The electronic search was conducted between November 2018 and March 2019. The screening process was adapted, for an integrative review, from the procedure outlined in the Preferred Reporting Items for Systematic Reviews and Meta- Analyses (PRISMA) statement for reporting of systematic reviews (Moher et al., 2015) (Figure 1). The database search identified 351 publications. Three additional articles were identified through hand searching of reference lists in retrieved articles. After removal of 208 duplicates, a total of 146 publications were screened. One hundred and thirty publications that did not meet the inclusion criteria were excluded based on abstract screening. Of the 130 publications, 106 were studies carried out in developed countries; 7 involved moral distress in other professionals, editorials, and

commentaries. Eventually, a total of sixteen studies which examined moral distress in developing economies was included in the review: 6 qualitative studies, 9 quantitative studies and 1 mixed methods study (Table 6).

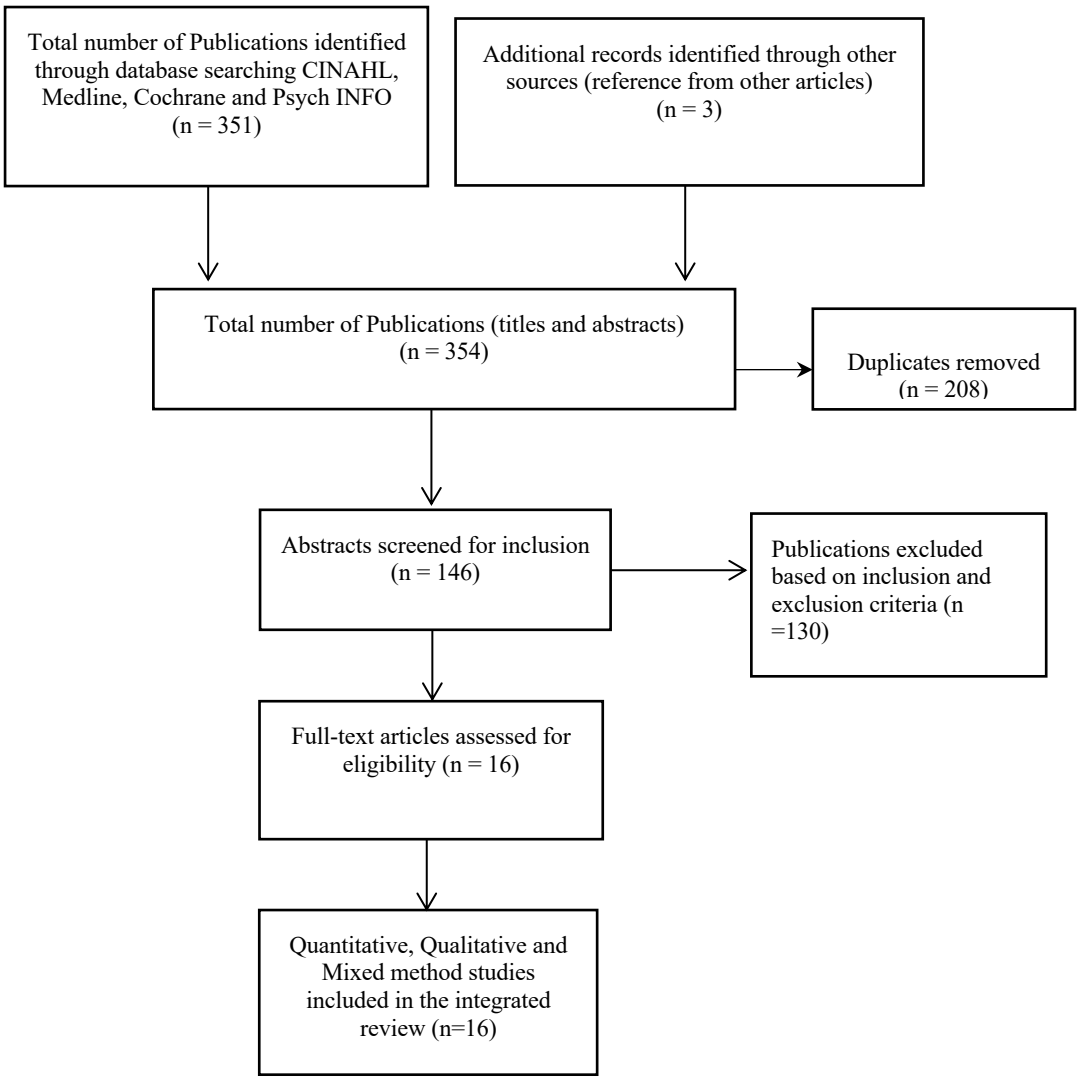


Figure 1: PRISMA flow diagram (Adapted from Moher et al., 2015)

4. 6 Summary of study characteristics

4. 6. 1 Age, gender, and work experience of participants

In the articles reviewed demographic characteristics such as age, gender and work experience were linked with the experience of moral distress. Five studies reported a substantial positive correlation ($P = 0.015 – P < 0.05$) between moral distress, age, and work experience (Shoorideh

et al., 2015; Borhani et al., 2015; Asayesh et al., 2018; Robaee et al., 2018; Almutairi et al., 2019), indicating that older and experienced nurses were more inclined to have higher levels of moral distress than younger and inexperienced nurses. However, Borhani et al., (2017) found that younger nurses experienced higher intensity and more frequent levels of moral distress than older nurses, showing differences in moral distress for different age groups. Although the relationship to age and experience is not conclusively proven.

Overall, both females and males experienced similar levels and frequency of moral distress. However, Shoorideh et al., (2015) reported that female nurses experienced moral distress arising from error regarding the care of patients more than their male counterparts.

4. 6. 2 Geographical distributions

Two of the studies were of nurses in Uganda (Fournier et al., 2007; Harrowing and Mill, 2010), one of nurses in Malawi (Maluwa et al., 2012) and one study of nurses in South Africa (Langley et al., 2015). Seven of the studies were carried out in Iran, this is probably because a modified moral distress scale has been developed to measure moral distress in nurses in Iran (Shoorideh et al., 2012). This scale assesses 24 causes of moral distress in Iranian ICU nurses. This has enhanced the understanding of the experience of moral distress in ICU nurses in Iran contributing to the increased number of studies. There were also two studies from Israel, and one study each from Tanzania, India, and Saudi Arabia.

4.6.3 Setting and professional distribution

All 16 articles reported studies of moral distress in nurses working in developing economies, however, 2 publications included other health care professionals such as medical practitioners (LeBaron et al., 2014; Almutairi et al, 2019). All publications (n = 16) were related to clinical care settings, such as general wards, paediatric wards, oncology wards, critical care, intensive care units (ICU), NICU and other specialized units such as coronary care units. Many of the studies were undertaken in more than 1 clinical care setting in specific hospitals, hence the

increased number of clinical settings. Table 4 lists the clinical settings where the studies were carried out.

Table 4: Clinical settings where studies were carried out

No.	Type of ward	Number of Articles
1.	Adult wards	6
2.	Intensive care units (ICU)	7
3.	Paediatric wards	2
4.	NICU	1
5.	Others specialized units (coronary care, oncology ward, dialysis unit)	3

4.6.4 Methodological quality of the studies reviewed

Sixteen included articles were of good to fair quality as seen in table 5 below. This was based on the Hawker et al., (2002) framework for scoring articles. Twelve of the studies (Borhani et al., 2015; Maluwa et al., 2012; DeKeyser and Berkovitz, 2012; Shoorideh et al, 2015; Fournier et al, 2007; Asayesh et al., 2018; Robaee et al., 2018; Almutairi et al, 2019; Langley et al, 2015; Harrowing & Mill, 2010; Borhani et al., 2017; Häggström et al, 2008) provided sufficient information concerning recruitment and sampling, however, the sample size calculation (for quantitative studies), target population, and response rates were not made clear. All studies explained their analytic approaches, study results and discussed findings in connection with the pertinent literature. In one of the studies reviewed (Maluwa et al., 2012), all study participants were females this is probably because most nurses are females (Magar et al., 2016; Boniol et al., 2019).

Table 5: Methodological rigour of articles

Methodological rigour based on Hawker et al., (2002)	No. of articles classified in each section
Good: 30 – 36	14
Fair: 24 -29	2

4. 6. 5 Measurement of moral distress

All nine quantitative articles used various scales to measure moral distress in nurses in developing economies. Three studies (Almutairi et al., 2019; Borhani et al., 2015; Borhani, 2017) used Corley's modified Moral Distress Scale-Revised (MDS-R) (Corley et al., 2001) to measure the prevalence of moral distress among nurses in Saudi Arabia and Iran. Three studies (Shoorideh et al., 2015; Robaee et al., 2018; Haghighinezhad et al., 2019) measured nurses' moral distress using an Iranian ICU Nurses' Moral Distress Scale (IMDS) which was developed by Shorideh et al., (2012) for the Iranian culture based on Corley's moral distress scale and Jameton's theory of moral distress. Another study (Ganz et al., 2015) investigated moral distress among middle level nurse managers using an Ethical Dilemmas Nursing -Middle Manager (EDN-MN) Questionnaire.

Lutzen's Modified Moral Sensitivity Questionnaire (MMSQ) and Corley's Moral Distress Scale (MDS) were used in combination by Borhani et al., (2015). Haghighinezhad et al., (2019) utilized IMDS and Organisational Justice Questionnaire (developed by Niehoff and Moorman, 1993) to measure moral sensitivity, moral distress, and Perceived Organisational Justice in Iranian intensive care nurses. Further, Asayesh et al., (2018) used a Futile Care Perception Questionnaire developed by Mohammadi and Roshanzadeh (2015) and Jameton's theory (1984) of moral distress to investigate moral distress in nurses. Research to date has measured moral distress in different ways which has implications for understanding what it is and how it is experienced. The question as to whether these tools adequately elucidate the experience of moral distress in nurses is problematic, for it may not adequately capture the nature of moral distress in nurses in developing economies.

In all 9 quantitative studies reliability was claimed based on a Cronbach's alpha coefficient greater than 0.80. All 6 qualitative studies used in-depth individual interviews and or focus

group discussions for data collection. The only mixed method study utilized both focus group discussions and questionnaires to explore the experience of moral distress in nurses

Table 6: Summary of studies included in the integrative review

No.	Author(s) and Year of Publication	Country of Study	No. of Participants, type of participant	Measurement Variables	Methods of Data collection	Research design	Data Analysis Criteria	Findings of Study
1.	Ganz et al., 2015	Israel	133 Middle nurse managers	Ethical dilemmas Moral Distress	The Ethical Dilemmas in Nursing–Middle Manager Questionnaire and a personal characteristics questionnaire	Cross-sectional approach	Pearson's product–moment correlations or analysis of variance	- Participants reported low to moderate levels of frequency and intensity of ethical dilemmas and moral distress. - Highest scores were seen in administrative dilemmas
2.	DeKeyser and Berkovitz., 2012	Israel	119 Nurses	Moral Distress	Ethical Dilemmas in Nursing and Quality of Nursing Care questionnaires	Descriptive, cross-sectional study	Descriptive statistics were used to describe the sample and the frequency data of the questionnaires	- Nurses tended to be satisfied with their level of quality of care. - Increased frequency of ethical dilemmas was associated with aspects of perceived quality of care.
3.	Almutairi et al., 2019	Saudi Arabia	342 Participants 239 nurses/staff physicians 103 fellows' consultants	Moral Distress	21-item Moral Distress Scale	Cross-sectional approach	Bi-variate analyses, and logistic regression.	- 24.3% of respondents experienced severe forms of moral distress, while 75.7% reported mild form of moral distress. - Age of participants was noted to be a significant factor; the experience of moral distress was notably higher in those younger than 37 years compared to participants 37 years and older - Less than half of the participants (137, 42.8%) revealed their willingness to leave their jobs. - There was a connection between severe moral distress and leaving the career
4.	Shoorideh et al., 2015	Iran	159 Nurses	Correlation between Moral Distress, Burnout and Anticipated turnover	ICU Nurses' Moral Distress Scale,'' ''Copenhagen Burnout Inventory'' and ''Hinshaw and Atwood Turnover Scale.	Descriptive-correlation approach	Descriptive statistics	- A positive statistical correlation between ICU nurses' age, their work experience and moral distress - No link between gender, marriage status, educational degree and work shift and moral distress.
5	Shorideh et al., 2012	Iran	28 Clinical Nurses, 3 nurse educators	Moral Distress	Semi structured, in-depth interviews	Qualitative approach	Content analysis	- The causes of moral distress for participants were institutional barriers and constraints, communication problems, futile actions, malpractice, and medical/care errors, inappropriate responsibilities, resources, and competencies.

6	Borhani et al., 2015	Iran	300 Nurses	Moral distress and perception of futile care in intensive care nurses	Corley's 21-item questionnaire and a researcher-made 17-item questionnaire on futile care	Descriptive-analytical Research	Descriptive statistics	- A positive link was seen between moral distress and futile care
7	Borhani., 2017	Iran	153 Nurses	Moral sensitivity Moral Distress	Lutzen's moral sensitivity questionnaire and Corley Moral Distress Questionnaire were used to gather data	Descriptive-Correlation Research	Descriptive statistics	- Results showed a moderate level of moral sensitivity. - Participants also experienced a moderate level of moral distress
8	Haghighinezhad et al., 2019	Iran	284 Nurses	Relationship between Perceived Organizational Justice and Moral Distress in intensive care unit nurses	Organisational Justice Questionnaires, ICU Nurses' Moral Distress Scale	Descriptive-Correlational Research	Descriptive statistics	- A statistically significant negative relationship between the total perceived organizational justice and the total moral distress. There was no link found between distributive justice and dimensions of moral distress.
9.	Robaee et al., 2018	Iran	120 Nurses	Perceived organizational support and moral distress among nurses	Survey of Perceived Organisational Support, and Iranian ICU Nurses' Moral Distress Scale	Correlational-descriptive study	Descriptive statistics	- The mean for perceived organizational support was low. - The mean for experience of moral distress showed a high level of moral distress. - Statistical analysis revealed no notable connection between perceived organizational support and moral distress
10.	Asayesh et al., 2018	Iran	117 Nurses	Relationship between futile care perception and Moral Distress	Futile Care Perception Questionnaires, Jameton's Moral Distress Questionnaires	Correlational-descriptive study	Descriptive statistics and univariate regression tests.	- ICU nurses' perception of futile care and work experience increases their moral distress - The experience of moral distress notably increased among participants
11.	Langley et al., 2015	South Africa	100 Nurses	Moral Distress	An exploratory, descriptive design was used. A short survey/interview guide was administered to registered and enrolled nurses	Exploratory descriptive approach and Qualitative approach (Mixed method approach)	Content Analysis.	- Findings revealed that participants experienced moral distress as a result of collegial incompetence or inexperience, resource constraints. end-of-life issues. lack of consultation, communication and negotiation; and support.
12	LeBaron et al., 2014	India	37 Nurses 22 other providers	Moral Distress	Semi-structured interviews and field observations	Ethnographic approach	Thematic analysis	- The experience of moral distress resulted from futile care, administrative hurdles, interdisciplinary conflicts, patient suffering, and thwarted advocacy.
13	Häggström et al., 2008	Tanzania	29 Nurses	Ethical dilemmas Workplace distress	Data collected from written responses to open questions	Phenomenological-hermeneutic approach	Structural analysis	- Participants in Tanzania revealed that the anguish of moral distress was a result of workplace distress: ethical dilemmas, trying to maintain good

								quality nursing care, lack of respect, appreciation and influence, and a heavy workload.
14	Harrowing and Mill, 2010	Uganda	24 Nurses	Moral Distress	Interviews, observations and focus group discussions	Critical Ethnography	Thematic Analysis	- Participants experienced moral distress as a result of lack of resources that puts patients' wellbeing at risk.
15	Fournier et al., 2007	Uganda	12 Nurses	Moral Distress Nurse caring for individuals with HIV illness	In-depth interviews, focus groups and photo voice were used to collect the data	Participatory Action Research	Analysis as described by Miles and Huberman (1994).	- Sources of moral distress were challenges with participants daily care, poverty, insufficient resources and lack of ongoing education
16	Maluwa et al., 2012	Malawi	20 Nurses	Moral Distress	In-depth interviews using a semi-structured interview	Qualitative approach	Thematic analysis	- Moral distress resulted from inadequate resources and lack of respect from patients, guardians, peers and management.

4. 7 Findings- principal factors contributing to moral distress in nurses in developing economies

Braun and Clarke's (2006) approach to thematic analysis was used to analyse both qualitative and mixed method articles, because it provided a clear procedure for analysing data. This involved six phases, familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining, and naming themes and report writing. All identified papers were read thoroughly to gain a comprehensive understanding of the main issues, a search of themes began after initial codes were generated. The codes were sorted into potential themes alongside supporting quotations, and subthemes developed among the reviewed articles. Finally, themes were then identified, and a report written on each theme. Table 7 shows an example of codes and themes arrived at in the data analysis process. The main themes that emerged were nurses' experience of moral distress, inadequate material resources, inadequate human resources, end of life challenges, cultural and religious beliefs as a source of moral distress perceived inaction of colleagues, impact of moral distress on nurses, and coping mechanisms used by nurses.

Sections of quantitative studies were also analysed based on the frequency and intensity of moral distress in nurses (DeKeyser and Berkovitz, 2012; LeBaron et al., 2014; Ganz et al., 2015; Shoorideh et al., 2015; Borhani et al., 2015; Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Haghighinezhad et al., 2019; Almutairi et al., 2019).

Table 7: Examples of codes and themes in the data analysis process.

Codes	**Linkages with codes**	**Sub themes**	**Main theme**
Sadness, hopelessness, anger, feels bad, worries (felt by participants)	Effects on personal emotions	Psychological effects of moral distress	Impact of moral distress
Headaches, loss of appetite(participants)	Impact on the physical well-being of participants	Physical effects of moral distress on the participants	

4. 7 .1 Nurses' experience of moral distress

All 16 studies (Fournier et al., 2007; Häggström et al., 2008; Harrowing and Mill, 2010; Maluwa et al., 2012; Shorideh et al, 2012; DeKeyser and Berkovitz, 2012; Shoorideh et al., 2015; LeBaron et al., 2014; Langley et al., 2015; Borhani et al., 2015; Ganz et al., 2015: Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Almutairi et al., 2019; Haghighinezhad et al., 2019) explored moral distress in nurses in developing economies. Though the term 'moral distress' was not well-known among nurses in developing economies, all participating nurses in Uganda, Malawi, South Africa, India, Israel, Saudi Arabia and Iran reported experiencing negative feelings associated with being unable to provide the care they believed patients needed. The term moral distress was not familiar to nurses in Malawi until the meaning of moral distress was explained (Maluwa et al., 2012). Once the understanding was clear they recounted experiencing feelings that could be classified as moral distress daily (Maluwa et al., 2012). Nurses' experiences of moral distress mostly related to issues of their 'suffering' (Harrowing and Mill, 2010). The term 'suffering' was commonly used by the nurses in Uganda to describe not only their own personal suffering (moral distress) but the suffering of their patients, of the community, and of the nursing profession (Fournier et al., 2007; Harrowing and Mill, 2010).

A participant in a study from South Africa recounted an experience of moral distress.

> *'I got back ... his condition had deteriorated, blocked ET (endotracheal tube) tube, SATS (statistics) less than 80, hypotensive, bradycardia. I was frightened and depressed. His safety was compromised because of staff shortage. Afterward I couldn't concentrate' (Langley et al., 2015 pg. 38).*

The level of nurses' experience of moral distress varied from moderate (Borhani, 2017; Haghighinezhad et al., 2019) to high (Maluwa et al., 2012; Fournier et al., 2007; Langley et al, 2015; Häggström et al, 2008; Harrowing and Mill, 2010) to severe (Shoorideh et al., 2015: Asayesh et al., 2018; Robaee et al., 2018; Almutairi et al, 2019). The experience of moral

distress by critical care and palliative care nurses were similar (LeBaron et al., 2014; Borhani et al., 2015; Asayesh et al., 2018).

4. 7. 2 Inadequate human resources

The most common source of moral distress identified was inadequate staffing (i.e., in terms of number and skill level) resulting in insufficient patient care (Fournier et al., 2007; Häggström et al., 2008; DeKeyer and Berkovitz, 2012; Shorideh et al., 2012; Maluwa et al., 2012; LeBaron et al., 2014; Langley et al., 2015; Borhani et al., 2017). The ratio of nurses to patients was low- for example, nurses in Uganda, stated that 1 nurse cared for 50 patients on a day shift and 1 nurse cared for 100 patients on an evening shift (Fournier et al., 2007). In Malawi, nurses reported that patients often left hospital without receiving care because of the absence of a doctor (Maluwa et al., 2012).

A participant stated:

> *Lack of human resources is a major pressure, leading to fatigue. We have to work on long day and/or evening- night shifts . . . Consecutive shifts reduce our effectiveness . . . it can reduce quality of care . . . it produces burn- out . . . It bothered me . . .' (Shorideh et al., 2012 pg. 473).*

Shortages of nurses led to increased workload. LeBaron et al., (2014) found that heavy workload was the main cause of decreased job fulfilment, and the nurse-patient ratios were unsustainable on some wards, for example in one setting one nurse cared for more than 60 patients (LeBaron et al., 2014). Similarly, DeKeyer and Berkovitz (2012) concluded that the item cited most frequently in their study (with scores of 3 or more on the frequency scale) was inadequate staff (n=91, 76·5% of respondents to that item).

4. 7. 3 Inadequate material resources

Another common source of moral distress was inadequate material resources. All participants felt distressed and frustrated because of a lack of material resources. Nurses in Uganda reported that due to a lack of basic instruments they were unable to use their professional skills and

knowledge and thus could not meet their professional and ethical standards (Fournier et al., 2007; Harrowing and Mill, 2010). Similarly, Maluwa et al., (2012), Borhani et al., (2017), reported that a lack of basic equipment, materials, and facilities (such as thermometers, drugs, medical supplies, protective equipment, lighting systems, access to blood bank) contributed to nurses' experience of moral distress.

Inadequate materials and equipment meant that some nursing procedures patients needed were not carried out. For example, a lack of protective gloves prevented nurses from providing care for patients with HIV-AIDS (Fournier et al., 2007). In such situations patients were expected to bring their own bed sheets, and any medical supplies (e.g., gloves, gauze) needed for treatment (Fournier et al., 2007). The patients' chances of survival and whether they obtained good care depended on the resources available. Moral dilemmas and workplace distress arose because nurses were concerned about the safety of their patients resulting from a lack of gloves, aprons and masks that could increase the risk of serious infections (Fournier et al., 2007). Nurses were also concerned about their own safety and reported their fears of contaminating themselves in the process of caring without the necessary materials and equipment (Fournier et al., 2007).

Participants shared distressing stories of serious supply shortages, such as blood products for transfusion needed to continue cycles of treatment (LeBaron et al., 2014). A participant in Malawi recounted a story of an experience of moral distress.

> *'Sometimes I fail to check patients' vital signs such as temperature because there are no thermometers or when they are there they are not working. I feel sorry and bad because sometimes you can miss someone who needs attention' (Maluwa et al., 2012 pg. 200).*

Fatal outcomes occurred because of the lack of these resources (LeBaron et al., 2014). In one setting it was reported that some patients could not afford to purchase blood and as a result they had low platelet counts (thrombocytopenia) and they died (LeBaron et al., 2014).

4.7.4 Perceived inaction of medical and nursing staff

Perceived inaction of medical and nursing staff was cited as a cause of moral distress. Langley et al., (2015) in a mixed method study concluded that perceived inaction of medical and nursing staff was a source of moral distress in nurses particularly when it seemed to compromise the safety of patients. This was particularly the case when these staff were part- time nurses and other health care professionals who were considered to have insufficient knowledge or experience of patient care. A participant reported that some medical officers would not evaluate the *'treatment of a confused patient but prescribed sedation (haloperidol) and mechanical restraint'* (Langley et al., 2015 pg. 8). Similarly, nurses in Malawi described feeling morally distressed when colleagues behaved in an unprofessional manner. For instance, a participant stated:

> *'I was alone on night duty at a health center. A clinician was at large, (not available at the ward the time the patient arrived) and a patient came who needed to be reviewed by a clinician. I could not do anything and therefore decided to refer the patient to another hospital. The patient refused because he had no transport money. I felt bad because if the clinician was there, the patient could have been treated' (Maluwa et al., 2012 pg. 201).*

4. 7. 5 End-of-life challenges

End of life care challenges were the focus of some of the studies reviewed. Using univariate regression analysis, Asayesh et al., (2018) concluded that experienced ICU nurses with increased awareness of futile care experience high levels of moral distress ($P = 0.02$). Likewise, LeBaron et al., (2014) reported that administering chemotherapy to patients approaching the end of life was likely to invoke distress in nurses related to futile care ($P = 0.03$, $r = 0.4$). Believing death would follow if chemotherapy were given to mainly frail patients with leukaemia, it was difficult and challenging for nurses to give chemotherapy to patients they perceived could not tolerate the treatment (LeBaron et al., 2014). Nurses' awareness of futility

that, patients suffer and may not survive, irrespective of the care rendered to them was recounted as a distressing part of their work (LeBaron et al., 2014).

Almutairi et al., (2019 pg. 10) in a study which investigated the prevalence of severe moral distress among healthcare providers in Saudi Arabia, found the highest percentage of mean scores on the moral distress scale were "*Carry out medical orders for what I consider to be unnecessary tests and treatments"* and "*Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient*". Even though nurses may not always be right in their beliefs about such matters, they are obliged to set aside their beliefs and consider the wishes of patients and their family members regarding care.

4. 7. 6 Cultural and religious beliefs as a source of moral distress

Religious and cultural beliefs were reported to be a significant source of moral distress in nurses in four of the studies reviewed (Maluwa et al., 2012; Langley et al., 2015; Shorideh et al., 2012; Harrowing and Mill, 2010). Shorideh et al., (2012) reported that in the Iranian Islamic setting, nurses experienced moral distress because of a conflict between their personal values and religious beliefs. For these nurses' cardiopulmonary resuscitation (CPR) may be futile for patients at the end of life perhaps because of its little effect on patients. Nonetheless because of their Islamic belief, they are required to perform CPR even when they know it may be ineffective.

Another study carried out in South Africa by Langley et al, (2015) revealed that there is a culture of maintaining hope among patients and relatives when caring for dying patients, as hope produces an optimistic attitude and that when patients and relatives are informed about their serious conditions they might die quicker. For instance, some participants in the study said the difficulties they experienced in communicating with family members regarding the

imminent death of a patient resulted in moral distress. Patients and relatives still had hope and wanted to receive more positive news. A participant stated:

> *'they've been told by the doctor, but they still come and ask you, miracles do happen so you can't say the patient will die' (Langley et al., 2015 pg. 38).*

4. 7. 7 Impact of moral distress on nurses in developing economies

The review showed an increased interest in the impact of moral distress on nurses in developing economies. All 16 publications reviewed, identified, and discussed the impact of moral distress on nurses (Fournier et al., 2007; Häggström et al., 2008; Harrowing and Mill, 2010; Maluwa et al., 2012; Shorideh et al, 2012; DeKeyser Ganz and Berkovitz, 2012; Shoorideh et al., 2015; LeBaron et al., 2014; Langley et al., 2015; Borhani et al., 2015; Ganz et al., 2015: Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Almutairi et al., 2019; Haghighinezhad et al., 2019). The impact of moral distress was reported to have psychological and physical effects. Nurses felt frustrated, angry, hopeless, and helpless (Fournier et al., 2007; Harrowing and Mill, 2010; Maluwa et al., 2012). In Malawi and Saudi Arabia, nurses experienced grief because of moral distress (Maluwa et al., 2012; Almutairi et al., 2019). Fifteen of twenty participants in a study conducted in Malawi, reported lack of sleep, pain (headache), lack of appetite, and a feeling of sadness when they experienced morally distressing situations on the wards. Further, nurses felt guilty for not being able to provide the needed care to patients and sometimes angry towards patients and family members because of moral distress (Maluwa et al., 2012). The experience affected nurses' personal lives (Maluwa et al., 2012). For instance, Almutairi et al., (2019) concluded that nearly half of the participants 137 (42.8%) in their study reported an intention to leave their jobs because of moral distress. The analysis showed a statistically significant variation between participants linked to their profession classification (P=0.007): 104 (47.9%) nurses/physicians wanted to leave their job due to moral distress compared to 33 (32.0%) medical consultants. Likewise, length of career was significantly linked with the

intention to leave due to moral distress (P<0.008) in nurses and Shoorideh et al., (2015) found that the mean of predicted turnover for intensive care unit nurses was 3.03 ± 0.75. Although nurses wish to leave the clinical setting because of moral distress, they were unable to do so because of levels of unemployment, and low income in many developing economies (Borhani et al., (2015).

4. 7. 8 Coping strategies

Some studies recommended coping techniques to mitigate the experience of moral distress. Various coping mechanisms were utilized by participants, these included discussions with colleagues regarding consensus on patient care, reporting the moral challenge to higher management, sharing moral experiences with colleagues, and ignoring or disregarding morally challenging situations (Fournier et al., 2007; Häggström et al., 2008; Maluwa et al., 2012; Langley et al., 2015; Harrowing and Mill, 2010). A participant reported her experience as follows:

> *'I try as much as possible to discuss the situation with concerned people and higher authorities until the problem is solved' (Maluwa et al., 2012 pg. 202*)

Some nurses were guided by the patient's right to good care, to think positively and hope for a change in the care of patients as a form of coping (Häggström et al., 2008). Dwelling on the positive aspects of the moral situation encountered helped nurses cope with the distress (Häggström et al., 2008).

Further, the review revealed that in times of shortage of nurses and added work, nurses coped by transferring care to patients' family members by giving instructions of how to perform specific nursing care (Fournier et al., 2007). For example, some nurses delegated responsibility for tube feeding a patient to family members (Fournier et al., 2007). Although a perceived coping mechanism for these nurses possibly not a safe one because of family members lack of

knowledge and skill to carry out nursing tasks. This is a challenge because it does not solve the moral difficulty but seems to create another one. Other nurses improvised in situations where there were equipment shortages to help them cope with the moral difficulties (Fournier et al., 2007). For instance, a participant recounted improvising with an intravenous tube to administer oxygen in the absence of an oxygen administering tube.

One other major coping mechanism used by nurses was praying to and seeking forgiveness from God for their inability to render needed care to patients (Maluwa et al., 2012). Prayer gave comfort and gave nurses the strength to continue their nursing care daily (Maluwa et al., 2012; Langley et al., 2015).

Many reported that simply writing down their experiences had helped them slightly manage their emotions (Langley et al., 2015). In Uganda, nurses concentrated on their nursing goals keenly even though they were unable to render the desired care to many patients as required, they felt a sense of motivation with the little care they offer to patients. This helped them cope with moral distress (Harrowing and Mill, 2010). Maluwa et al., (2012) reported that participants' ability to cope with moral distress was related to their years of working experience.

4. 8 Discussion

This integrative review revealed eight themes: nurses experience of moral distress, inadequate material resources, inadequate human resources, end of life challenges, cultural and religious beliefs as a source of moral distress, perceived inactions of medical and nursing staff, impact of moral distress on nurses and coping mechanisms.

Generally, the picture painted in this review is that researchers are beginning to identify the significance of moral distress in nurses in developing economies. There has been a gradual increase in the number of studies published over the last 10 years as seen in the reviewed

articles from 2012 to 2019 (Maluwa et al., 2012; Shorideh et al, 2012; DeKeyser and Berkovitz, 2012; Shoorideh et al., 2015; LeBaron et al., 2014; Langley et al., 2015; Borhani et al., 2015; Ganz et al., 2015: Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Almutairi et al., 2019; Haghighinezhad et al., 2019). Seven of the 16 studies reviewed were conducted in Iran (Shorideh et al, 2012; Shoorideh et al., 2015; Borhani et al., 2015; Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Haghighinezhad et al., 2019), this is probably due to the development of a modified moral distress scale in the last 10 years (Shorideh et al., 2012).

Furthermore, this review has revealed that nurses experienced moral distress whilst working in hospital settings in developing economies. These experiences mainly resulted from difficulties that made it challenging to render care believed to be in the best interest of the patients in a morally perceived environment which is consistent with Morley's et al., (2017) broader definition of moral distress. This suggests the experience of moral distress has no geographical boundaries, as it is also perceived and identified in economies where it was not originally conceptualized (Malawi, Iran, Uganda, Saudi Arabia, and Egypt). Although there are some similarities in the causes of moral distress among nurses in developing and developed economies, there are also distinct differences (Huffman and Rittenmeyer, 2012; Oh and Gastmans, 2015). The experience of moral distress in nurses in developing economies is mainly linked to lack of material resources (basic items and consumables), lack of staff, and issues with traditional beliefs. Lack of items and consumables to work with meant that nurses faced 'practical' and 'fundamental' challenges when providing care for their patients (Maluwa et al., 2012). In developing economies, such as Malawi, South Africa and Uganda, there was a lack of essential medicines, safe water, and basic medical instruments for the care of patients. Similar findings were reported in Iran, participants stated that lack of material resources was because of limited funds to purchase essential instruments for the care of patients (Shorideh et al, 2012).

The contribution of lack of material resources to moral distress in nurses in Malawi and Uganda may be greater compared to Iran because of its high health care expenditure. In 2017 the government health expenditure (percentage of the annual budget) was 22.94 % for Iran and 5.14 % for Malawi (Countryeconomy.com, 2021). Inadequate material resources can conflict with moral responsibilities as it prevents nurses from providing the care patients need thereby causing moral distress. For instance, all studies reviewed reported that lack of material resources contributed to nurses' experience of moral distress (Maluwa et al., 2012; Shorideh et al, 2012; Harrowing and Mill, 2010; Häggström et al, 2008 Fournier et al., 2007; LeBaron et al., 2014; Ganz et al., 2015). Tally (2006) reported that nurses in Ghana worked in community outreach with limited consumables (disposable gloves, needles, cotton wool and disinfectants) causing moral distress.

Shortage of nurses was consistently highlighted as a major factor contributing to the experience of moral distress in nurses in this review. Ghana for instance, had just over 22,000 nurses in the country in 2010, signifying a nurse/patient ratio of under 10 nurses for every 10,000 of the population (International Organization for Migration, 2019). Further, Ghana was among the top 20 African migrant economies in 2019 (International Organization for Migration, 2019) which contributes to the shortage of health care professionals. Many studies conducted in developing economies documented the lack of nurses as a source of moral distress (Maluwa et al., 2012; Langley et al., 2015; Häggström et al., 2008; DeKeyer and Berkovitz, 2012; Shorideh et al., 2012; LeBaron et al., 2014). Moreover, it seems in some instances, a lack of nurses reflects a general level of worker displeasure and frustration and the declining appeal of the work, resulting in a high rate of turnover as well as migration of nurses to developed economies (Dovlo, 2007).

Globally, the healthcare sector, is severely affected by nurse turnover which is an increasing human resource challenge (Dewanto and Wardhani, 2018). The global rates of nurse turnover are between 15 and 44% (Alotaibi, 2008; Duffield et al., 2014; Roche et al., 2015) and many nurses had considered leaving nursing because of the experience of moral distress (LeBaron et al., 2014; Shoorideh et al., 2015; Whittaker et al., 2018). This is consistent with the findings of Dyo et al., (2016), Soleimani et al., (2019), Lusignani et al., (2017), Oh and Gastmans, (2015) and Whitehead et al., (2015) where the frequency of moral distress in nurses had a positive relationship with intention to leave a position of employment. Further, lack of capacity on the part of governments to recruit and train new nurses contributes to the lack of nurses in developing economies (Fournier et al., 2007). Corley et al., (2005), Morley et al., (2019) and Prompahakul and Epstein (2020) suggest that the lack of nurses leads to morally difficult and challenging situations where effective teamwork is reduced and nurses' relationships with patients are affected negatively. Similar studies have documented nurses' inability to provide essential patient care in hospitals because of lack of staff (Lake et al., 2016: Recio-Saucedo et al., 2018).

Although only four of the articles reviewed (Shorideh et al., 2012; Harrowing and Mill, 2010; Maluwa et al., 2012; Langley et al., 2015) reported the influence of religious and cultural beliefs on the experience of moral distress, it is important to discuss it because of the diverse cultural and religious beliefs of patients and nurses in developing economies. This review showed that, there is a culture of maintaining hope among patients and relatives regarding the care of the dying in some cultures. It was believed that hope concerning the recovery of patients produces an optimistic attitude and that when patients and relatives are informed about their serious conditions they might die quicker (Shoorideh et al., 2012; Langley et al., 2015). This echoes a cultural belief held by nurses that patients are not emotionally prepared to acknowledge the truth (Donkor and Andrews, 2011). This belief that when patients are told

about their serious illness, they might die sooner is also found in some parts of the Ghanaian culture (Donkor and Andrews, 2011). This is consistent with Bressler et al., (2017) who found that nurses became frustrated when they were unable to carry out what they felt was the right course of action regarding truth telling. Managing the difference between the nurses' view and those of patients and family members regarding prognosis was challenging (Bressler, et al., 2017). Furthermore, the difficulty for nurses can be particularly challenging if the belief of a patient or family member is directly linked to a medical action. For instance, religious obligations are one example of culture, such as Jehovah's Witnesses' rejection of blood and its products. This belief can be challenging for the nurse if a patient has a haemoglobin level of 2.5mm/dl and requires blood transfusion to survive. However, nurses may not agree with these views but are required to recognize that these beliefs are significant to patients and their family members as it is considered good nursing care (Berlinger and Berlinger, 2017).

Not all strategies helped nurses manage their experience of moral distress. Counselling of nurses was not generally reported by the authors in the studies reviewed as a form of coping with moral distress nevertheless, 1 participant reported that while counselling had been provided after a traumatic incident it did not help in resolving the distress (Langley et al., 2015). Yet in the same study, some participants recommended professional counselling for nurses who experience moral distress (Langley et al., 2015). Evidence in the moral distress literature reports that professional counselling could be used to help nurses cope with moral distress in their workplace (Emmamally and Chiyangwa, 2020). Depending on the factors contributing to nurses' experience of moral distress counselling could be offered to nurses.

Various coping mechanisms were used by nurses to manage their experience of moral distress in the articles reviewed. Faith in religion was a coping strategy used by some nurses when they faced morally challenging situations on the wards (Maluwa et al., 2012; Langley et al., 2015).

Some nurses viewed ‘God’ and prayers as means of consolation because they provided some form of resilience when moral distress was encountered.

Other studies have confirmed the use of adaptive coping strategies in moral distress. For example, Wolf et al., (2016) reported that nurses used exercise, psychological counselling, staff debriefings, and stress management to reduce moral distress. In a literature review Oh and Gastmans (2015) reported that nurses came together and deliberated on moral circumstances, others sought the services of social workers or counsellors to address their concerns about moral distress. Although mal-adaptive coping mechanisms (use of alcohol, food, or medication) were not reported by nurses in the reviewed articles, they have been identified as a response to moral distress in nurses in the United States (Wolf et al., 2016; Whittaker et al., 2018).

The experience of moral distress can serve as a stimulus or a catalyst for constructive action (Pauly et al., 2012; Rushton, 2016). In recent times, moral resilience has been suggested as an idea that can assist nurses to manage the experience of moral distress (Rushton, 2016). Nurses must foster their personal health appropriately so that they can adequately adopt a healthy individual and professional balance in the care of patients. Because the contributing factors such as lack of instruments to work with, dozens of patients to care for are beyond the nurse’s control, nurses must learn to be resilient in circumstances that lead to moral distress. Moral resilience is ‘the ability and willingness to speak and take the right action in the face of adversity that is moral/ethical in nature’ (Lachman, 2016 pg. 122). In other words, moral resilience is evident when nurses can arrive at a compromise regarding the best option to patient care and not let moral events cause moral distress.

In preparing nursing students for the clinical work environment, Monteverde (2016) studied the teaching of ethics through lectures, by introducing a typology of moral difficulties as a form

of educational intervention to reduce the experience of moral distress. Pre - measurements were taken using a moral distress thermometer (MDT) to serve as a base line for the study. The post measurements that were taken after the lectures showed a statistically significant ($p < 0.05$) decrease in measured stages of apparent moral distress (Monteverde, 2016). However, this may lead to biases, for example the scores students give themselves can be influenced when they know the lecturer who delivered the training. Certainly, students in the classroom may not be as morally distressed as when they are in clinical practice.

Harmonized connectedness symbolises 'the nurses' main concern in respect to moral practice and at the same time it represents the pattern of behaviour in their social interactions and what nurses' yearn for' (Defilippis et al., 2020 pg. 6). The theory of harmonized connectedness is characterised by 'equality in guiding values and reciprocity of emotional and energetic effort' (Defilippis et al., 2020 pg. 6). Nurses in this process, consider the values and beliefs of other parties involved in the moral challenge and eventually strive to attain mutuality in the process. Moral resilience through harmonized connectedness was reportedly used by intensive care nurses to manage morally distressing difficulties on the wards in Switzerland (Defilippis et al., 2020).

Finally, in the reviewed articles, the highest level of moral distress was reported by ICU nurses (Harrowing and Mill, 2010; DeKeyser and Berkovitz, 2012: Borhani et al., 2015; Shoorideh et al., 2015; Ganz et al, 2015; Langley et al., 2015; Asayesh et al., 2018). This is where most work on moral distress has been carried out. Due to the increased morally complex nature of ICU work in these clinical settings can entail the provision of end-of-life care, futile care, oncological care, emergencies, and severe diseases which may come with moral challenges.

4. 9 Rationale for my thesis

This review has revealed the experience and impact of moral distress in nurses in developing economies. It has shown that nurses encounter moral difficulties daily in the quest to care for patients. The nursing professional as described by Corley, (2002) is generally morally oriented. Once nurses are unable to act in accordance with their stated professional goals and responsibilities to provide care and prevent complications, they experience moral distress (Corley, 2002). This review complements the results of a recent integrative literature review on moral distress in nurses in developing economies (Prompahakul and Epstein, 2020) which indicated the need for more studies in developing economies. The major findings reported by Prompahakul and Epstein (2020) were that poor teamwork, practice errors and organizational constraints contributed to nurses' experience of moral distress in developing economies. Further, the experience of moral distress impacted negatively on nurses necessitating the need to identify coping mechanisms (Prompahakul and Epstein, 2020).

Moral distress is an experience that draws attention to the social and contextual components of moral action. Amid mounting pressure on nurses worldwide to achieve efficiency and ensure patient safety, it is believed that further empirical study using Morley et al's., (2017) definition of moral distress is appropriate and practical. Presently, it is not known whether nurses in Ghana experience and perceive moral distress in the same way as nurses in developed economies. Thus, this empirical study seeks to fill this gap by exploring the experience and impact of moral distress in nurses in Ghana. The outcome of this study could produce a theoretical and practical understanding of the experience of moral distress in Ghanaian nurses. This will further contribute to the understanding of moral distress from the perspective of nurses in developing economies especially African economies.

4. 10 Limitations

While this integrative literature review was successful in answering the stated question, it has some limitations. Comparison of the study findings were limited because of the utilization of modified moral distress scales to measure moral distress in nurses in different clinical care settings making the discussion challenging. Moreover, the combination of instruments (Lutzen's MMSQ, Corley's MDS, Organisational Justice Questionnaire and Futile Care Perception Questionnaire) utilized to measure moral distress provide a limited understanding of the experience of moral distress in nurses. Findings of this review may not apply to specific developing economies because of cultural differences, as such more qualitative studies of nurses in developing economies are needed.

Moreover, most of the qualitative studies reviewed did not provide enough information about the demographic characteristics of participants to enable comprehensive interpretation. Other limitations included small sample sizes in quantitative studies that limited comparison of the experience of moral distress. A specific limitation of many of the quantitative studies was that participant response rates were not accurately reported. Only one study (Almutairi et al., 2019) reported a response rate (71.3%).

An additional limitation was that some of the studies involved participants from a single institution. Hence, the quality of care, policies and procedures and institutional climate were the same thus, the findings cannot be generalized to portray the experience of moral distress in some specific developing economies.

4.11 A summary of strategies and responses to moral distress.

The integrative review demonstrates that moral distress is experienced by nurses working in clinical care in developing economies. The shortage of nurses, poor teamwork and lack of

equipment needed for patient care were identified as contributing to moral distress in nurses. It is therefore prudent to recognize some strategies and responses nurses and nurse managers can utilize to mitigate the experience of moral distress. In view of this, an overview of some strategies and responses documented in the literature on moral distress is provided here. The responses are discussed at an individual level, team/group level and institutional level.

Individual level

Early recognition

Recognising moral distress is the first step in trying to reduce its incidence in nurses (Jackson-Meyer, 2020; AACN, 2004). Various qualitative, quantitative and mixed methods studies have been used to establish nurses' experience of moral distress in clinical care settings (Morley et al., 2019; Prompahakul and Epstein, 2020; Oh and Gastmans, 2015). One way of recognizing moral distress and identifying appropriate coping mechanisms in good time may be by using the Moral Distress Thermometer' (MDT) (Wocial and Weaver, 2013). The MDT measures moral distress 'within the past 2 weeks', and nurses are asked questions like 'Do you have it?' and 'How bad is it?' indicating whether the nurse experiences moral distress (Wocial and Weaver, 2013 pg. 172). It is especially useful to identify the risk of high levels of moral distress at an early stage and thus support early interventions (Wocial and Weaver, 2013). Its usage may be problematic if nurses are unfamiliar with the concept moral distress as was showed in studies in developing economies. Nevertheless, in a systematic literature review of instruments for detecting moral distress in nurses, Tian et al., (2021), suggest that the MDT can assist in evaluating the usefulness of interventions designed to decrease nurses' levels of moral distress. This tool was used by Monteverde (2016), for pre and post measurement of moral distress in nursing students. Interventions such as lectures and skills training on moral problem resolution were instituted for participants, the post intervention measurements taken after the lectures

showed a statistically significant ($p < 0.05$) decrease in reported moral distress (Monteverde, 2016).

Character/virtues

Moral courage has been advocated for nurses to ameliorate their experience of moral distress (Gallagher, 2011). Moral courage is the confidence a person has when acting in moral disagreements according to moral values and one's own beliefs, even in the face of potentially adverse consequences for the individual concerned (Fahlberg, 2015). Moral courage has been described as a willingness to take personal risks to protect patients and ensure quality nursing care (Black et al., 2014; Nunthawong et al., 2020; Taraz et al., 2019; Numminen et al., 2017; Lindh et al., 2009). Even though courage is a quality a nurse must hold, one must be mindful of having too much courage or too little courage, either of these is problematic thus, a balance is necessary for the nurse to sufficiently advocate for patients as suggested by Gallagher (2011). Nurses who are brave in their daily actions need professional knowledge, a professional wisdom that guarantees that they exhibit the correct response to the uncertainties they meet (Banks and Gallagher, 2009). Virtue, as a feature of a person, can be studied and advanced through development, and moral courage can become a normal part of a person's behaviour (Papouli, 2019). Moral courage on the part of an individual can support morality and moral bravery of others (Olsthoorn, 2016). Though nurses are encouraged to be morally courageous, being courageous and maintaining courage and trying to make a change in the best interest of patients can be problematic when institutional cultures are unsupportive, for the virtue of courage may not be enough to change a circumstance (Gallagher, 2011; Pajakoski et al., 2021). As proposed by Gallagher (2011) it is essential for institutions to also up-hold the virtues of moral courage, understanding, and reliability. Institutions need to commend nurses who raise concerns rather than trying to silence them and invest in leaders who will mentor and take forward the moral agenda (Gallagher, 2011).

Moral resilience and mindfulness

According to some, the experience of moral distress can serve as a stimulus or a catalyst for constructive action (Pauly et al., 2012; Rushton, 2016). Moral resilience has been described by Morley et al., (2019) as being useful in reducing the experience of moral distress in nurses. Moral resilience 'is the ability to deal with an ethically adverse situation without lasting effects of moral distress and moral residue' (Lachman, 2016 pg. 121). When nurses are resilient, they use transformational coping approaches of understanding and contextualizing the situation. They understand the reality of the culture in which they work and sometimes must take action that does not support the cultural norm (Lachman, 2016). This is linked with situation-focused problem solving to reframe the event in terms of a challenge over which they have some level of control (Lachman, 2016). Further, moral resilience is evident when nurses can arrive at a compromise regarding the best option for patient care and not let moral events cause moral distress.

Moral distress according to Rushton et al., (2015) causes increased empathetic feelings leading to emotional fatigue, therefore mechanisms that teach nurses to manage their emotions, as a form of resilience have the possibility to reduce moral distress in nurses. Rushton et al., (2015) investigated factors involved in burnout, moral distress, and resilience in nurses in critical care environments such as neonatal, oncology and adult critical. Participants in this study completed six scales measuring burnout, moral distress, stress, resilience, meaning and hope. A 25-item resilience scale (Connor-Davidson Resilience Scale) consisted of items such as able to adapt to change, close and secure relationships, sometimes fate or God can help, can deal with whatever comes and coping with stress strengthens, was used to measure hardiness, faith, support/purpose, and persistence factors using a 5-point Likert scale (Rushton et al., 2015). Total scores range from 0 to 100, with higher scores representing greater resilience (Rushton

et al., 2015). They concluded that nurses who experienced moral distress also scored highly for burnout and used resilience (76.7 score) to mitigate the effects (Rushton et al., 2015 Rushton, 2016).

Tied to resilience, is mindfulness (Gallagher, 2016), mindfulness and resilience have been used by nurses to care for themselves in situations of moral distress. Mindfulness is the ability to be 'present with awareness', tolerant, and considerate in circumstances that are worrying regarding patient care (White, 2014). Mindfulness enables nurses to consciously create time and space for themselves, assess situations and to take care of themselves (Gallagher, 2016). For instance, Vaclavik et al., (2018) used mindfulness as an intervention to assist oncology nurses who experienced moral distress as measured using a 21-item Moral Distress Scale-Revised (MDS-R) scale. The results indicated that mindfulness interventions decreased nurses' perceptions of distress. This was consistent with 'comments made during the support sessions when nurses stated that, at times, they were providing treatment to patients who were in the active stages of dying' (Vaclavik et al., 2018 pg. 329). Post intervention MDS-R survey outcomes revealed a decrease in the frequency of moral distress. Nevertheless, mindfulness should not be used dishonestly by nurses who wish to placate overworked staff.

Harmonized connectedness symbolises 'the nurses' main concern in respect to moral practice and at the same time it represents the pattern of behaviour in their social interactions and what nurses' yearn for' (Defilippis et al., 2020 pg. 6). Harmonized connectedness was developed through theoretical coding of data from participants in a study to explore how intensive care nurses cope with moral issues (Defilippis et al., 2020). In harmonized connectedness the health care team and family members must ensure they are guided by common beliefs and values that are mutually recognized and accepted among them for the benefit of the patients (Defilippis et al., 2020). Nurses using harmonized connectedness, consider the values and beliefs of other

parties involved in the moral problem and eventually strive to reach a mutual understanding in the process. Moral resilience through harmonized connectedness was reportedly used by intensive care nurses to manage morally distressing difficulties on the wards in Switzerland (Defilippis et al., 2020).

Reflective tool kit

The American Association of Critical-Care Nurses (AACN) developed a toolkit called *the 4 As to Rise Above Moral Distress;* ask, affirm, assess and act (AACN, 2004). In this approach of reflecting, nurses first and foremost examine whether they are experiencing moral distress and if they are, they commit to identifying and tackling their experience of it. Further, the nurse recognises and evaluates the factors contributing to the distress and plans to act and apply the needed change. By planning to act the nurse develops a self-care plan, identify appropriate sources of support, and investigate outside resources for guidance. Actions are taken to address the precise causes of distress regarding patient care. Examples of actions that can be taken are constantly involving the patient's family members in the care that is provided to patients, advocating for the patient and family members by consulting other services, such as Chaplain and social work, identify the nurse manager of the unit and inform him/her of the situation. When the situation is solved, consider creating a support group or mentor- ship program for novice nurses who may face similar circumstances (AACN, 2004). This strategy to lessening the experience of moral distress emphasizes the need for the nurse to identify his/her experience of moral distress to act in the best possible through compromise regarding patient care. This framework has been used effectively in a variety of moral situations (McCue, 2010; Molazem et al., 2013).

Educational programmes

Another intervention that could be instituted to lessen the experience of moral distress are educational programmes (Jackson-Meyer, 2020; Grady et al., 2008; Pauly et al., 2012). An example is the neonatal end-of-life educational program (Rogers et al., 2008). In this study a quantitative pre-test, intervention and post-test design with a single group undergoing educational sessions in 6 areas. In this approach an hour education session was conducted once a month for 6 months and its impact evaluated. The areas taught were pain management, symptom management, moral issues, communication, concerns at end-of-life, and avoidance of compassion fatigue. A quantitative pre-test and post-test were carried out before and after each educational session. The results showed a statistically significant higher level of wellbeing and knowledge in care for dying children in the areas of moral issues and symptom management after the educational programs (Rogers et al., 2008). However, nurse educators may face problems in harmonizing challenging curriculum demands and making moral education a priority, and face challenges regarding whether ethics education is best addressed through ethics-specific courses, or integrated throughout the curriculum (Pauly et al., 2012).

In summary the individual responses (recognizing moral distress, moral courage, advocacy for moral resilience, *the 4 As to Rise Above Moral Distress,* harmonized connectedness, and mindfulness) discussed above can be useful for nurses to manage their experience of moral distress. Nurses and nurse managers could incorporate discussion of moral distress into responses and strategies such as during clinical supervision to encourage conversation about clinical moral issues. These approaches are applicable to clinical care settings in Ghana and other developing economies because of their practicability. Hanna (2004) has suggested that if nurses individually cope with moral distress effectively, positive change and growth can be attained. However, nurses must be cautious, for focusing too much on personal, resilience risks

placing all responsibility for the management of moral distress on the individual (Traynor, 2018), which can be detrimental for it could lead to nurses leaving the nursing profession and optimal patient care will be affected.

Team/group level

Group reflective debriefs

A group level of mitigating the experience of moral distress in nurses may be the involvement of a nurse ethicist who would assist nurses with conversations (Unit Based Ethics Conversations (UBECs) concerning moral difficulties they encounter (Helft et al., 2009). This approach has been found to lessen nurses' experience of moral distress (Helft et al., 2009; Wocial et al., (2010). Wocial et al., (2010) assessed UBECs and reported that nurses described feeling equipped to deal with morally difficult circumstances because as part of the process nurses discuss moral issues that contribute to their experience of moral distress, and this strengthens the teamwork dynamics through developing trust in nurses. For example, a participant reported:

> *'I think it's helpful that you find out that others have kind of the same concerns you do. That you're not alone in your concern over, "is this the right thing to do or the wrong thing to do?", and it's nice to find out that ... we're all thinking the same thing so we can kind of think it through together.'* (Wocial et al., 2010).

The conversations in UBECs are group conversations and mainly involves nurses. Both ethics consultations and UBECs have been shown to lessen the experience of moral distress at an individual and group level (Wocial et al., 2010).

Part of improving the ethical climate of an institution is to recognise and have ethics committees for instance, Clinical Ethics Committees (CECs) as a group. Health institutions in the USA are progressively utilizing CECs (Doyal, 2001). CECs are instituted to offer ethics consultations, evaluation of cases of a moral nature, advance and review existing guidelines

concerning clinical ethics, examples are informed consent and enabled moral teaching (Caulfield, 2007). There are about 82 CECs in health institutions in the UK, that offer ethics consultation and education (Slowther et al., 2012). Helmers et al., (2020) reported in a qualitative study on paediatric intensive care nurses in a tertiary hospital that nurses found formal support from such ethics committees helpful in mitigating the experience of moral distress.

In summary, with nursing essentially, a moral profession, that is driven by the goals of protecting patients from harm, advocating for patients, and creating healing environments (Corley, 2002), there is no doubt that nurses may experience moral distress when these professional goals are constrained. It may thus be expected that moral distress disturbs nurses on an individual level. Some of the individual and group level responses presented above can be combined in a broad approach in clinical care settings in developing economies including Ghana. Educational programs such as the neonatal end-of-life educational program (Rogers et al., 2008) similar programmes can be developed by nurse educators like myself that will encompass the essential coping response to moral issues and distress. The *4 As to Rise Above Moral Distress;* ask, affirm, assess and act (AACN, 2004) is also a practical approach that can be adapted to help nurses in Ghana address complex moral issues that arise as they strive to provide care in clinical care settings.

Institutional level

Creating institutions that have a more progressive awareness of moral climate is known to lessen the experience of moral distress in nurses at an institutional level (Silén et al., 2011; Whitehead et al., 2014). Whitehead et al., (2014), used a condensed version of Olson's Hospital Ethical Climate Scale (HEC-S) to examine health professionals' perceptions of their institutions' ethical climate in the USA. The HEC-S mean scores were negatively correlated

with Moral Distress Scale-Revised (MDS-R) scores (p<0.0001), showing that higher perceptions of the institutional ethical climate were linked with lower levels of moral distress scores (Whitehead et al., 2014). Similar findings have been documented by Silén et al., (2011), who reported a positive perception of moral climate associated with lesser experience of moral distress (p<0.001). Improving the ethical climate in an organization can diminish moral distress in nurses at an institutional level.

In the US, the Joint Commission for the Accreditation of Healthcare Organizations instructs that all hospitals must have formal means for addressing issues encountered by health care professionals regarding patient care (Caulfield, 2007). This directive has ensured that many hospitals now offer an ethics consultation service. Ethics consultation related to moral dilemma or moral uncertainty is to look for an appropriate patient-centred ethical resolution. This service can also be accessed by patients, family members and staff (American Society for Bioethics and Humanities Clinical Ethics Task Force, 2009). Health Ethical Committees (HECs) oversee provision of ethics consultation where there is a difficult moral issue in their organisation. It is an official meeting where all members of the health care team can attend. In morally distressing situations nurses may demand an ethics consultation without medical team consent. While an ethics consultation does not necessarily reduce the experience of moral distress, the understanding is that the procedure of discussion can be helpful to nurses in their encounter (Wocial, 2002). The discussion approach provides opportunities for members to engage with one another openly and candidly about moral challenges encountered on the wards. In this process of ethics consultation, moral difficulties can be identified, understanding of the issues enhanced, evidence-based options of resolving the issues discussed which can all help build more shared and trusting relationships. It is ultimately the responsibility of organizations to support the implementation of programmes such as this one.

Morley and Horsburgh (2021) recommend an approach called Moral Distress Reflective Debriefing (MDFD) which seems to reduce the impact of anguish that is experienced by nurses in clinical settings. This method is composed of five stages (introduction, shared experiences, action points, empowerment, and wrap-up) and if necessary, there may be a follow-up stage and assisted by a clinical ethicist and a licensed social worker (Morley and Horsburgh, 2021) MDFD was influenced by Browning and Cruz's Reflective Debriefing model, Browning, and Cruz (2018). The definition of moral distress that underlies the structure of MDRD is based on Morley et al's., (2017) broader definition of moral distress which focuses on the significance of managing the psychological distress and the moral event. The introductory stage generates a safe space for nurses to share their feelings and experiences. In the shared experience phase participants are given the chance to speak about their anguish where they are assured that the experience of moral distress is common, and they are not alone. The action points stage is where lessons are deliberated and learnt regarding nurses of moral distress. In the empowerment stage, the facilitator, begins to change the group discussion towards individual/group coping strategies, self-care and enhancing an emotional safe return to work. In the final stage, participants recognise lessons learnt and, agreement is sought regarding the likely action items and next steps. Follow-up may be necessary depending on the result of the MDRD and can comprise a written summary of the session, exercise, education, or follow-up with management on institutional concerns. This approach was used in two clinical cases involving nurses who had experienced moral-uncertainty distress and moral-constraint distress. The results from the approach received constructive feedback from participants of MDRD exercises in lessening their experience of moral distress.

An overview of individual level, team or group level and institutional level responses to the experience of moral distress in nurses has been presented in this final section of the literature

review to summarise the evidence which indicates how the experience of moral distress can be managed. Evidence suggests that there is a range of responses comprising educational workshop based on ‘4A model, Moral Distress Reflective Debriefing, moral empowerment program, educational programs, nursing ethics committees, and moral resiliency approaches for lessening moral distress in nurses. For instance, MDFD (Morley and Horsburgh, 2021) can be used for nurses in Ghana experiencing moral distress because of its systematic process and its practicality. Tackling moral distress may reduce the migration of nurses from their profession, preserve moral sensitivity and integrity, increase consciousness of powerlessness in nurses and eventually help patients.

4. 12 Conclusion

This integrative review demonstrates that moral distress is experienced by nurses working in developing economies. The results confirm that although the concept of moral distress is not well known in developing economies, studies suggest nurses experience moral distress in similar ways to nurses in developed economies. Factors such as, lack of resources needed for patient care were identified as particular points of difference between developing and developed economies. The modified moral distress scale used to measure moral distress in nurses in some developing economies is useful and helpful, however, consistency in measurement is a challenge among developing economies because of cultural differences in beliefs in religion and traditional values. As a result, qualitative descriptive studies are needed to provide rich and culturally distinct accounts of moral distress. The experience of moral distress affects nurses and patient care. However, empirical evidence on moral distress in developing economies remains sparse making it challenging to describe the experience of moral distress and to identify appropriate coping mechanisms. Therefore, further studies are needed to explore the experiences of moral distress in nurses in developing economies.

Chapter 5 examines the methodological approach used to investigate moral distress in nurses in Northern Ghana.

Chapter 5: Philosophical assumptions, methodology and method

5.1 Introduction

This chapter discusses the methodology and method used to answer the thesis questions stated in chapter 1. This chapter begins by discussing the ontology and epistemology that underpins the design and its use in a qualitative approach. Then the reason for the use of a qualitative descriptive design is discussed followed by the rationale for the type of data collection and analysis used. How ethical conduct in the study was ensured is also discussed in this section.

5. 2 Philosophical assumptions

According to Creswell (1994), it is necessary for researchers in qualitative studies to make their philosophical assumptions clear to others. Philosophical assumptions guide researchers on what forms knowledge and how a phenomenon is understood (Weaver and Olson, 2006). Thus, it enables researchers to identify the kind of data essential for their studies, how it should be gathered, and how it should be analysed and understood. These assumptions arise from how the researcher knows what they know (epistemology), beliefs about the nature of reality (ontology) and the approaches used in the process of the study (methodology).

Crotty's (1998) framework was used to develop the design for this study. Crotty (1998 pg.10) identified four basic questions researchers must reflect on when designing studies: 'What methods do we propose to use? What methodology governs our choice and use of methods? What theoretical perspective lies behind the methodology in question? and What epistemology informs this theoretical perspective?' Epistemology is the theory of knowledge that is principal to all studies, examples include objectivism, constructionism, or subjectivism (Crotty,1998). A theoretical perspective is the precise philosophical viewpoint that informs the methodology and offers a background for the study process and basis for a particular method (Crotty, 1998). The methodology is the general plan of action for carrying out studies, for instance, qualitative descriptive approach, ethnography, and survey research. Lastly, methods are the actual method

used, such as interviews and questionnaires. There is a relationship between these elements in that, based on the foundation of epistemology and ontology, the theoretical assumption informs the methodology, and the method is selected based on the extent to which it is consistent with the ontology (Crotty, 1998). Although, Crotty's (1998) framework does not include ontology, for this study ontology was included because of the need to determine the philosophy of the nature of reality for empirical studies. Further, for Crotty (1998 pg.18) ontology and epistemological questions 'tend to emerge together'. Table 8 below shows the ontological and epistemological assumptions that guided the study design.

A social constructionist approach informed my decision to use a qualitative approach. The methodology also guided the choice of the study design (qualitative descriptive approach) and tools used for data collection. Consequently, the ontology, epistemology, and methodology had a bearing on the methods that I used to explore moral distress in nurses in Northern Ghana. Each of these theories and assumptions is discussed further in the forthcoming section of this chapter.

Table 8: Development of a research framework (adapted from Crotty 1998 pg. 11)

Paradigm	Definition	Selected	Rationale
Ontology and Epistemology ↓	The nature of reality How truth can be known Theory of knowledge	Realism (Crotty, 1998) Social Constructionism (Crotty, 1998; Berger and Luckman, 1966)	To understand how moral distress is understood in nurses in Northern Ghana To comprehend how nurses create their realities and what they are
Theoretical perspective/Assumption ↓	Philosophy informs methodology	Interpretivism (Crotty, 1998)	To understand how nurses create meaning through interaction with their environment
Methodology ↓	Design linking methods to the outcome of the study	Qualitative Descriptive Approach (Sandelowski, 2000)	To collect data which describes the experiences and accounts of participants
Method ↓	Implementation of methodology	Individual Interviews (Fetterman, 1998)	To achieve an in-depth understanding of participants descriptions of moral distress through dialogue
Sample ↓	Participants are selected based on the study goal	Purposive sampling (Patton, 1990)	To reflect diverse age groups, ethnic and religious orientation, a range of educational achievement, and professional rank through the enrolment process
Analysis	A systematic process of applying logical procedures to describe, demonstrate, and evaluate data	Inductive (Braun and Clarke, 2006) Thematic Analysis (Braun and Clarke, 2006; Sandelowski, 2000)	The description is built in the data To examine and analyse participants' experience of moral distress logically and practically whereby findings reflect a true representation of their accounts

5. 2. 1 Ontology

Ontology has been defined as "the study of being" (Crotty, 1998 pg.17). It deals with the nature of reality in its broadest sense. Ontological questions are concerned with 'what is there that can be known?' or 'what is the nature of reality?' (Lincoln and Guba, 1989 pg. 83). Generally, in social science, there are two key ontological views, realism, and idealism (Ritchie et al., 2013). Realism is the notion that there is an external reality which exists independently of people's beliefs and ideas (Crotty, 1998). Idealism on the other hand proclaims that reality is essentially mind-dependent, in that understanding of a phenomenon is solely through the human mind (Ritchie et al., 2013). This suggests there is a difference between the way the world is, and the meaning and interpretation of that world by people (Crotty, 1998).

At a fundamental level all qualitative studies agree with socially constructed experiences because experiences of human beings are constructed and are mind dependent (Crotty, 1998). The ontological assumption is generally a social world of meanings (Crotty, 1998). Within this domain, researchers believe that the world they examine is a world inhabited by people with their views, understandings, and meanings (Crotty, 1998). Crotty (1998) posits that, in combination ontology and epistemology tend to determine the theoretical viewpoint of a study. For the theoretical viewpoint symbolises a way of appreciating ontology and understanding epistemology (Crotty, 1998). According to Crotty (1998 pg. 18), a theoretical perspective involves 'a certain way of understanding what is' (i.e., ontology) and 'a certain way of understanding what it means to know' (i.e., epistemology). Theoretical perspective is 'a way of looking at the world and making sense of it' (Crotty, 1998 pg. 15).

For Crotty, reality exists and if one must know about a phenomenon or an item there must be an interaction with the phenomenon by meaning-making people. Crotty's (1998 pg. 76) position is that meaningful reality is socially constructed, he does not deny entirely the fact that

it ‘is real’ and contends that the world is meaningless without the interaction between people and the environment. For Crotty (1998) the world exists regardless of whether people are aware of it or not, for people to have a significant meaning they will have to interact with the world and its objects to construct a social reality. This is because knowledge of reality is influenced by the mind and arises when interpretation is linked with objects that have meaning for people (Crotty, 1998). In other words, the experience of constructionism is an outcome of the involvement of people and the environment in a circular manner.

The environment is important because this is where people relate with one another and understanding of the nature of reality is made (Crotty, 1998). For instance, money or the idea of currency exists as something that can be felt and touched, and it is also socially constructed because people have decided to give it value. The value of money is socially constructed for it is created through people’s interaction with it. In some cases, money represents power which is influenced by values, beliefs and wants. However, its value may change in nature because of peoples’ perception or thoughts of it over time. There are different ways of viewing and investigating phenomena. Observing ‘real’ (physical) objects (mountains, trees) requires approaches such as measurement and calculations. Other elements of human activity do not lend themselves to the same approach such as social experiences. As a result, we need a different way to access and understand social experiences of participants. Some claim morality is socially constructed, and others claim it is a form of realism. Social construction of morality assumes that people are motivated to act from several circumstances which are guided by societal norms, situations, and personal beliefs (Wolfe, 2020). In other words, individuals construct their own moral obligations in the situations of their daily life.

5. 2. 2 Epistemology

Epistemology is defined by Crotty (2003 pg. 3) as ‘a way of understanding and explaining how we know what we know’. Epistemological assumptions are concerned with how knowledge can be generated, advanced, and utilized (Denzin and Lincoln, 2011).

The epistemological assumption used in the study is social constructionism. Social constructionism is a perspective which holds that ‘all human knowledge, and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of an interaction between human beings and their world and developed and transmitted within an essentially social context’ (Crotty, 1998 pg. 52). Comprehension of the world is an outcome of peoples’ views, associations, emotions, and opinions about the community they live in. For Crotty (1998) there are other ways of studying the world other than through quantitative approaches. Human beings relate with a phenomenon to understand and make meaning of it.

According to Crotty (1998), in social constructionism meaning is constructed in the world ‘with objects in the world’. People may be portrayed in a ‘constructionist spirit’ engaging in the world and making meaning out of it, such a description should be situated in its historical and traditional context (Crotty, 1998 pg. 64). For we build experience or knowledge as ways of understanding the world, and that these methods of understanding are a subsection of how the social world can be comprehended.

In social constructionism researchers can examine social experiences using interpretive designs and methods such as interviews.

5. 2. 3 Implications of a social constructionism approach in my study

The connection between epistemology and ontology is that if social reality is made up of the experiences and understanding of individuals, then knowledge of that reality will be found in those experiences and understanding as they occur in a social setting. Given that this study aimed to explore how moral distress was experienced in nurses in NICU and paediatric wards

in Northern Ghana, using an approach grounded in social constructionism with a focus on collective accounts of experiences was appropriate. The construction of meaning was in a social context, accessed through individual interviews conducted with nurses and nurse managers in NICU and paediatric wards.

5. 3 Theoretical perspectives of the study

Expressing a theoretical position helps readers comprehend and appreciate how study approaches are arrived at (Sandelowski, 2000). A theoretical perspective as defined by Crotty (1998) is the viewpoint that informs the methodology and the methods of a study. It is through these theoretical assumptions that researchers view the world which serves as a foundation for studying a phenomenon. Interpretivism was the theoretical assumption based on ontological realities and epistemological social constructionism.

Interpretivism underscores a theory that human beings make meaning of their experience and assign meaning to it (Saunders et al., 2009; Ritchie et al., 2013). The arguments of interpretivism are that people and their social environment cannot be investigated in the same manner as objective events as a result social sciences research require to be distinct from natural sciences research (Saunders et al., 2009; Ritchie et al., 2013). For instance, study participants of a different socio-economic and cultural settings, and at different periods may create distinct meanings, and experience different social realities (Saunders et al., 2009). In contrast to positivist theory, that includes definite general ‘laws’ that are applicable to everyone, interpretivism consider that deeper understandings into human beings are lost if such intricacy is abridged wholly to a chain of ‘law- like generalisations’ (Saunders et al., 2009 pg. 140). For this current study, I sort to create a new deep understanding and interpretation of the experience of moral distress through the lens of nurses working in NICU and paediatric wards in Ghana.

5. 4 Qualitative research

In conducting qualitative studies, the researcher conducts interviews to capture the participants' experience of an event or phenomenon (Sandelowski, 2000). Data in this form is analysed having in mind intricacy, nuance and amalgamations of individuals accounts into themes. Codes are assessed, categorized and eventual realization of themes. Outcomes of studies that embrace comprehensive descriptions of phenomena are built on the viewpoints and accounts of participants. Developing themes is characteristic of a qualitative descriptive approach (Sandelowski, 2000). Finally, a reflexive method is needed where the role and viewpoints of the researcher in the study are recognized to develop an understanding of their implications for the data analytic process (Attia and Edge, 2017; Mortari, 2015).

The relationship between social constructionism and qualitative studies is based on the essential assumption of social constructionism, which is that social reality is constructed through interaction (Crotty, 1998; Bradshaw et al., 2017). Further, the phenomenon under study is usually located in a specific context within which experience occurs. In this regard, an appropriate way to understand and acquire knowledge of the experience of moral distress in nurses was through qualitative individual interviews. Individual interviews were used to ascertain how moral distress was experienced by nurses in NICU and paediatric wards in Ghana.

5. 4. 1 Methodology

Methodology refers to the philosophical framework and the fundamental assumptions of research (Van Manen, 1990). Methodological assumptions reflect how investigators approach an examination of a phenomenon (Denzin and Lincoln, 2011). The purpose of this section is to describe and justify the use of the specific approach to data collection taken in this study (Wellington, 2000), a qualitative descriptive approach. A qualitative descriptive approach is a

well-developed but unacknowledged approach which provides a 'comprehensive summary of an event in the everyday terms of those events' (Sandelowski, 2000, pg. 336). This approach generates an understanding of a phenomenon by accessing the meanings participants assign to it (Sandelowski, 2000). Researchers utilizing the qualitative descriptive approach describe the experience of participants accurately as a beginning point (Sandelowski, 2000). Efforts are then made to move past the literal account of the data to interpret the results of participants (Sandelowski, 2000). The emphasis on producing detailed accounts about the experience of moral distress from nurses and nurse managers who may have the experience provides an opportunity to obtain knowledge about moral distress. The main aim of the qualitative descriptive approach is to remain true to the experience of participants like other qualitative studies.

5. 4. 2 Rationale for the research design

Within a qualitative descriptive framework, this thesis is concerned with exploring the experience of moral distress in nurses working in NICU and paediatric wards in Northern Ghana. To examine moral distress in nurses in Ghana, it was necessary to use an approach which focused on the description of participants' experiences (Schultz, 1962). This is firstly because of the widely contested nature of the causes of moral distress (Fourie, 2015; Barlem and Ramos, 2015; Campbell et al., 2016; Prompahakul and Epstein, 2020) and secondly the fact that moral distress was first conceptualised in a developed economy, as a result it was best to utilize an approach which allowed nurses recount their experiences of moral distress in their own context. This approach provided a channel for the voices of nurses to be heard. Further, the utilization of qualitative descriptive approach could potentially bring about a positive outcome in nursing practice and the health care system in general (Sullivan-Bolyai et al., 2005). When nurses' voices are heard regarding their experience of moral distress in NICU, and

paediatric wards interventions may be identified to lessen their experience which will in turn positively affect the health care system.

With qualitative descriptive approach situated in an orientation that represents the constructed and contextual nature of nurses' experiences, this method allowed an examination of the experiences of nurses in the Ghanaian socio-cultural context.

The qualitative descriptive approach allowed for a clear understanding of the socially constructed reality of nurses working in NICU and paediatric wards in Northern Ghana and their individual experience of moral distress as influenced by professional roles and responsibilities, clinical setting variables and levels of organizational support.

In this form of enquiry, researchers examine nurses' experiences of a phenomenon to generate comprehensive descriptions. Nurses reflected on and recounted their experience of moral distress working in the NICU and paediatric wards. In this regard, a qualitative descriptive approach enabled a comprehensive description and understanding of the perception and experience of moral distress of nurses in Ghana by accessing the contextual cultural factors that shaped their experiences.

5.5 Study settings

This study was conducted in NICUs and paediatric wards of 4 hospitals in the Tamale metropolis, the capital city of the Northern region of Ghana located within the Guinea Savannah belt. Tamale is the third largest city in Ghana with a population of 223,252 (Ghana Statistical Service, 2010). It has a large community consisting of Muslims, Christians, and Traditionalists. The first study site (site 1) is a large teaching hospital that serves as a referral center for the surrounding regions namely Upper East, Savannah region, North-East and Upper West region. As a large hospital, it partners with medical, nursing, and other health related educational institutions to advance health care through knowledge and research. This 800-bed capacity hospital also meets the daily health care needs of outpatients and in-patients. It offers

specialized and advanced services not offered anywhere else in the region. Approximately 100 nurses work in its NICU and paediatric ward. The hospital is headed by a Chief Executive officer who is supported by heads of various directorates including the nursing directorate.

The second study site (site 2) is a regional hospital that offers reproductive and child health services including NICU, maternal health, adult medicine, consultation services, laboratory services, pharmaceutical services, outpatient services, surgeries, and in-patient services. The type of health professionals employed in this hospital are general surgeons, general medical physicians, gynaecologists, general and specialized nurses, and midwives. It has a bed capacity of 200 with approximately 50 nurses working in its NICU and paediatric wards.

The third and fourth study sites (3 and 4) are district hospitals with a bed capacity of 80 each. Services provided include reproductive and maternal health, adult medicine, minor surgery, consultation services, laboratory and pharmaceutical services, outpatient and in-patient services, child health services excluding neonatal care services. These services are provided for the community and cases from the surrounding communities are referred to the next level of care for advance management. In site 3 the total number of nurses were 60 with 15 nurses working in the paediatric ward. Site 4 had a total number of 52 nurses with 12 nurses working in the paediatric ward.

These four study sites were chosen because neonatal and paediatric care services were provided in these hospitals. Nurses were chosen from NICU and paediatric wards because they are in direct and constant care of patients on the wards and spend up to 9 hours a day in patient care and management. Nurse Managers have over-site responsibilities to nurses in these wards regarding patient care.

5. 6 Methods

Methods are the procedures and techniques used to collect data in an empirical study. They should be consistent with the ontological and epistemological assumptions supporting the study (Van Manen, 1998). Qualitative descriptive design can incorporate a range of approaches. Four data collection methods were used to understand the perception and experience of moral distress in nurses in NICUs and paediatric wards in Ghana. These were: semi-structured interviewing of individual participants, the collection of demographic information, reflective journaling, and completion of field notes. This process was also followed to enhance the trustworthiness of the findings (Sandelowski, 1995; 2000; Colorafi and Evans, 2016; Kim et al., 2017; Bradshaw et al., 2017). The study of the experience of moral distress in nurses in Northern Ghana was carried out ethically as discussed in section 5.10 of this chapter and in chapter 6 respectively. Findings of the current study represented an account of the experiences of the participants. A semi structured and open-ended interview guide was used to avoid limiting responses and to enable participants to express themselves freely (Sandelowski, 2000). According to Robson (1993) the flexibility of the semi-structured interview is appropriate for research exploring novel ideas. This form of interview gives participants a chance to offer deeper descriptions and allows the researcher to ask for further information (Dicicco-Bloom and Crabtree, 2006).

Demographic information of participants was also collected to support the description of participants in a cultural context.

5. 7 Data collection methods in qualitative descriptive approach

5. 7. 1 Interviews

Interviewing is an effective way of collecting information for it takes the researcher into the core of the phenomenon of study (Fetterman, 1998). Its use allows the researcher to investigate a phenomenon with participants by providing detailed accounts (Doody and Noonan, 2013)

thereby contributing to the "richness of data" needed in a qualitative descriptive approach (Bradshaw et al., 2017 pg. 5). Further, qualitative interviews allow a researcher to "see the research topic from the perspective of the interviewee" (King, 2004 pg.11). Through these conversations and relationship, the researcher built with the participants, clarifications can be made in events where the researcher cannot understand the participants' descriptions of their stories to enhance comprehension of the phenomenon. Using interviews, I hoped to attain an in-depth understanding of the nurses' accounts through discourse. I made a conscious effort to minimise bias by building trust and rapport with the nurses which enabled them to share their own experience of moral distress freely and willingly without being judged. It made it possible for me to explore the nurses' personal experiences of moral distress.

Taking account of the study goals, the interview guides focused on moral concerns to provide an understanding of the participants' perspectives of their experience (Corley, 2002; Sullivan-Bolyai et al., 2005; Miles et al., 2014).

5. 7. 2 Sampling

In considering sample selection in a qualitative study, it must be consistent with the design (Sandelowski, 1995). Study participants are usually selected because they can offer in-depth reports of their experiences and are prepared to speak about their experiences, thus offering data that is rich and increases the researcher's understanding of the phenomenon (Crabtree and Miller, 1992).

Parahoo (2014) suggests nonprobability methods such as convenience or purposive sampling approaches in qualitative studies especially qualitative descriptive designs. This is because convenience sampling permits the researcher to enroll participants who are voluntarily available (Bradshaw et al., 2017). Nevertheless, convenience sampling may restrict the data and increase risk of bias. Purposive sampling allows for accessibility of participants however

it provides added benefit of enabling the choice of participants whose experiences are necessary for the study (Bradshaw et al., 2017). Participants in purposive sampling are selected based on the study aim in order that each participant will provide diverse, and rich information of significance to the study (Patton, 1990).

I used a purposive sampling technique to select participants from two groups, nurses, and nurse managers in NICU and paediatric wards in four hospitals in Ghana. This enabled me to consider diverse age groups, type of participants, fluency in English, type of employment and working experience of potential participants. This approach allowed for a detailed understanding of moral distress in nurses and support measures available to nurses from the perspective of nurse managers.

Kim et al., (2017) in a systematic review of the characteristics of qualitative descriptive studies reported that sample sizes ranged from 8 to 50 participants. For this study, a target was set for the number of participants to be interviewed based on recommendations (8 to 50 participants) made in the literature (Kim et al., 2017). An initial sample size of 38 participants was proposed (24 nurses and 14 nurse managers) however, the sample size was guided by data saturation. Data saturation refers to the point in data collection when no additional ideas are recognized, information is repeated, no new data is being collected from the study participants and further data gathering becomes unnecessary (Coyne, 1997; Kerr et al., 2010; Guest et al., 2006). There is no agreement on the number of interviews needed to achieve data saturation (Guest et al., 2006, 2020; Sandelowski, 2008; O'reilly and Parker, 2013; Hennink et al., 2017, 2019; Sebele-Mpofu, 2020). For example, 9 interviews may be adequate to capture a complete range of ideas from participants, nevertheless, additional data may be required to develop a thoroughly textured understanding of those issues (Hennink et al., 2017). When a complete set of data is obtained, the researcher may need to collect more information about the phenomenon of study. However, in a complete data set, the researcher cannot add to it because it is a collection of

related groups of data consisting of distinct sections that contributes to a comprehensive understanding of a phenomenon. Since evidence on the perception and experience of moral distress in nurses working in NICU and paediatric wards in Northern Ghana is not yet documented, it was necessary to fully understand their experiences. Data saturation was reached after I carried out 40 interviews with nurses and 14 interviews with nurse managers. Thus, a satisfactory and sufficient sample size of 54 provided rich data from participants (Fawcett and Garity, 2008).

5. 7. 3 Demographic data

Generally, investigators study a sample of a particular population (Connelly, 2013) such as nurses, and demographic data is collected to inform readers about the participants. The demographic data collected included information such as age, gender, ethnic background, religion, work experience, workplace and educational achievement that might influence the experience of moral distress. A brief structured self-completion demographic questionnaire was completed by the participants at the beginning of each interview.

5. 7. 4 Journaling

Journaling involves documentation of subjective (my perspective of the study process) and objective (impartial) information that emerges during the research process and becomes a core element of informing the analysis process in qualitative studies (Maheu and Thorne, 2008; Colorafi and Evans, 2016). Journaling is a process which involves researchers recording their thoughts, explanations, data collection procedures, questions, concerns, and reflections (Strauss and Corbin, 1998). I documented activities of the data collection process and challenges (such as facial expressions of participants as they recounted their experiences, noted moral distressing situations experienced by participants and distressing moments of participants in the interview process) of the interview process. Since it was not possible to

capture the non-verbal behaviour of participants on digital recordings these were documented in my journal.

Further, I noted my thoughts, ideas, and questions about the data analysis process. This allowed me to assess the products of the inductive examination by asking questions such as why is this here? why this? what is happening here? and what does it mean? how did this happen? To gain a complete understanding of participants experience of moral distress.

Summaries of individual interviews (nurses and nurse managers), of participants' experience in each hospital setting (nurses in sites 1, 2, 3, 4), of nurse managers in all four sites were written down after the interviews were conducted and I returned to these summaries at various stages to remind myself of the whole of each participant's experience so as not to lose the logic of each narrative during the analysis process. This approach helped me maintain awareness of the aspects of individual participants and participants in groups. Table 9 below shows an example of my journaling work

Table 9: Example of my journaling

Journal
I set out to explore the perception and experience of moral distress in nurses working in NICU and paediatric wards. And determine support measures available by nurse managers to assist nurses navigate through moral distress. I reflected on the broad implications of this study; what are the implications of identifying the experience of moral distress in nurses in Ghana, what will it mean for the health sector in Ghana and nursing training institutions in Ghana? How will the experience of moral distress in nurses look like in a developing economy? My assumptions in experiencing moral distress in a developing economy. I worked in NICU and paediatric wards where materials such as gloves, cotton, methylated spirit were in short supply. I know it is challenging to work as a nurse in such challenging settings, I am aware of family members beliefs interfering in the plan of care of patients. Which made it difficult to provide quality care. I was not aware of moral distress until I got a job at the university, will nurses working in NICU and paediatric wards know the term moral distress? What is moral distress for nurses in Ghana? I reflected on these issues before the start of data collection. **Date: 16th October 2019** **Time: 1 pm** **Venue: Meeting room for staff on the ward** **Activity:** First interview with participant, interview was successful - Site 1. NICU. N. 1 Participant was willing to speak about her experience; not sure whether it is because I am a fellow nurse or because of my previous interactions with nurses throughout the years. I felt a bit at ease because that meant the challenge of not getting adequate participants for the study was resolved. In the process of the interview, the participant was emotional recounting her experience, I noticed a deep sense of sadness as she gave her personal experiences of the moral encounter. - Not aware of the term 'moral distress' - Feels sad, frustrated about the moral events - Loves caring for neonates - Lack of basic items and consumables to work with on the ward - Feels inadequate with her roles and responsibilities The participant was appreciative thanked me of the knowledge gained on the term moral distress through the interview. Updated supervisors on the first interview; I was given the go ahead by my supervisors to continue interviewing.

5. 8. Inclusion and exclusion criteria

Aligned with purposive sampling, the inclusion criteria for participants were stipulated because of the need for participants to have the relevant experience of nursing practice. Table 10 below shows the inclusion and exclusion criteria for participants for the study.

Table 10: Inclusion and exclusion criteria for participants

Inclusion Criteria	Exclusion Criteria
Nurses aged 18-59 years	Nurses working in wards other than NICU/ Paediatric wards
Currently practicing as a nurse for not less than 6 months	Student nurses and nurses qualified less than 6 months
Serving as a nurse or as a nurse manager within a NICU and or paediatric wards	Nurses on orientation
Full-time employment in the hospital	Nurses with part-time employment
Fluency in the English language	Nurses not fluent in the English language
Prepared to talk about their perception and experiences of moral distress	Paediatricians and non-nursing staff of NICU/Paediatric Wards

5. 9 Data analysis method

Data analysis techniques in qualitative descriptive studies are flexible (Sandelowski, 2000, 2001, 2010). Thematic analysis can be used, and I felt this was necessary to ensure a comprehensive account of the participants' experiences was presented (Willis et al., 2016; Bradshaw et al., 2017). In this study, the approach to thematic analysis developed by Braun and Clarke (2006) was used. This involved six stages: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining, and naming themes and report writing (the analysis process in these stages is described in chapter 6).

The process of transcribing the interviews and listening to the expressions of participants several times enabled me to immerse myself in the data during the analysis to search for themes and sub-themes (Bradshaw et al., 2017). The data analysis process in qualitative descriptive method involves numerous iterations to identify themes and subthemes in the data (Bradshaw et al., 2017; Ayres et al., 2003). Data was analysed to identify participants' accounts of moral

distress and these areas were incorporated into the results (Braun and Clarke, 2006; Sandelowski, 2000). For instance, similar and distinct opinions, thoughts, and beliefs of participants were identified, these commonalities and differences in the data helped to describe accounts of moral distress.

Initially, numerous themes were identified however as the analysis proceeded, I focussed on the goal of the study, and the number of themes was reduced (Bradshaw et al., 2017). Subthemes can then be identified by recognizing similar patterns within the themes (Braun and Clarke, 2006). The process of thematic synthesis ensured that these commonalities and differences in the data were identified to attain a comprehensive understanding of moral distress in nurses. This involved grouping codes to create themes to recognize recurring ideas and patterns between themes, which were then organised into a framework of descriptive themes. This approach incorporated the nurses' experiences and perceptions of moral distress within the context of a specified event. Quotations from participants' accounts are used to illustrate aspects of the experience of participants (Braun and Clarke, 2006). I wrote down personal experience of moral challenges I encountered working as a nurse in clinical care in a notebook and placed it aside, and constantly reminded myself of the need to stay neutral in the analysis process.

5. 10 Ethical considerations

Researchers are obliged to address ethical values pertinent to their study to establish "professional, legal and social accountability" (Cluett and Bluff, 2006 pg. 199). Measures to address confidentiality and informed consent were adequately managed (in chapter 5. 10. 3).

5. 10. 1 Ethical approval

Applications for ethical approval for the study were made to the University of Birmingham Research Ethics Committee and the Navrongo Health Research Centre Institutional Review Board., I contacted the management of the Navrongo Health Research Centre Institutional

Review Board by email to inform them of my intention to carry out a Ph.D. study in Northern Ghana. The application form was emailed to the Navrongo Health Research Centre Institutional Review Board with hard copies of the study proposal, participant information form, participant consent form, interview schedule for nurses and nurse managers, participant demographic form, and participant recruitment form. A review cost was paid to the institute for the Navrongo Health Research Centre Institutional Review Board. After two weeks I received an email from the management of Navrongo Health Research Centre Institutional Review Board requesting further clarification of the reasons why I chose to use Northern Ghana as the setting for my study. The explanation I provided was that l chose to conduct the study in four hospitals in Tamale (Northern region) because of the similarities of health care delivery in the three regions of the North. Moreover, limitation of fund and time required to carry out the study made it impossible to include the other two regions in northern Ghana. Approval was received from Navrongo Health Research Centre Institutional Review Board (Appendix N). The approval number is NHRCIRB315 (Navrongo Health Research Centre Institutional Review Board).

Ethical approval was also obtained the University of Birmingham Research Ethics Committee with approval number ERN_18-0934 (Appendix M).

Once approval was given, letters were written to the hospital management teams of all study sites seeking permission to carry out the study. Once permission was granted an advert was placed in NICU and paediatric wards of all the participating hospitals for recruitment of participants.

5. 10. 2 Informed consent

To ensure the quality and reliability of the study, all participants were given an information sheet explaining the purpose of the research in clear and simple terms. The information sheet included details about informed consent, dissemination of the findings, data management,

agreement to take part in the study, confidentiality, study benefits, approval from the University of Birmingham ethics board and the Navrongo Health Research Centre Institutional Review Board including contact information for monitoring. There were two versions of the information sheet, one for nurses and the other for nurse managers (Appendices A and B).

Participants were given 2 weeks to review the participant information sheet and to ask questions before providing consent. Once eligible participants agreed to take part in the study, they were requested to give their consent to participate by checking applicable boxes, signing, and writing the date at the bottom of the consent form before being interviewed (Appendix C). The consent form was also signed by the researcher after participants' consent was recorded. All elements of the study were explained, and participants given time to ask questions before the start of interviews. As a senior nurse, I was careful not to influence the participation of nurses and nurse managers working in NICU and paediatric wards. Nurses and nurse managers were repeatedly informed that participation into the study was voluntary. Participants were informed of their right to withdraw from the study at any time without any negative consequences or penalty.

Researchers are obliged to pay close attention to the potential psychological effects of participants in a study (Savin-Baden and Major, 2013) this was particularly important in this study because discussing moral distress in individual interviews can induce distressing emotions (Lowes and Gill, 2006). Although no participant withdrew during the interview and all were able to complete their interviews, careful consideration was given to the participants who did become distressed when reflecting on their experiences. Five participants (12.5%) became upset (e.g., became tearful) during the interview process. I paused and offered the participants some time for their emotions to settle. I enquired if they wanted to proceed with the interview, all five participants continued with the interview. The participants were comforted and reassured. At the end of the individual interviews, the participants and the

researcher debriefed by discussing the interview process and its impact. Participants stated that they appreciated the interviews conducted with them because it had enlightened them generally on the term 'moral distress'.

5. 10. 3 Anonymity and confidentiality

Confidentiality of the participants and information given was maintained. In a qualitative descriptive approach, individual interviews are often used which are friendly and cordial owing to the skill of the interviewer. The more details researchers include when creating a rich description, the greater the possibility of participant identification (Bradshaw et al., 2017). According to Doody and Noonan (2016), researchers must disguise details such as the names of participants to protect their identities.

In this study, all participants were assigned a unique number so that any personal data collected could be held separately from the interview and demographic data. This unique number was used on all information collected about the participants during this study to ensure the protection of participant anonymity and confidentiality. Names of participants were not used in the digitally recorded interview. Further, the names of the hospitals where the participants worked were given pseudonyms: site 1, site 2, site 3 and site 4. Nurse participants were given identity numbers 1 to 40. Table 11 below lists the identification numbers assigned to participants.

Table 11: Identity numbers assigned to participants

Study sites	Number of participants (nurses)	Identity number assigned nurses in NICU	Identity number assigned to nurses in Paed. wards	Number of participants (nurse managers)	Identity number assigned To NICU NM	Identity number assigned To Paed. ward NM
Site 1	23	NICU: 1 - 11	Paed: 17 – 28	6	NICU:1 - 3	Paed: 6 - 8
Site 2	9	NICU: 12 - 16	Paed: 29 – 32	4	NICU: 4 - 5	Paed: 9 - 10
Site 3	5	-	Paed: 33 – 37	2	-	Paed: 11 - 12

Site 4	3	-	Paed: 38 – 40	2	-	Paed: 13 - 14

As part of ensuring confidentiality and anonymity, the researcher and her supervisors were the only ones who viewed anonymised information about participants. After the completion of the study, all electronic documents such as the demographic survey, list of participants with their unique numbers, digitally recorded interviews, transcripts, and field notes were stored on a secure password protected computer. Comments made by participants could not be traced to the individual because no personal identities were recorded. However, the researcher was given permission, noted on the signed consent form, to use anonymized direct quotes from the data collected. Individual answers were not shared or presented in any way that would identify them as the source of information.

Transcription and organisation of the data was maintained in a confidential manner. To protect the participants further, all raw data and descriptions have been kept within the supervision team. Hard copies of these documents are kept in a folder and will be placed in a locked cabinet for 10 years and then destroyed in accordance with the University policy on data management.

5. 11. Conclusion

In this chapter, the ontological, epistemological assumptions and methodology used in the study were presented. It was argued that social constructionism was pivotal in shaping the qualitative approach used in this study and was appropriate to examine the perception and experience of moral distress in nurses working in NICU, and paediatric wards in Northern Ghana.

Furthermore, the subject of data collection within a qualitative descriptive approach was discussed in this chapter. Justification was provided for the use of semi-structured individual interviews and purposive sampling. Thematic data analysis was identified as being consistent

with the qualitative descriptive approach. Finally, detailed ethical consideration was discussed. In chapter 6, I present findings of the study.

Chapter 6: Findings

6. 1 Introduction

Fifty-four nurses and nurse managers were interviewed between November 2018 and April 2019 in Northern Ghana. The semi-structured interview schedule was designed to explore how participants experience moral distress, identify the factors that contribute to the experience of moral distress, and examine the impact of the experience on participants and any coping mechanisms developed in response. Nurse managers were also asked about the support measures available for nurses who experience morally distressing situations. The findings from these interviews are presented in the second part of this chapter.

Five main themes and 10 subthemes emerged during data analysis of the nurses' interviews. The main themes were, 1. nurses experienced morally distressing situations, 2. causes of morally distressing situations in nurses, 3. the impact of morally distressing situations on nurses, 4. coping mechanisms of nurses who experienced morally distressing situations, 5. recommendations by nurses to reduce the incidence of morally distressing situations. The subthemes were internal causes, external causes, psychological effects of morally distressing situations on nurses, physical effects of morally distressing situations on nurses, perceived effects on patient care, perceived effects on the health organization, internal coping mechanisms, external coping mechanisms to ameliorate the experience of morally distressing situations, recommendations to the hospital management and recommendations to nurse managers (ward).

Two additional themes and 2 subthemes were realized from analysis of the nurse managers' interviews these were 1. inadequate support measures offered by nurse managers to address morally distressing situations in nurses and 2. morally distressing situations not limited to

nurses; nurse managers experienced it too. The subthemes were nurse managers not equipped with adequate skills to address morally distressing situations in nurses and lack of formal structures at the hospital to address morally distressing situations on the wards.

Chapter 6 presents the data collection procedure, data analysis process and study findings. This chapter is presented in 6 sections these are, the process of data collection; analysis of data; study findings from the interviews with nurses; findings from the interviews with nurse managers; a summary of findings of nurses and nurse managers; and how rigour was ensured in the study. The findings of nurses and nurse managers were summarized to provide a holistic account of the experience of moral distress in nurses working in NICU and paediatric wards in Ghana.

6. 2 Process of data collection

The participants for this study were recruited in two groups. The first group was 40 nurses who worked in NICU and paediatric wards, the second group was 14 nurse managers who worked in managerial and supervisory roles in these same wards. The rationale for conducting face-to-face interviews with nurses and nurse managers was to better understand the experience of moral distress in nurses and the support measures available for nurses working in NICU and paediatric wards.

The invitation to participate in the research was communicated in two ways: 1. through meeting individual nurses and 2. attending scheduled daily ward meetings of nurses and nurse managers in the four study sites. This gave me an opportunity to brief nurses on the aim of the study. Adverts were placed on the notice boards of all study sites for interested and eligible nurses to contact me for detailed information about the study.

Participant information leaflets were also made available on the NICUs and paediatric wards. Participants had up to 2 weeks to review the participant information sheet and to ask questions before providing informed written consent. Participants were assured of confidentiality in the

interview process, private interview locations (both within and outside the hospital environment) were used to ensure confidentiality and a relaxed environment.

The date, time and location of the individual interviews were arranged with the participants by telephone. Participants were informed that the interviews would last approximately 60 minutes. Study participants did not receive any financial benefit however, they were served with a drink and biscuit as a token of appreciation.

6. 3. 1 Face - to - face interviews with nurses and nurse managers

The first 15 interviews I conducted were overseen by a senior researcher (see discussion chapter). Prior to starting the interview, I confirmed that each participant understood what was on the information sheet and participants were given a further opportunity to ask any questions. Participants were asked to sign a consent form confirming their agreement to take part in the study and for digital recording of the interview. The right to withdraw from the study before data analysis without giving a reason was reiterated to participants. The need to stop or pause the interview process if participants felt distressed or uncomfortable recounting their experiences was discussed. After oral and written consent was confirmed, participants were asked to complete a brief demographic survey (appendices D and E).

The semi-structured interview schedule was designed to cover moral difficulties. Broad and narrow questions were asked, for instance participants were asked; 'Tell me what it is like working as a nurse in NICU/paediatric ward?' 'Can you tell me about an upsetting situation or an experience in which you find it difficult to carry out your responsibilities as a nurse/nurse manager in NICU or paediatric ward'? These questions were used to facilitate the discussion and served as a guide during the interview process (Appendix F and G). All participants were asked the same questions to ensure uniformity. Probes were also used (example of probes: *If yes, give specific examples, if not, why is that)* to gain a better understanding of participants' experiences.

The interview process began with thanking the participants for their involvement in the study. A digital recording device was used to record the interviews. At the end of each interview, participants were thanked for their participation.

6. 4 Preparing for data analysis

To make the data clear and manageable, the data were categorized into four main segments. Namely, demographic questionnaires, digital audio recordings of interviews, field notes and journaling. I put these raw data into a database to make it manageable and enable analysis. Each digital recording was assigned a unit number that corresponded with the demographic data of each participant.

6. 4. 1 Stage 1: Familiarizing myself with the data set

I listened to all digital audio recordings several times before I transcribed them. As discussed in chapter 5, data analysis was conducted using Braun and Clarke's (2006) 6 step method. I transcribed the first digital recording and to ensure accuracy of the transcription I listened to the audio recording again whilst reading the transcript. The first transcribed recording was reviewed by my supervisors and once accuracy and formatting were established, I continued to transcribe the interviews to immerse myself in the data as recommended by Braun and Clarke (2006). This process was carried out in combination with reviewing parts of my journal (discussed in chapter 5) to gain a contextual understanding of the accounts of participants' constructs of moral distress in Ghana.

All transcripts were read in combination with the field notes and journal entries made regarding the experience of moral distress, frequently used terms, phrases, and statements of participants. Patterns and relationships in the data were noted. An initial list of thoughts about what was in the data and interesting ideas was made. This stage was challenging because of the large amount of data (54 transcribed interviews amounted to 727 pages and 324, 334 words). Figure 2 below is an example of some of my early thoughts in my journal as I studied the data.

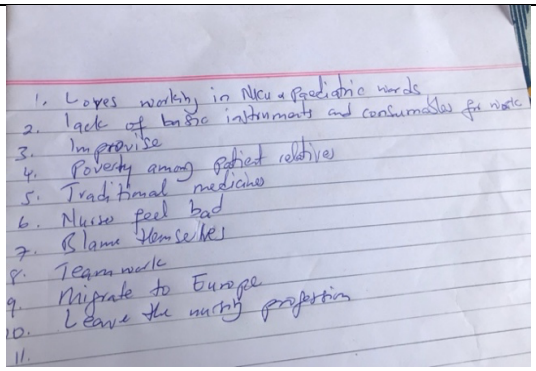


Figure 2: Journal extract.

An excel document was generated which recorded participants' demographic data (appendices H and I). Marital status, religion, age, workplace, ward, work experience, ethnic orientation of each participant was documented.

6. 4. 2 Stage 2: Creating initial codes from the data set

Once, I completed stage 1, I uploaded the transcribed data for each participant into NVivo (version 12©) software (Edhlund and McDougall, 2019). This is a qualitative data analysis computer software package which enables researchers to organise and analyse study data. Codes were created from the data sets using the NVivo application. Codes are 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon' and a good code captures the qualitative fullness in the data (Braun and Clarke, 2006 pg. 88).

I coded the data having in mind my research questions, I worked through all the transcripts one after the other. Issues linked to moral distress in participants were identified in the process of coding. Further, terms and statements that were used to describe their experiences in the data and could form the foundation of themes were also coded. Once a code was created the portion of the extract that represents the code was moved into a holding section using the NVivo software. In this manner, when a particular code is opened all extracts from the data that are coded against that code will be seen. I re-read the data that were not coded to confirm that I

had not overlooked any material. Whilst I coded the first transcript, my supervisors independently coded the same transcript, thereafter the codes were compared and discussed, and a consensus reached. Some data extracts were coded once, others into more than one code and a few were un-coded because they were not supported with data extracts. The initial codes were all exported into a codebook using the NVivo software, and then exported into an excel spread sheet to ensure a more detailed analysis. Four hundred and sixty-two codes were developed in this stage. Below in table 12 are examples of some of the codes with data extracts that reflect them.

Table 12: Codes and correspounding data extracts using NVivo 12

Initial Code	**Data extract**
Sad	*'It makes me sad because I don't know whether management is not looking up to it or I don't actually know where the problem is coming from' (Site 2. NICU. N. 25).* *'You feel very sad especially when you have a very healthy baby that can easily get cured and at the end of the day you go and the baby's condition has changed completely, it's very sad' (Site 1. NICU. N. 3).*
Upsetting situations Lack of trust on the part of patient family members	*'... this morning there is one case that a child came in with malnutrition, severely malnourished. We admitted the child then the mother took the child and ran away' (Site 1. Paed. N. 17).* *'They seek other means of care, and some go to the extent of giving concoctions and all that. So, by the time they come the situation is out of hand' (Site 1. Paed. N. 19).*
Frequency of occurrence of morally distressing situations	*'it's often, it's often, let me say on the average I can get like three times in a week yeah, it could be more it could be less but on the average three times a week ....' (Site 1. NICU. N. 10).*

6. 4. 3 Stage 3: Examining codes and searching for themes

Stage 3 of the analysis process started after some data had been coded in stage 2. The coded data were sorted and examined to identify potential themes. Firstly, the codes were considered in terms of frequency, relationship with other codes and relationship between possible themes. In the process, similar codes were combined to form cognate themes. Codes that were different

but related were also grouped and codes that were totally different stood alone for further analysis. All pertinent data extracts of codes were examined in relation to possible themes. Facial expressions of participants that were documented in the interview process were evaluated in relation to their experience of moral distress. To aid visualization of this analysis process, mind maps were used to organize the codes into themes. At this stage the relationship between codes and themes was considered to create comprehensive themes and potential subthemes. As the analysis proceeded some codes stood alone. For instance, 'loves working on the ward', 'paediatric ward is a specialized place' stood alone, this was a code that did not fit any of the themes developed in the analysis. These codes were reassessed, data extracts analysed broadly for further refinement and combined with other codes or separated as themes. A code may become a theme depending on supporting data extracts, codes could also be categorized to form a theme. For this study several codes were grouped/categorized to form themes based on their meanings, similarities, relation with other codes and aim in relation to the study questions. At the final phase of stage 3, 42 possible themes were identified, and I had developed a better understanding of the individual themes. Table 13 below is an example of the process of examining codes to formulate themes. All pertinent data extracts within the themes were collated in preparation for analysis in stage 4.

Table 13: Categorization/grouping of codes in search of themes

Codes	Groups / categories of codes	Data extracts of codes	Potential themes
Powerlessness Qualities of the nurse Experience of the nurse	- Powerlessness - Fear of repercussion	*'I feel very powerless because looking at this ill child that you can easily save him but because of some moral constraint I am unable to help this patient…. I feel powerless.' (Site 1. NICU. N. 3).* *'Certain tasks may cause distress if you fail to do them. If you believe that a particular action is best for the patient, but you are unable to carry it out because of fear. Later after work I sit down and say oh, I could have done this why didn't I do it, oh morally I should have done this, I have failed to do it because I was afraid (Site 1. Paed. N. 17).*	- Causes of morally distressing situations among nurses - Internal causes
Borrow from other wards Improvise Lack of nurses Lack of basic items Religious and traditional beliefs of family members Poverty among family members (can't buy drugs, laboratory requests, buy fuel for ambulance to travel (referral) Lack of teamwork	- Organizational Inefficiencies - Lack of basic items to work with - Inadequate staff leading to increased workload - Lack of teamwork - Poverty among caregivers (can't buy drugs, laboratory requests, buy fuel for ambulance to travel (referral) - Religious and traditional beliefs affecting care of the patients. - Disagreement among nurses and medical officers	*'the supplying officers' inability to take stock to know what we really needed at the peak season, you know the peak season, there is increase in attendance and you know this rainy season, a lot of malaria cases, anaemias and so it's like he wasn't able to check his stocks, what he had and what he did not have, so when you request then he tells you it's not there, it's not there, ….' (Site 2. Paed. N. 31).* *'….. we improvise a lot of times, we don't have basic items, especially tourniquet to use on the patients so, we tear the tip of the disposable glove then we use it for the neonate that is the improvised thing that we do' (Site 2. NICU. N. 15).* *'The nurse-to-patient ratio is high, six staff managing about 50 clients surely you would be distressed, and you may not be able to do your best in helping the patients' (Site 4. Paed. N. 40).* *'….. it is affecting the treatment of my patients. And then it will affect my patients because if I have arguments with my co-workers just because of things I think are right and he thinks are not right; in the end if my assessment is true and his assessment is not true, and he is supposed to order it and he is not ordering*	- External causes

		it. It affects my baby because he is not going to get the right thing' (Site 1. NICU. N. 4). *'Sometimes you know what is best for the patient and you carry it out, but your senior colleagues are still insisting that it should be done in another way meanwhile I know that this person can be helped through my way, what happens to the patient….? (Site 1. Paed. N. 17).* *'Because the baby was not all that fine and a baby on oxygen is a very critical case so why should you allow the religion, because of naming ceremony you have to discharge this baby; that made me very upset' (Site 2. NICU. N. 15).*	

6. 4. 4 Stage 4: Examining themes

Stage four involved two levels of analysis to enable further refinement of the themes developed in stage 3 (Braun and Clarke, 2006). Individual data extracts related to themes were examined to determine if the themes were well-defined and coherent. Majority of the data extracts formed a coherent pattern, however themes that were not adequately supported with data extracts were re-examined and reviewed. For instance,

> *'NICU is a nice place to work in because you encounter a lot with the babies, I like babies, I enjoy working there' (Site 2. NICU. N. 13).*

This was the only statement of this nature, but it is an important issue because it contributes to understanding the passion nurses have towards the care of patients as a result it was incorporated in a theme.

The second level involved a more comprehensive examination and review of themes in relation to the data extracts. At this stage the themes formulated are examined having in mind the data collected from participants. The big picture (having in mind the accounts of participants) was examined in relation to the themes. As part of this analytic process the critical questions considered included: *Why is it like this? How do they manage? What is happening here?* I went back to the data set several times to review and refine the themes. The first themes were revised by my supervisors and based on their feedback a more critical review was carried out to determine whether the themes accurately reflected the data collected from participants. Below in figure 3 is an example of a developed theme.

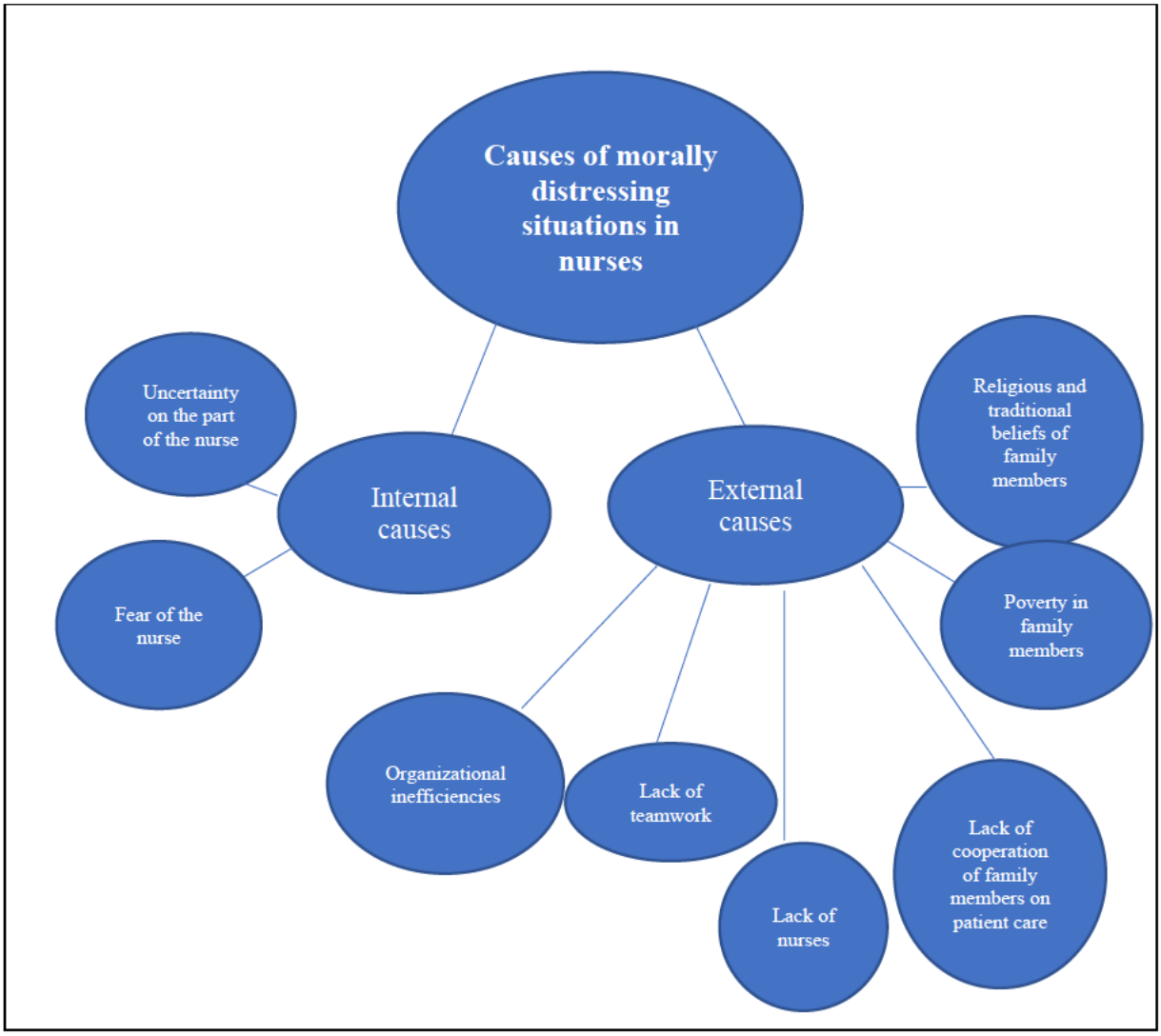


Figure 3: An example of a theme: Causes of morally distressing situations in nurses

6. 4. 5 Stage 5: Defining and naming themes

This stage began after I felt the themes had been formulated and represented the data collected. I defined and further analysed what each theme meant and represented in relation to data extracts. The data extracts for each theme were identified and organized in a clear and logical manner that reflected the data. By this, themes were clearly examined to represent the way participants experienced moral distress in NICU and paediatric wards. Themes were not overloaded and were not overly varied so as not to lose the essence of participants' experience

of moral distress. I re-examined the data extracts several times for individual themes to stay true to the accounts of participants.

In the process of this refinement of the themes, I recognized themes that should have sub-themes. Sub-themes are described as 'themes-within-a-theme' (Braun and Clarke, 2006 pg. 92). Most themes I developed had sub-themes that provided a structure of accounts within the data. A description of each theme, in relation to how it fitted with the broader findings and study questions was written. The final themes and sub-themes identified were then named. For instance, figure 4 below, shows two overarching themes; causes of moral distress among nurses and the impact of morally distressing situations on nurses. In these themes six sub-themes were identified, internal, external causes, physical effects of morally distressing situations on nurses, psychological effects of morally distressing situations on nurses, perceived effects on patient care, and perceived effects on the hospital.

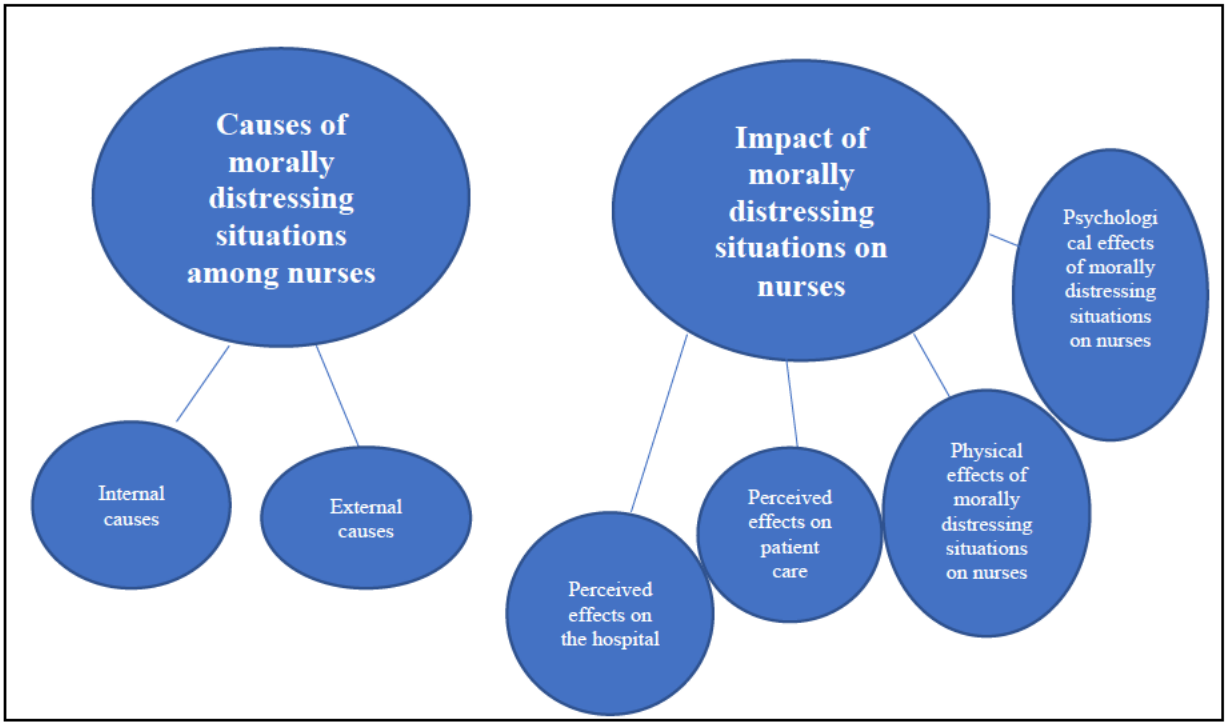


Figure 4: Final thematic map, depicting two themes and six sub-themes

6. 4. 6 Step 6: Generating the report

Summaries of the findings were written for all nurse participants' and nurse managers' interviews (appendices J and K). In this phase, a final examination of all themes and subthemes was undertaken and a report written of the experiences of moral distress in nurses. This is seen in the forthcoming sections of this chapter. Analysis of the transcribed interviews revealed seven themes with twelve sub-themes which portray the experience of moral distress in nurses and nurse managers in Northern Ghana. The results of the interviews with nurses and nurse managers are presented below.

6. 5 Findings from nurses

6. 5. 1. Demographics: gender and age distribution

The gender distribution of study participants was 23 females and 17 males. The age range of participants was from 21 to 40 years with the majority in the 31 to 40 years age range.

6. 5. 2 Ethnic origin of participants

Most of the participants were of Mole-Dagbon ethnic origin from the Northern region of Ghana. Figure 5 below depicts the distribution of participants according to ethnicity.

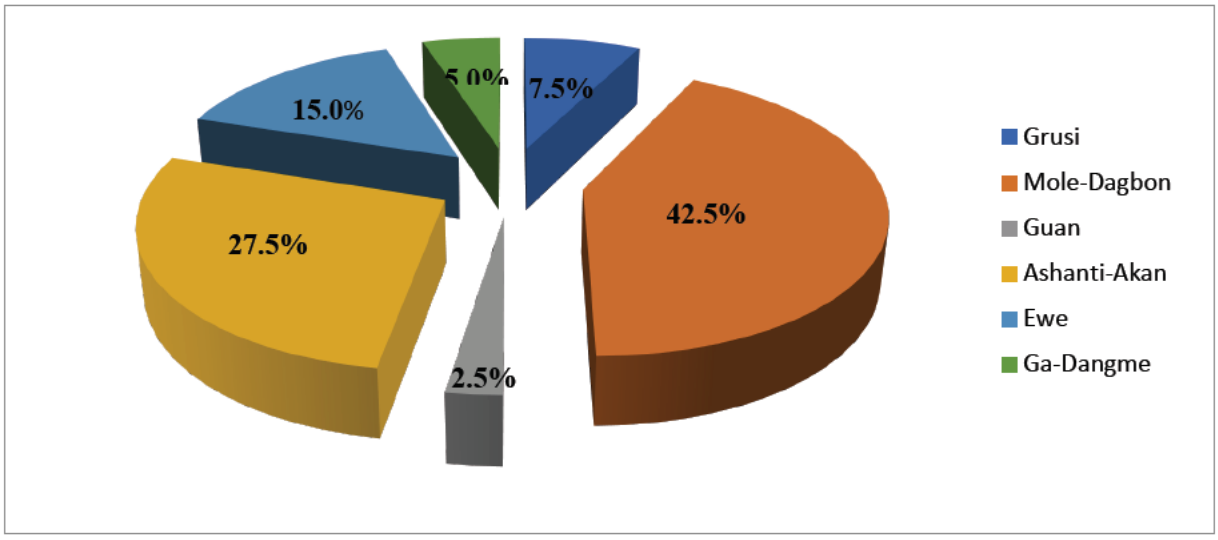


Figure 5: Ethnic origin of participants

The religions of the participants were as follows: twenty-eight (64.2%) Christians and twelve (35.8%) Muslims. There were no traditionalists.

6. 5. 3 Work pattern

All participants worked 8 hours per shift in NICU and paediatric wards. The distribution of nurses working in all four study sites were 24 nurses in paediatric wards and 16 nurses in NICU. The number of participants was higher in the paediatric wards because two (site 3 and site 4) of the hospitals are district hospitals and did not have a NICU.

Table 14: The distribution of participants in study sites.

Number of participants from study sites	No. %	NICU	Paediatric ward
Site 1	23 (57.5%)	11	12
Site 2	9 (22.5%)	5	4
Site 3	5 (12.5%)	-	5
Site 4	3 (7.5%)	-	3

6. 5. 4 Distribution of rank among participants and number of participants per hospital

The highest rank among the study participants was a senior nursing officer. In a typical Ghanaian context, it is not unusual to have a mixture of nursing ranks such as senior nursing officers, nursing officers, senior staff nurses and staff nurses as nurses working directly with patients and family members on the ward. This occurs because of the process for promotion of nurses. Nurses are appraised and promoted to the next rank every three years whilst in clinical practice. Hence senior nursing officers (SNO) were included as study participants as nurses. The distribution of nurses by rank is shown in table 15.

Table 15: Distribution of participants (nurses) according to rank

Study Participants (Frontline Nurses)	No. (%)
Number of participants	40 100%
Rank of participants	
Senior Nursing Officer	2 (5%)
Nursing Officer	11 (27.5%)
Senior Staff Nurse	13 (32.5%)
Staff nurses	14 (35%)

6. 5. 5 Level of education and work experience

The highest level of education of the participants was a postgraduate speciality qualification. Table 16 below shows the levels of education, work experience, and number of years in current workplace.

Table 16: Level of education, work experience and experience of current workplace.

Participants (Frontline nurses)	**N0. (%)**
Highest level of education	
Post Graduate Speciality training	1 (2.5%)
Master's degree	1 (2.5%)
BSc. Nursing	11 (27.5%)
Diploma in nursing	27 (67.5%)
Length of nursing experience	
1 – 5 years	24 (60%)
6 – 10 years	14 (35%)
More than 10 years	2 (5%)
Number of years in current workplace	
Less than 1 year	4 (10%)
1 – 5 years	29 (72.5%)
6 – 10 years	6 (15%)
More than 10 years	1 (2.5%)

6. 6 Description of themes – nurses

Five major themes and 10 sub themes emerged from the data analysis of the nurses' interviews. These themes are explained in the Ghanaian context, where nurses try to adhere to moral and professional standards in their quest to manage patients in their care. Direct quotes have been used in the presentation of findings to illustrate the themes. Table 17 shows the main themes and corresponding sub themes.

Table: 17 Main themes and subthemes

Main Themes	Sub-Themes
1. Nurses experienced morally distressing situations	-
2. Causes of morally distressing situations in nurses	2.1 External causes 2.2 Internal causes
3. Impact of morally distressing situations on nurses	3.1 Psychological effects of morally distressing situations on nurses 3.2 Physical effects of morally distressing situations on nurses 3.3 Perceived effects on patient care 3.4 Perceived effects on the health organization
4. Coping mechanisms of nurses who experienced morally distressing situations	4. 1 Internal coping mechanisms 4. 2 External coping mechanisms to ameliorate the experience of morally distressing situations
5. Recommendations by nurses to reduce the incidence of morally distressing situations	5.1 Recommendations to the hospital management 5.2 Recommendations to nurse managers (ward)

6.6.1 Theme 1: Nurses experienced morally distressing situations

Nurses in NICU and paediatric wards in Ghana care for and manage patients with a variety of health problems such as congenital abnormalities, prematurity, cancers, malnutrition, anaemia, malaria, and malformations. The scope of responsibilities for the nurses on NICUs and paediatric wards ranged from minimal supportive care to highly complex intensive care. Nurses experienced moral difficulties in some situations, in their quest to do the right thing for the patients. Data analysis revealed that all nurse participants experienced morally distressing situations irrespective of where they worked (NICU or paediatric wards).

Thirty-two (80%) participants (nurses) had not heard the term 'moral distress 'before the interviews. For example:

> *'I've not actually heard of it as a term but dividing it into moral and distress I understand those two individual words but tying together like moral distress I have not actually come across it' (Site 1. NICU. N. 11).*
>
> *'This is the first time of hearing it ….' (Site 1. Paed. N. 19).*

A participant recalled that he heard the term for the first time when I came to advertise and recruit participants for this study. At that point he read about moral distress. Here is what he shared:

> *'Nurses have been experiencing this always, because of this interview, I have been able to go and learn a bit about it that is why I know about it… (Site 3. Paed. N. 35).*

When I explained moral distress and followed up with examples all participants identified with the term and recounted their experiences. Participants used various examples from their daily work on the wards to explain the situations they experienced. Participants reported that moral distress was always present in nurses working in NICU and paediatric wards. The following data extracts record such experiences of moral distress:

> *'These babies sometimes are very tiny so usually we need the tiny items to work with like tiny nasal prongs, the tiny suctioning bulbs. Sometimes when they bring in a baby and you really need those tiny items to work with on the babies and you can't find it it's very hectic. Because you are trying to improvise something to achieve what you still want to achieve can be time consuming and morally distressing. Getting the right things for them is quite difficult in our area because we are not that equipped. But sometimes you must use the adult items to attend to them especially my concern now is about the nasal prongs. Because we are seeing that most of them are having lacerations because the prongs are big, so we keep pushing it in and it comes out and before you realize baby is having some small lacerations and you have to handle that one too' (Site 1. Paed. N. 20).*

A participant recounted a difficult moral challenge encountered:

> *'The whole physical space of NICU is small, there are eight cots, four warmers. So, in all we have ten cots, four warmers and one incubator. However, if our patients are more than the number, we normally pair them because the warmers are bigger. We normally pair them, two in a warmer. The most disturbing part is if a baby needs phototherapy, and the only phototherapy cot is being used by another patient. That means one must wait until the baby is done with the phototherapy' or we have to pair them in the cot for the therapy although we know that only one baby at a time in the phototherapy cot' (Site 1. NICU. N. 1).*

Twenty-seven participants described the occurrence of morally distressing situations as quite common on the wards. The morally distressing situations were discussed in nurses on duty, and experiences were shared during patient hand over to the nurses on the next shift. Two participants recalled:

> *'It's often, it's often, let me say on the average I experience it three times in a week, it could be more it could be less but on the average three times a week….' (Site 1. NICU. N. 10).*

> *'There are a lot of instances where you know that these are the right actions you should take for your patients, but you are literally forced to act differently, it happens a lot in this ward ……' (Site 1. Paed. N. 21).*

The experience of morally distressing situations was not limited to nurses working in the paediatric ward and NICU. Participants explained that the experience was widespread in many wards and hospitals in Northern Ghana. Many of the nurses had worked on other wards and in other hospitals and had experienced similar morally distressing situations in these clinical settings. A participant shared this:

> *'….in this hospital, there is no ward you will work and will not experience moral distress. All nurses in other departments keep complaining of those things so it's everywhere, so you can't go anywhere if it's because of that. Because we are really distressed, for in all the wards they have that complaint' (Site 1. NICU N. 8).*

She went on:

> *'… and it is not just in NICU, but I will say around these parts of the country we do experience a lot of these situations' (Site 1. NICU. N. 8).*

Another participant reported:

> *'I have worked in the paediatric ward, I have worked in the surgical ward, Outpatient Department (OPD) and emergency department. But they are always the same moral difficulties that come up they may look different, but it all boils down to the same thing' (Site 3. Paed. N. 37).*

Participants' demographic information, such as religion, age, work experience and ethnic orientation, were examined in relationship to the experience of moral distress. It was not possible to determine if participants' religious faith contributed to their experience of moral distress, however participants believed their religion (Christianity and Islam) helped them cope with morally distressing situations on the wards (this is presented in more detail in section 6.9. 2).

Paediatric wards and NICUs are clinical settings that are emotionally draining for nurses with morally difficult cases that they must manage daily. Participants described how moral situations were unavoidable in NICU and paediatric wards. For example:

> *'It is unethical to discharge a baby on oxygen, but the client relatives have their rights, family members bring a letter for discharge against medical advice that means you have to discharge the client because we cannot keep the patient on the ward against their will' (Site 2. NICU. N. 15).*

> *'I knew that was not right, but I had no option because there were no gloves to work with, they were just inadequate. I had a last pair of disposable gloves; I wore them to care for three ill babies. I feed the babies, checked their intravenous lines, changed their diapers, although I knew that was wrong, I needed to attend to all the babies' (Site 1. NICU. N. 9).*

6.7 Theme 2: Causes of morally distressing situations in nurses

The causes of moral distress among nurses were categorised into two sub themes namely, external, and internal causes of moral distress. All participants described several internal and external causes that contributed to their experience of morally distressing situations working in NICU and paediatric wards.

6.7.1 External causes

External factors were the frequently reported causes of moral distress reported by all participants. External causes included organizational inefficiencies, increased workload because of lack of staff, and lack of cooperation of family members in patient care. Additionally, disagreements between nurses and medical officers' regarding patient care and lack of teamwork were identified as external causes of moral distress.

Other contributing causes were poverty of family members (patient family members were unable to buy drugs, pay for laboratory tests or buy fuel for the ambulance to take patients to the next level facility if referred), religious and traditional beliefs of family members that interfered in the care of patients such as 'Suuna', which is a child naming ceremony. Finally, blood transfusions challenges and delays in sending patients to the hospitals for care were also reported. These are all discussed below.

Organizational Inefficiencies

All participants believed that organizational inefficiencies occurred because, hospital management delayed the ordering of daily ward consumables (oxygen, gloves, cotton wool, glucose strips, syringes, medicines) that were needed for the appropriate and effective care of patients. Nurses recounted how they believed they knew what was required for clincal care yet because they lacked resources to deliver the care they experienced moral distress. For instance, in the raining season (April to August; typical period of rains in Ghana, also known as the rainy season) the number of infections among children increases and hence the number of admissions is higher in this period necessitating more consumables. However, plans to order more consumables were not made. All nurses from the four hospitals reported a lack of daily ward consumables as a major cause of their distress. A participant from Site 2 commented:

> *'the supplying officers' inability to take stock to know what we really needed at the peak season, you know the peak season, there is increase in attendance and you know this rainy season, a lot of malaria cases, anaemias and so it's like he wasn't able to check his stocks, what he had and what he did not have, so when you request then he tells you it's not there, it's not there, ...' (Site 2. Paed. N. 31).*

Lack of basic items led to reuse of certain 'single-use' articles (gloves, syringes for feeding) to continue to manage the patient even though participants were aware of the risks of reusing them. Below is an example to illustrate the sort of morally distressing situations participants encountered:

> *'Because you see that the baby is suffering you want to help and there is nothing you can do. Or you wear a pair of gloves and go around the whole ward because that is what you've been given' (Site 1. NICU. N. 1).*

Nurses resorted to using other items because of the lack of basic equipment to work with. A nurse shared her experience:

> *'..... we improvise a lot of times, we don't have basic items, especially tourniquet to use on the patients so, we tear the tip of the disposable glove then we use it for the neonate that is the improvised thing that we do' (Site 2. NICU. N. 15).*

Participants recounted that malfunctioning items prevented them from managing patients who needed urgent care. A participant recounted her experience:

> *'We were resuscitating a patient and went looking for a resuscitation machine not knowing that the machine was not working. The start knob on the machine was not operative, we then had to use a manual device, the 'ambu' bag instead which did not give us the urgent results we needed for our patient' (Site 4. Paed. N. 38).*

Participants did their best to care for the patients despite the lack of basic equipment. A participant shared this:

> *'We are lacking a lot, for instance as I said we have only one oxygen cylinder with oxygen, we have to pass it from one baby to another, we share it among the patients who need oxygen, one patient gets a little oxygen then we move it to another patient……' (Site 2. NICU. N. 13).*

Increased workload

Excessive workload was cited as a major source of moral distress among the participants. The participants reported that lack of nurses (in terms of numbers) contributed to their experience of moral distress. This was reported in study site 4 where 2 nurses cared for 50 or more patients and study sites 1, 2 and 3 (2 nurses to 30 - 40 patients). A participant stated:

> *'The nurse-to-patient ratio is high, 2 staff managing about 50 clients surely you would be distressed, and you may not be able to do your best in helping the patients. In nursing training, I assumed a particular perception about the nursing profession when I came to the practical it feels different. I would be disturbed, because I was not prepared for some of the things I am facing now' (Site 4. Paed. N. 40).*

Disagreement among nurses and medical officers

Disagreement among nurses and medical officers was felt by more than half (67.5%) of the participants to be a source of moral distress. Some participants felt that nurses should be aware of their duties and responsibilities and continuously seek the best and advocate for their patients. However, in the quest to do what was right for the patients there were sometimes misunderstandings among them on issues regarding patient care.

A participant recounted her experience:

> *'…. because if I have arguments with my co-workers just because of things I think are right and he thinks are not right; in the end if my assessment is true and his assessment*

is not true, and he is supposed to order it and he is not ordering it. It affects my baby because he (the baby?) is not going to get the right thing' (Site 1. NICU. N. 4).

Lack of teamwork

Lack of teamwork among staff was a major source of moral distress for participants. Nurses generally consult each other about the day-to-day management of patients on the ward, however, there were times when colleagues were not sufficiently involved in the care of their patients. Eighteen nurses explained that lack of adequate teamwork contributed to their experience of morally distressing situations working in NICU and paediatric wards. A participant shared his experience:

'On the part of nurses, not everyone cooperates or always in agreement all the time regarding patient care, so when you need colleagues to support you in carrying out a procedure it is difficult because some people are so reluctant to help….' (Site 3. Paed. N. 34).

Lack of teamwork among nurses was also attributed to the relationship between some colleagues and the junior nurses. Participants recounted that some senior nurses behave as though they know everything and ignore the contributions of junior nurses in the care and management of patients. A participant shared an experience of lack of teamwork among nurses:

'Sometimes you know what is best for the patient and you carry it out, but your senior colleagues are still insisting that it should be done in another way meanwhile I know that this person can be helped through my way, what happens to the patient….? (Site 1. Paed. N. 17).

In my interviews with senior nurses, they acknowledged the challenge of inadequate teamwork among the staff in NICU and paediatric wards. The seniors in the ward can collaborate with the junior staff to effectively manage care of patients. A participant stated this:

'...Decisions about patients are taken without involving all nurses in the care of patients. Senior nurses fail to involve junior this affects the care of patients'... (Site 1. Paed. N. 22).

Other health care professionals, particularly medical doctors, did not involve nurses sufficiently in the care and management of patients on admission. Nurses on duty usually monitor patients therefore involving them in the care and management is the most appropriate

thing to do. However, participants reported that lack of teamwork led to lack of coordination of patient care plans, resulting in difficulties in the care of patients.

> *'...Work here is separated, there is no teamwork. There is no cooperation among us regarding patient care. We do not really come together to take decisions for patients. And sometimes it leads to a lot of lapses in patient care' (Site 1. Paed. N. 18).*

In certain situations, meetings were scheduled for nurses and other health care professionals to deliberate on improvement of patient care, but the attendance was low. There was no collaboration making it difficult to achieve a common goal and, in the end, everybody was stressed, and patient care not carried out.

> *'...even sometimes when you call for meetings not everybody can turn up so when you take a decision it is not inclusive' (Site 1. NICU. N. 9).*

Lack of cooperation of family members in patient care

Participants shared their difficulties of working with patients' relatives and family members. They recognised how clinical circumstances concerning critically ill patients led to family pressures. Nurses felt morally distressed in situations where family members refused care for the patients and insisted on discharge against medical advice for example. This is because the nurses believed the patient would not survive if discharged.

> *'So, we really have those situations where they come and demand discharge against medical advice. Even if they see the condition of the baby, they still want to take the baby home' (Site 1. NICU. N. 5).*

The request for discharge against medical advice was quite common on the wards which was a source of moral distress.

> *'And we've been experiencing a lot. Yesterday for instance, I think we had 2 family members demanding for discharge of their child (against medical advice) and then this morning we were even discussing with one of the specialists, the paediatrician. He said he is even going to research into the reason why people are requesting for discharge against medical advice. And I think these are some of the cases' (Site 1. Paed. N. 17).*

Poverty in patient family members

Poverty of family members of patients was reported to be a major source of distress by participants. Some family members were not insured by any health insurance scheme and could

not pay out-of-pocket therefore did not have enough money to buy drugs for their ill children. In Ghana, the premium or payment of the National Health Insurance scheme is paid once a year. There are times when families below the poverty line are unable to pay the premium. Those who manage to pay, believe that once paid, then all drugs and medications are covered by the health insurance scheme, however, the scheme does not cover all illness affecting the populace in Ghana. This was a source of moral distress for nurses. A participant recounted her experience:

> *'…the mothers are willing to buy but the finance is not there, they are waiting for their husbands. … they too will tell them that they don't have money for that medication because health insurance has been paid' (Site 1. Paed. N. 22).*

Another participant stated:

> *'if at the end of the day we have a situation a baby is presented to us and the parents don't have the necessary funding. If we are able to ascertain that it's really genuine that they can't afford then the baby has a very good chance. Why don't we come up with a system where you have some structures in place for those kinds of isolated cases the hospital will take up that responsibility' (Site 1. NICU. N. 1).*

Family members' inability to buy medicines, pay for laboratory examinations and fuel for ambulance transportation because of poverty led to situations where nurses and doctors contributed money to help family members. The participants tried to do what they felt was best for the patients. For example:

> *'For you to probably stay and watch a baby die slowly when you eventually have little you can do to help, because there are instances where nurses or staff have come together to make contributions to buy medications' (Site 1. NICU. N. 1).*

> *'There are some instances where family members do not have money to buy medicines for their patients, in such cases some nurses contribute to purchase medicines for the patients' (Site 1. Paed. N. 17).*

Religious and traditional beliefs

Religious and traditional beliefs about the care of patients were described by all participants as a common source of moral distress in nurses. Participants explained how difficult and challenging it was to manage some family members who were motivated by religiously beliefs.

In the Muslim community, 'Suuna' is the naming ceremony for a new-born baby. The ceremony is carried out exactly on the seventh day after birth and requires that the baby be at home for the ceremony. The hair of the baby is shaved then the baby is given a name, and relatives and friends of the family are invited for the celebration. The woman's husband buys her a new piece of cloth to sew a garment for the ceremony. Muslim prayers are then recited for the child early in the morning. A participant commented:

> *'... because the baby was not all that fine and a baby on oxygen is a very critical case so why should you allow the religion, because of naming ceremony you have to discharge this baby; that made me very upset' (Site 2. NICU. N. 15).*

Some family members with a particular religious faith would not consent for blood transfusions which was a difficulty for the nurses. A participant recounted:

> *'…… a Jehovah's witness does not take blood as well. These people refused to take the blood until the baby was discharged home' (Site 2. Paed. N. 31).*

> *'Patient relatives believe that once my child takes blood, the next year the child would continue to take blood. So, it is very difficult getting them to allow us to transfuse their child' (Site 2. Paed. N. 31).*

Another participant shared her experience:

> *'Sometimes we admit patients who need to be transfused and then their parents refuse the transfusion because of their beliefs, and you can't also do it without their consent. So sometimes you try your best to explain to let them understand that this is necessary but then they still refuse, so there is nothing you can do about that. There is nothing you can do about it because when they just say no, they don't want it; there is nothing you can say. But then they just refuse, and you can't understand it, but you can't force them, especially with blood transfusion you can't force and give it simply because you think it is right. Because you need the consent, you need them to sign the consent form before it's done …. (Site 4. Paed. N. 39).*

Some cultural beliefs among family members influenced and interfered with the care nurses provided for patients in certain clinical situations. For example, there is a belief in the Mole-Dagomba culture in Northern Ghana, that patients with carbuncles or boils should not receive any form of injections. A participant commented:

'There is nothing the nurse will do to convince them to agree to the medication because they believe that the person has a boil and once you inject the person the person will die' (Site 2. Paed. N. 29).

Participants recounted cultural beliefs of a patient's family members that delayed the provision of care to ill patients. The participants reported that family members consulted local herbalists and spiritualists when their children were ill before they brought them to the hospital. A participant described his experience:

'……. Our people believe so much in concoctions (local mixtures). That is our major problem in this part because they always say that it is less expensive compared to modern medicine. It is very distressing yes, they believe, it's only when the situation gets out of hand that they normally rush to the hospital. And most of the cases that they bring in critical conditions are due to that and most of them don't survive it' (Site 1. Paed. N. 19).

Another participant recounted losing a patient as a result of delayed admission and treatment:

'……. other times too they believe so much in the local treatment because we witness that a child passed away because of that. They gave a lot of local treatment in the house before the child came here so when the patient was admitted the doctor realised it and asked the relatives: 'did you give anything at home?' They said no, when they realized that the condition of the child was getting critical then they disclosed that the child was complaining of stomach-ache, and they gave some local medicine at home before bringing the child to the hospital so finally the child passed on' (Site 3. Paed. N. 36).

Some family members of patients requested that their ill new-born babies be sent home with them so that they could seek guidance from small gods regarding the destiny of the new-born in accordance with their traditional beliefs. This was to determine whether it had been ordained by small 'gods' (local gods) that the new-born should be hospitalized. A participant shared a story.

'The father said the child is a new-born and they have not made any enquiry pertaining to the child's destiny; he said it's a traditional kind of thing so they will take the child to the traditionalist, they will perform some rituals. And you know in that part of the country people believe in spirituality compared to modern medicine. When they have done all, they can do with the spiritualists and they fail, that is when they seek medical treatment' (Site 1. NICU. N. 2).

6.7.2 Internal causes

Through the data analysis process some contributing factors to moral distress in nurses were categorised as internal causes because they constituted personal features of the nurse (characteristics of the individual nurse) which constrained their moral action linked to the care of patients. In this study nurses felt uncertain, lacked confidence, and harboured fear that limited them from caring for patients. Participants recognized that their own internal inabilities contributed to their experience of moral distress. Nurses were unable to act on what might have been best for the patients because of uncertainty regarding care of patients. A participant stated:

> *'I felt very unsure of what to do looking at the ill child. I could have easily saved him by checking the patient's blood glucose, but I did not, I felt sad.' (Site 1. NICU. N. 3).*

Another participant recounted:

> *'it's a big burden when you realize that you didn't do what you were supposed to do for a particular baby due to my hesitancy. It's very challenging, your conscience worries you, it's a bad feeling, I feel helpless….' (Site 1. NICU. N. 9).*

Some nurses lacked confidence in areas where they should have acted swiftly in the care of patients. A participant commented:

> *'. If I had at least set an intravenous line on the ill baby, checked the random blood sugar and administered dextrose till the mother starts to lactate, maybe that death could have been avoidable, but I didn't do it, and this was a big difficulty for me….'. (Site 2. NICU. N.1).*

Another internal cause of moral distress was participants' fear of carrying out the wrong act of care for patients. A participant stated this:

> *'Certain tasks may cause pain if you fail to do because of fear. One day, I believed that a particular action was best for the patient, but I was afraid, and became confused not knowing which action to take because of my own fear of doing the wrong thing, it hurts' (Site 1. Paed. N. 18).*

6.8 Theme 3: Impact of morally distressing situations on nurses

All participants acknowledged that the experience of morally distressing situations had a significant impact on them psychologically and physically. Appendix J shows words and phrases used by participants to describe how they felt when they experienced moral distress.

6.8.1 Psychological effects of moral distress on nurses

Participants reported feelings of sadness and anger when experiencing moral distress. These emotions were also evident in their body language and facial expressions during the interviews. A participant from site 2 shared some of her emotions:

> *'It makes you feel so bad because you know this baby will not survive if it's discharged it might be a chance of 50/50. You have counselled them to stay but they still insist that they'll go, it is very sad clients have their rights you cannot force them but it's very sad' (Site 2. NICU. N. 15).*

Participants used words and phrases such as, I feel sad (39), feels bad (16), frustrating (7), feel angry (6), as psychological descriptors of their experience of moral distress. For instance, participants emotions such as sadness, anger and pain were captured during the interview process. Many participants used more than one phrase to describe the experience. As demonstrated here:

> *'So, you will feel demoralised and then sad' (Site 2. NICU. N. 12).*
>
> *'I feel bad. Your conscience doesn't set you free….' (Site 2. NICU. N. 13)*
>
> *'And you become weak, you become so powerless that you don't know what to do because you know that you are supposed to do it, you know it's right for you to do it, as a professional' (Site 1. Paed. N. 18).*

Participants in NICU and paediatric wards recounted sad experiences of moral distress because of the nature of patients that they cared for. For example:

> *'I feel very bad, in that incident that we lost a baby because of delay in blood transfusion I wept. I couldn't see them carry the child knowing well that the blood could save the life of this child. Sometimes I am sad, and if it's because of the patient's relatives it gets me even more sad'. (Site 2. Paed. N. 32).*

There was a common thread through the accounts of all the participants that moral distress affected them and their family members. Four participants described the effect in this way:

> *'It affects me psychologically, sometimes when I go to the house, all I do is to lie down and reflect on the situation ….' (Site 1. NICU. N. 4).*

> *'Well, it does affect my family life psychologically. Sometimes if you are not able to perform a task and you get home, your mind would keep reminding you and this may alter your mood and influence how you relate with people around you (family)' (Site 3. Paed. N. 35).*

> *'My experience affects me psychologically, because I am constantly sad that I could not carry out what I needed to do at work. When, I go home, your mind will cast back to the ward concerning what I should have done for a particular patient. As result I am not myself at home…' (Site 3. Paed. N. 35)*

> *So, when I get home, I call my colleagues on the ward to check on the patient's situation. In some cases, although I will be coming for morning shift the next day before I go to work, I call again, I do this constantly which affects me psychologically….' (Site 3. Paed. N. 33).*

Another psychological effect that many of the participants experienced was that they sometimes blamed themselves and felt guilty about the moral difficulty. These are 3 examples from the 40 participants:

> *'…it feels like you didn't do your best, you feel you haven't done enough for the patients. Even for some of them, you feel you are the cause even though sometimes it might not be really your fault. So sometimes you feel guilty….' (Site 1. Paed. N. 20).*

> *'… it's really frustrating and makes you feel you could have done more for the child; you feel guilty…' (Site 3. Paed. N. 34).*

> *'You feel like a failure sometimes, you feel like you've not done what you are supposed to do' (Site 1. NICU. N. 5).*

The experience of moral distress sometimes lingered for months after the situation:

> *'…it's really difficult for it to go off my mind completely, there are times the difficult situation escapes, and it comes back, so it's like on and off, on and off. After I have experienced a difficult situation after months it still comes back to mind, three four months, five months issue comes back to your mind' (Site 1. NICU. N. 7).*

6.8.2 Physical effects of moral distress on nurses

Several nurses reported the experience of moral distress affected them physically. Effects of stress induced by moral distress included loss of appetite, fatigue, headache, and insomnia. The most common physical effects reported were headaches and loss of appetite. For example:

> *'You go home, and you are feeling so sad the whole day you cannot even eat' (Site 1. NICU. N. 3).*
>
> *'At a point in time in the difficulties, you are too tired, it gives you a headache, because you do not have what you need to render care' (Site 1. NICU. N. 5).*
>
> *'I have headaches in the night when I experience such difficulties….' (Site 1. Paed. N. 19).*

6.8.3 Perceived effects on patient care

All the participants identified and described the effects of moral distress on patient care. The participants reported that the quality of care was compromised when nurses experienced moral distress. If nurses were frustrated it affected the care given to the patients.

> *'.. it does impact on our patient care because the experience influences our thinking of how much care I could have given to the baby. It is quite disturbing….' (Site 1. NICU. N. 9).*
>
> *'Certainly, it has an impact on patient care in that patients don't get the required treatment that they needed, they don't get the care they needed, they don't get the kind of assessments they need, family members do not get the counselling they need and so on and so forth while on admission due to all the moral distresses we experience' (Site 3. Paed. N. 34).*

When a nurse is unable to care for a patient because of moral distress patients are neglected. All 40 participants perceived that patient care was neglected because of the experience of moral distress.

> '*For instance, some patients will be neglected as a result of the experience. Sometimes you even forget the other patients, after running around because of a difficulty regarding another patient. The experience makes me forget other ones who also need my care So, I think it goes a long way to cause the neglect of other patients' (Site 1. Paed. N. 19).*
>
> *'...I don't feel good working on patients when I experience distress. When I get depressed, you don't feel happy working for patients, and I am forced to neglect them.*

Sometimes, the situation you faced caused patients' death, I feel so depressed that, I don't even feel happy working for other patients' (Site 1. Paed. N. 20).

Twenty participants reported that patients' family members had lost confidence and hope in them because of perceived lack of care. This was the case when nurses were unable to carry out procedure deemed essential.

'... family members are sometimes not assured that we will render care to their ill child, which I agree because nurses are sometimes constrained with what to render care with or policies that does not seek the interest of the child' (Site 1. Paed. N. 17).

All 40 participants perceived that their experience with morally distressing situations affected the nurse patient relationship on the wards. A participant stated:

'I have been told by family members of patients that they did not enjoy the ward because they were not getting much attention and interaction from the nurses.
So sometimes when you are affected it does affect your relationship with the patient greatly. So, I try as much as possible not to allow my sadness to affect my relationship with my clients' (Site 2. Paed. N. 31).

6.8.4 Perceived effects on the health organization

Participants reported that their experience of moral distress damaged the image of the hospital and contributed to a loss of revenue for the hospital. A participant commented:

'To some extent it will have an impact on the hospital because if nursing care is inadequate because of lack of staff the hospital will be labelled with a bad name, patients and family members may refuse to have anything to do with the nurses and the hospital. So, in the long run the name of the hospital will be tagged badly' (Site 2. NICU. N. 16).

Some participants felt that when nurses experienced moral distress and were unable to provide quality nursing care to patients, access to the hospital by patients would decline and the hospital would be unable to generate enough internal revenue from patients who pay out-of-pocket. A participant commented:

'Even the finances of the hospital, the hospital may not be able to generate enough resources. Because I am morally distressed, I am unwilling to care for patients' (Site 1. Paed. N. 17).

Another participant stated:

'…. the hospital may not be able to generate enough financial resources, because once nurses are morally distressed, they are unwilling to care for patients. Therefore, the patronage goes low, meaning that the hospital will not be generating enough money' (Site 3. Paed. N. 33).

Participants were asked if they had considered leaving the ward due to the experience of moral distress. Some respondents had considered leaving the wards in future. Participants perceived that a good option of escaping the experience of morally distressing situations in Ghana was to migrate to the United Kingdom, Europe, or United States of America where health facilities are better equipped with efficient support of nurses. Here is what a participant stated:

'I am opting to migrate to Europe, I have read and heard that hospitals in Europe are better equipped and there is smooth running of the hospitals which will help in making our nursing jobs better' (Site 1. NICU. N. 8).

Twenty-four participants had considered leaving the ward because of moral distress. Participants do not have a choice as to which ward or unit they work on. The allocation of nurses to wards is carried out mainly by the matron of the hospital. However, participants acknowledged that if they were able to choose to leave or remain on the ward, they would prefer to leave because of the experience of the morally distressing situations they encountered. Two participants commented:

'The impact is that it is moving us gradually out of the clinical field, most of us' (Site 1. Paed. N. 17).

'At a point in time I feel too tired to even continue caring for patients, so I feel physically distressed ……' (Site 1. NICU. N. 5).

However, sixteen participants acknowledged that although they experienced moral distress, they would not leave the ward because of their interest in and love of working with children. Children are vulnerable and need nurses to care and advocate for them in distressing situations. Two participants stated:

'I really like handling babies, so I don't think of leaving work at NICU. All babies are so innocent, and they look helpless, so I prefer being with them. So, I have decided to pursue a course in paediatric nursing' (Site 1. NICU. N. 3).

'When you experience distress, you still want it to act as motivation to you to work harder and to do better for your patients and not to let that discourage you and make you not put in what you are supposed to put in….' (Site 3. Paed. N. 35).

6.9. Theme 4: Coping mechanisms of nurses who experience morally distressing situations

The participants used various methods to cope with the experience of morally distressing situations they encountered working in NICU and paediatric wards. These were categorised into internal and external coping mechanisms. Internal coping mechanisms comprised comforting self, keeping to oneself, reflecting on morally upsetting issues. External coping mechanisms were support from colleagues and nurse managers, motivation from nurse managers and the hospital management, seeking counsel from a priest, and/or praying to God for strength, hope and direction.

6.9.1 Internal coping mechanisms

All participants reported using reflective coping mechanisms to navigate the experience of moral distress. A participant recalled:

'I sit down for a while, calm yourself, tell yourself it will pass, it's just a passing moment. And life goes on because other patients are waiting to be cared for, so I try to let it go and then move on' (Site 1. Paed. N. 24).

Participants reflected on morally distressing situations as a form of a coping. More than half of the nurses discussed this method of coping. Two participants recounted this:

'When I reflect, I look out for the positive and the negative ones, the things I didn't do right' (Site 3. Paed. N. 34).

'Sometimes when it happens like that you just let a colleague take over then you go and sit and reflect and then come back because I easily get emotional so when it's happening like that, I can just excuse them for some time and then come back.' (Site 2. NICU. N. 13).

Many participants reflected on how to make the morally distressing situations less difficult the next time they encountered such difficulties. Two participants had this to say:

'I go to the house, lie down and I think and reflect on the very first time the baby was admitted to the ward. I reflect to see what prevented me from acting or why I could not

carry out the procedure or action for the patient. This process of reflection sometimes helps' (Site 1. NICU. N. 4).

'When I reflect, I look out for the difficult situations, what didn't go right for the patients and continue to reflect on my daily activities of caring for the patients.' (Site 3. Paed. N. 33).

Some other coping strategies used by participants were keeping to oneself in morally difficult situations. A participant recalled this:

'I just deal with issues like that myself, most at times I keep to myself. I just don't really complain a lot, if I can't cope, I just keep to myself that is what I do. Because if you are complaining and things are not working out you just have to stop' (Site 1. Paed. N. 17).

6.9.2 External coping mechanisms

All participants recounted various forms of external coping mechanisms they had developed to navigate morally distressing situations. Participants sought counsel from religious leaders when they experienced moral distress. Some participants resorted to prayers for strength and hope in dealing with morally distressing situations. Three participants shared their experience:

'it's only God who can always console us' (Site 1. NICU. 7).

'The future to us Muslims it's only the almighty who has that knowledge, … so, if you accept good things in good faith, it's also part of religious obligation and part of faith that you accept the reverse of it' (Site 1 NICU. N. 1).

'Well sometimes I just give it up to God and say I hope for better things to come and then manage what I can, what I cannot do I just leave it … (Site 3. Paed. N. 36).

Fifteen participants sought support from colleagues and friends.

'We always encourage each other, so I don't know but every point in time when something of such sort happens you would definitely find a nurse by you, who will reassure you' (Site 3. Paed. N. 34).

'You know this type of work you need to be patient, so the words of encouragement give me the hope, especially when they share their experiences, last time this is what happened to me and I did this, so I take inspiration from my friends, those who have been working in NICU as well…' (Site 2. NICU. N. 15).

Most participants felt they had limited organizational sources of support in navigating moral distress. Two participants had used the services of counsellors to help them cope with the

distress. These counsellors were sought out independently by these two participants, because such services were not available to nurses at the hospitals:

> *'...I go to talk to a counsellor, when I visit him, we talk one on one. He asks about work, how you are coping with work and then when there are issues to thrash out, I bring them out and we talk... (Site 1. Paed. N. 17).*

6.10 Theme 5: Recommendations by nurses to reduce the incidence of morally distressing situations.

Participants had the opportunity to recommend measures they felt would help mitigate the experience of moral distress. Two sub themes emerged from the analysis of the data, recommendations to the hospital management and recommendations to nurse managers (ward)**.**

6.10. 1 Recommendations to the hospital management

The recommendations made by participants included the following: timely planning and procurement of instruments and equipment to enable effective management of patients; and establishment of support systems to help nurses manage their moral distress.

Participants felt that to reduce the incidence and negative effects of morally distressing situations, hospital management should establish an independent fund accessible to patients who did not have health insurance. In addition, nurses should enrol on regular in-service training programmes on nursing ethics and moral distress. The need for more staff to reduce the workload in NICU and paediatric wards was also identified.

All participants acknowledged that measures to mitigate the experience of morally distressing situations were needed. They felt the hospital management should provide basic instruments and equipment to work with in the management of patients. A participant stated:

> *'I think they should make all the resources available for us to work with and that will reduce the moral distress among the nurses, because we the nurses are with the patients 24/7 and they expect a lot from us, so all the things we need to work with they should make it available' (Site 1. Paed. N. 18).*

Timely planning and procurement of supplies to enable effective management of patients was one of the major recommendations of the participants.

'Management should plan for items timely and efficiently. They should provide basic items for quick use for our patients. ....' (Site 1. Paed. N. 19).

Participants also felt more nurses should be allocated to work on NICU and the paediatric wards:

'The number of nurses currently present at NICU is not enough. So, the best thing is for us to solve the patient nurse ratio, if I'm nursing one baby at a time alone, I don't think I will miss any responsibility because I cannot use two hours to feed that particular baby no' (Site 1. NICU. N. 4).

Participants recommended opportunities for in-service training on ethical issues in nursing and specifically on moral distress in nurses. A participant shared this:

'If we get in-service training on moral distress, it's better but what contributes to moral distress would have been the best. At least occasionally you pick a topic and talk about it, pick this one and talk into that it will be good (Site 1. Paed. N. 19).

Some participants felt that if nurses were given an opportunity to identify their concerns the causes of moral distress could be identified, and coping measures recommended. A participant explained:

'I think one is giving the nurse the opportunity to talk about what really affects the nurse. I think that platform alone will be enough to voice out your pain and your frustrations. And I think from there the solutions can come up, but they are not given that platform' (Site 1. Paed. N. 18).

6.10.2 Recommendations to nurse managers (ward)

The recommendations made by the participants for the nurse managers included the need for education of family members on health issues, and the establishment of regular departmental meetings to ensure effective management of patients. It was felt that nurse managers should make available and enforce nursing and medical protocols on the ward to facilitate swift patient care for the avoidance of complications and death of patients. Nurse managers should also ensure paediatric wards were child friendly environments to ensure effective management of patients.

It was felt regular meetings of nurses with nurse managers should be instituted to help identify the sources of moral distress in nurses. A participant suggested:

'..... if you are even having a meeting where the HOD is there, where all the nurse managers are there, the administrator is there it will go far....' (Site 1. Paed. N. 26).

Nurse managers should make available ward protocols for the nurses and health professionals to adhere to for the effective care of patients to address the issues of teamwork. A participant stated:

'We wish we had protocols because if there are protocols you know you are going by this; you are going by this. So that is what we are all hoping for that we have protocols posted on notice boards for everyone to read' (Site 1. Paed. N. 20).

The nurse managers should facilitate a cordial working relationship between senior and junior nurses in the care of patients. A participant commented:

'The nurse managers in the ward should plan with the junior nurses on how to effectively seek the best for patients' (Site 2. Paed. N. 29).

The above presented findings of 40 participants who described their experience of moral distress working in NICU and paediatric wards in Northern Ghana. The accounts of participants highlighted five main themes (1-5 themes) and 10 subthemes based on their explanation of their experience of moral distress. The second section presented findings from 14 nurse managers regarding support measures available for nurses who experience morally distressing situations in NICU and paediatric wards, which will continue as theme 6.

6.11 Findings from the nurse managers

In this second part of the chapter, the findings from interviews with nurse managers who worked in NICU, and paediatric wards are presented. This is preceded by a summary of data analysis for nurse managers. The purpose of interviewing the nurse managers was to explore the organisational and professional strategies nurse managers used to address morally distressing situations experienced by nurses in hospitals in Northern Ghana. A nurse manager is a registered nurse appointed by the nursing management whose primary responsibilities are to ensure that human (especially nurses), technological and material resources are available.

They, also carryout general management activities concerning patient care at the ward level. The appointment of nurse managers in Ghana, is based on experience (Adatara et al., 2016), rather than leadership and managerial ability (Fennimore and Wolf, 2011). The premise is that nurses who are clinically competent or have a long working experience are likely to be good managers. However, McCallin and Frankson (2010) reported that some skilled clinical nurses are management novices. The roles and responsibilities of nurse managers are challenging because, they carry out the day-to-day monitoring and supervision of nurses to ensure that nurses provide the needed care for patients on the wards.

6.12 Summary of data analysis process for nurse managers

Braun and Clarke's (2006) analytic guidelines for thematic analysis were used to analyse the data obtained from the nurse managers. Table 18 below presents an example of codes and corresponding data extract using NVivo 12. While figure 6 below shows an example of a theme and two subthemes for nurse managers.

Table 18: Codes and corresponding data extract using NVivo 12 for nurse managers

Initial Code	Data extract
Nurse managers voice not heard Followed up on grievances Contacted management	*'I have followed this several times my assistant has followed it several times and it is still a challenge and so when it happens like that you are frustrated because you think what they are supposed to do for you to help you do the work it's not being done……' (Site 2. Paed. NM. 9).* *'We have even written letters to management. Currently was it last two weeks, we wrote a letter concerning this structuring we are very few. We have written their grievances, everything but it is like they keep on assuring you…' (Site 1. NICU. NM. 2).*
Disturbing Frustrating Increased workload Lack of nurses	*'For instance, I am on duty and there are 20 patients on admission and there are only two nurses on the ward to care for the patients. It's going to be very distressing because these two nurses have to take care of all those patients, give them medications and carry out all needed care that the patients will need. Meaning I have to help with the physical care of the patients. This is frustrating and it can also lead to moral distress, so inadequate staff is a big challenge.' (Site 1. Paed. NM 7).* *'…you are frustrated…' (Site 2. Paed. NM. 9).*

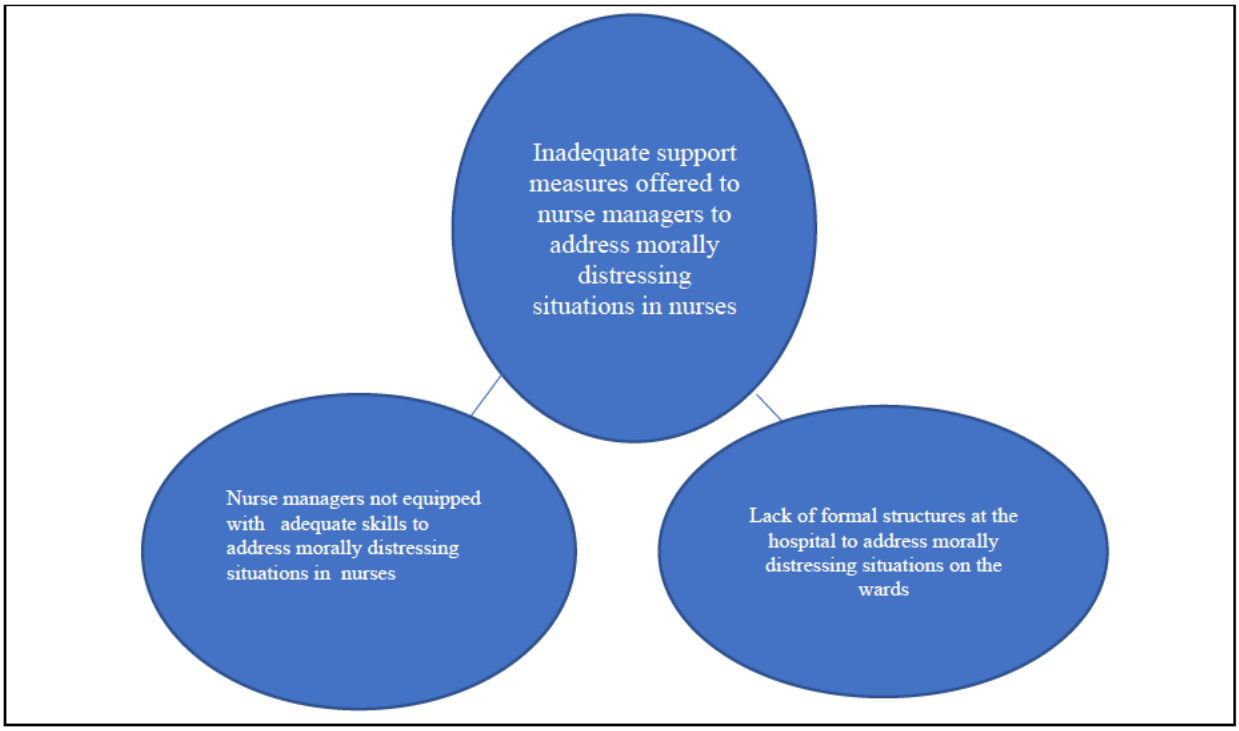


Figure 6: An example of a theme and two subthemes

6.13.1 Demographic findings of study participants

Fourteen nurse managers participated in the study. All study participants were registered professional nurses. The characteristics of the participants are summarised in graphs, tables and in the text.

6.13.2 Gender and religious background of study participants

Nine of the participants were female and 5 males. In terms of religion there were equal numbers of Christians (7) and Muslims (7).

6.13.3 Ethnic origin

The ethnic origin of the participants was Grusi, Mole-Dagbon, Dagaari, Ashanti-Akan, Ewe and Bulisa. These are presented below in figure 7.

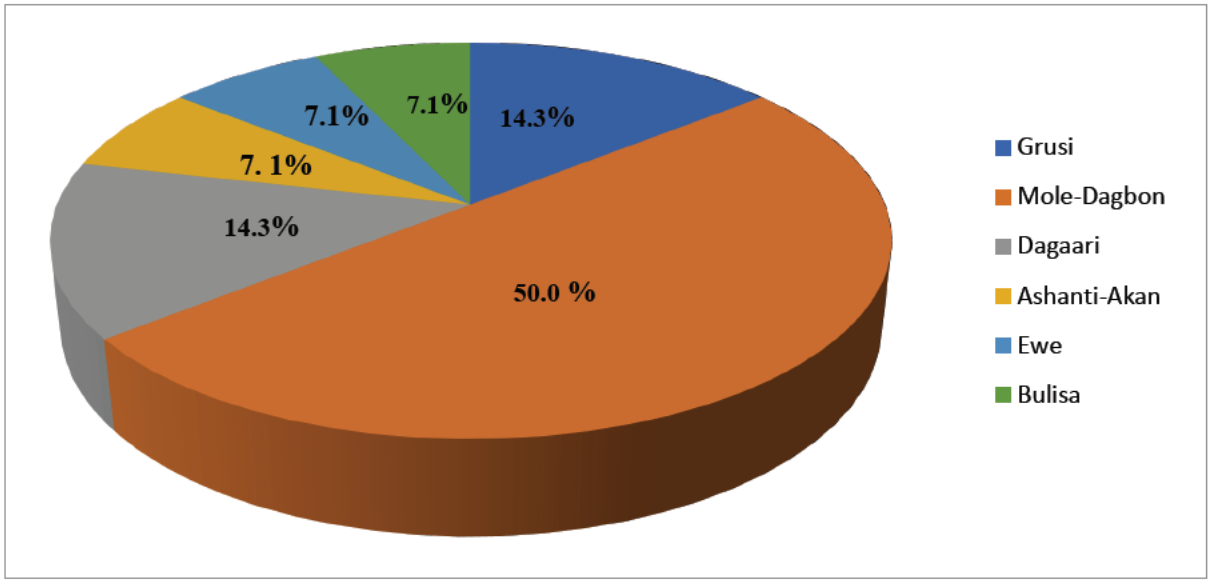


Figure 7: Ethnic origin of the nurse managers

6.13.4 Work pattern

All 14 participants worked 9 hours per shift with five shifts per week. The distribution of nurses' ranks, and, in the study, hospitals is shown in table 19. The highest grade of nurse manager was a Senior Nursing Officer in site 4.

Table 19: Participants' 'ethnic background, religion, level of education and work pattern.

Characteristics	N (%)
Highest level of education	
Master's level	3 (21.4%)
BSc. Nursing	10 (71.4%)
Diploma in Nursing	1 (7.1%)
Rank of participants	
Principal Nursing Officer	4 (28.6%)
Senior Nursing Officer	5 (35.7%)
Nursing Officer	3 (21.4%)
Senior Staff Nurse	2 (14.3%)
Number of participants from study sites	
Site 1	6 (42.9%)
Site 2	4 (28.6%)
Site 3	2 (14.3%)
Site 4	2 (14.3%)
Number of years of nursing experience	
1 – 5 years	2 (14.3%)
6 – 10 years	6 (42.9%)
More than 10 years	6 (42.9%)
Number of years in current workplace	
Less than 1 year	1 (7.1%)
1 – 5 years	11 (78.6%)
6 – 10 years	2 (14.3%)
Number of years as a nurse manager	
Less than 1 year	1 (7.1%)
1 - 5 years	11 (78.6%)
6 – 10 years	2 (14.3%)

6.13.5 Number of nurses supervised by nurse managers

The number of nurses supervised by a nurse manager was dependant on the type of health facility. The results revealed that nurse managers in site 1 supervised 50 nurses compared with a nurse manager in site 4, who supervised 20 nurses. Figure 8 shows the number of nurses supervised by nurse managers in all four study sites.

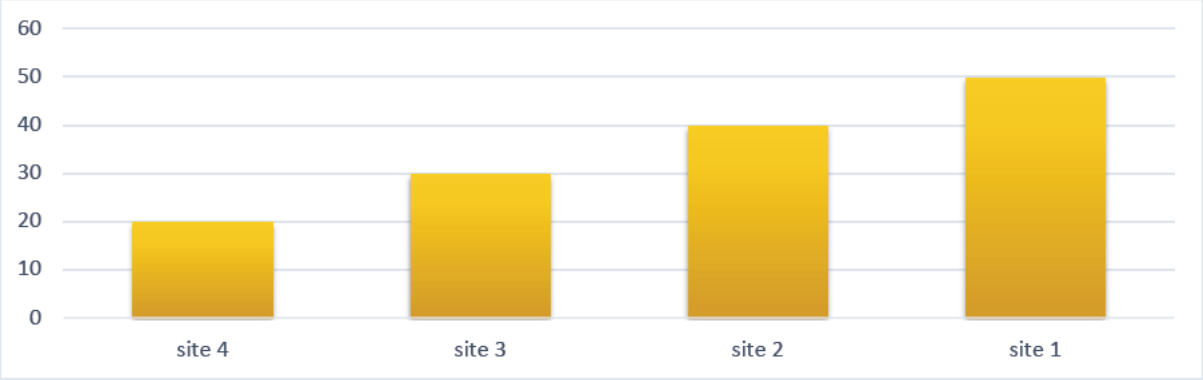


Figure 8: The number of nurses supervised by nurse managers on the wards

6.14 Description of themes – nurse managers

Two major themes and 2 sub themes emerged from the data analysis of the nurse managers' transcripts. Some direct quotes of participants have been used to illustrate the themes. Table 20 shows the main themes and sub themes.

Table 20: Main themes and subthemes of findings

Main themes	Subthemes
6. Inadequate support measures offered to nurse managers to address morally distressing situations in nurses	1.1 Nurse managers not equipped with adequate skills to address morally distressing situations in nurses 1.2 Lack of formal structures at the hospital to address morally distressing situations on the wards
7. Morally distressing situation not limited to only nurses; nurse managers experience it too.	

6.14. 1 Themes of nurse managers

Not all nurse managers were familiar with the term moral distress, however, when it was defined and explained all participants identified with the experience of moral distress. Fifty-seven percent (8) of the nurse managers were familiar with the term, whereas 20% (8) of frontline nurses were familiar with the term before I explained it.

6.14.2 Theme 6: Inadequate support measures available to nurse managers to address morally distressing situations experienced by nurses

The 6th theme that emerged was inadequate support measures available to nurse managers to address moral distress among nurses on the wards. The two subthemes are: nurse managers not equipped with adequate skills to address morally distressing situations among nurses and lack of formal structures at the hospital to address morally distressing situations on the wards.

6.14.3 Nurse managers not equipped with the skills to address morally distressing situations in nurses

Nurse managers were asked whether they felt equipped to address and manage the experience of moral distress in nurses. All 14 participants felt unable to support nurses who experienced morally distressing situations because they did not have the right skills. A participant from site 1 commented:

> *'..... I am not sufficiently equipped to solve nurses' difficulties....' (Site 1. NICU NM. 1).*

Another nurse manager felt that nurse managers did not have the capacity nor the ability to address morally distressing situations and suggested there was a need for in-service training programmes on moral distress.

> *'..... elsewhere you will have some in-service training as managers but here we don't always have it. There is no specific training for us or to equip you to address such morally disturbing situations, no we don't have such capacity' (Site 4. Paed. NM. 14).*

All 14 nurse managers felt that the hospital management did not adequately equip nor support them to address morally distressing situations among nurses:

> *'There is no such opportunity or guidelines that will help the nurse managers to address some of these issues' (Site 4. Paed. NM. 14).*

Two participants felt they were not appropriately recognized as nurse managers by the hospital management. They were not formally given contracts that spelt out their job description, this made their work more difficult. Because of the unstructured nature of appointment of nurse

managers in clinical practice, participants were of the view that nurses were appointed as nurse managers because they had clinical qualifications. Participants felt the way nurse managers were appointed was problematic. For example:

> *'We all know that a nurse was only a nurse manager by his/her rank. If you are the senior on the ward, you are automatically the nurse manager. However, a few weeks back something happened here on the ward with a colleague nurse. This nurse had done a speciality course in an area and was a junior staff. She came to NICU and said she was supposed to be the nurse manager, so I should hand over to her, I refused and reported the issue to the hospital matron, this brought about some confusion' (Site 1. NICU. NM. 2).*

One participant believed that the hospital management were not aware of the existence of morally distressing situations among nurses such that they could better support nurse managers to address them.

> *'I don't even know if they are aware of something called moral distress, I don't know whether they are aware of it' (Site 4. Paed. NM. 14).*

Participants described how they felt when nurses complained of experiences of morally distressing situations.

> *'.... I feel bad because I am helpless, I have done what I'm supposed to do for it to be resolved but it is not done' (Site 2. Paed. NM. 9)*

> *'I normally feel bad because being a manager you wouldn't want confusion in your ward. You want to see everybody working in a peaceful environment. So, when I hear about them, I feel bad' (Site 2. NICU. NM. 7)*

6.14.4 Lack of formal structures at the hospital to address morally distressing situations on the wards

Participants stated that there were no structures, policies or practices in the hospitals that supported nurses to navigate the complex clinical moral issues on the wards. All 14 participants stated there were no formal structures (moral distress committees, moral distress support groups) at the hospitals that addressed morally distressing situations among nurses on the wards. This is demonstrated by comments from two nurse managers:

'I do not know any policies on the ward that empowers me to support nurses; I have not heard or even seen something like that, like a policy to support nurses' (Site 2. NICU. NM. 7).

'Actually, there is no formal structure in terms of helping nurses to go through some of these situations. There is no formal structure in the facility that we have, there is nothing of that sort' (Site 4. Paed. NM. 14)

All 14 nurse managers recounted situations where they complained to the hospital management regarding the causes of morally distressing situations (lack of nurses, lack of basic items to work with, temporary accommodation for family members), and they felt their voices were not heard and were silenced regarding moral difficulties in the hospitals:

'…. nothing is done about nurses and nurse managers' challenges; management of the hospital does not often acknowledge suggestions from nurse managers at meetings' (Site 2. Paed. NM. 10).

Another reported:

'We have even written letters to management. Two weeks ago, we wrote a letter regarding the concerns of nurses and their grievances, but nothing was done about it……' (Site 1. NICU. NM. 2).

and continued:

'I remember sometime back the minister of health was around, we had a staff meeting and a place to accommodate patients' relatives came up. My colleague nurse in- charge raised her hand and proposed to the hospital management to get accommodation for patient's relatives. As she made the appeal the then chief executive officer of the hospital shouted at her to sit down. So, you see how things are, nobody will listen to you' (Site 1. NICU. NM. 2).

Nurse managers also urged the hospital management to address staff psychological and mental needs:

'…. recently the mental health nurse in -charge of the hospital suggested to the hospital management that nurses who have psychological challenges should be helped in a psychiatry hospital (a psychiatry hospital) but nothing has been done since last year ……' (Site 2. Paed. NM. 9).

6.15. Theme 7: Morally distressing situations not limited to nurses; nurse managers experienced it too.

Nurse managers' experience of moral distress was usually because they had to work as nurses on the ward (directly care for patients) because of lack of staff and increased number of patients that meant that they could not adequately care for patients. Nurse managers also felt morally distressed because of inability to provide the needed consumables and support for nurses in the care of patients. All 14 nurse managers found themselves working as nurses on some occasions approximately 3 times in a week on the wards because of increased workload and shortage of nurses. Therefore, nurse managers experienced a double form of moral distress working in NICU and paediatric wards. The two roles are different, for they are socialized as nurses, but are also required to 'manage' at the ward level. This made it difficult for them to focus on managing the nurses. Two participants recounted their experience:

> *'Working as a nurse manager in NICU is challenging, we try to provide logistics and guide nurses to work. We also care for patients in addition to our managerial roles. The work is so demanding that one works alongside his/her managerial role. We have official things to do like documentation and writing of reports and we still have to physically care for patients. For instance, this morning I am nursing 21 babies, alone. After this I will write reports on mortalities, referrals. I just had to share some of the patients with a staff nurse. She was also busy with about 15 babies here. The wards are full, with a nurse assigned to a cubicle and the last cubicle has no nurse, because of lack of nurses, increased number of patients and reports to write I was unable to care for the patients adequately like I should.' (Site 1. NICU. NM. 2).*

> *'.... for instance, I am on duty and there are 20 patients on admission and there are only two nurses on the ward to care for the patients. It's going to be very distressing because these two nurses have to take care of all those patients, give them medications and carry out all needed care that the patients will need. Meaning I have to help with the physical care of the patients. This is frustrating and it can also lead to moral distress, so inadequate staff is a big challenge.' (Site 1. Paed. NM 7).*

The lack of nurses was particularly pronounced in site 4 where most of the nurses were nurse assistants, making skill mix challenging on some shifts:

> *'.... inadequate staffing is a contributory factor because, many nurses on the wards are the auxiliary nurses, they are nurse assistants. And imagine we are looking at the skill mix of a particular shift, there are times where no professional nurse will be available to work with the nurse assistant and this affects the quality of care that is rendered to*

patients, as a result the nurse manager must step in and work as a nurse in addition to all managerial duties' (Site 4. Paed. NM. 2).

Nurse managers experienced moral distress when they were unable to support and help nurses with patient care on the wards. The nurse managers tried to perform essential functions in generating and enabling a moral work environment where nurses can offer quality patient care without restrictions. However, nurse managers felt powerless and acknowledged there were times when they could not secure items to work with nor create a moral work environment. The participants' perceptions of powerlessness exacerbated negative feelings related to moral distress. For example:

'I normally feel bad because being a manager I wouldn't want confusion in my ward. You want to see every nurse working well in a good environment. So, when I realise, I cannot get what my nurses need to care for their patients, I feel bad, it demoralises me. I ask these questions, could it be that I am not doing the right thing, that is why there is a challenge on the ward? It is not easy; it is like I am not capable of solving nurses' challenges. For instance, I go to the hospital medical stores and requested for 400 or 200 gloves, and they give you just a box (100). As a result, within a few days, they will all be finished and when I go back, I am not given again' (Site 2. NICU. NM. 4).

The effect of nurses experiencing morally distressing situations on the wards was acknowledged by nurse managers. Participants also felt the effects in multiple ways, effects on nurses and nurse managers, patients, and the hospital. Two participants shared this:

'…. we become discouraged for; we try our best to save the child but because of absence of glucose strip one could not check the blood glucose….' (Site 1. Paed. NM. 7).

'...there is serious emotional torture on us, when we are unable to carry out what we are supposed to do for the patient because of lack of gloves to care for the child.' (Site 1. Paed. NM. 9).

A participant had this to say on the effect of the experience on patient care:

'It definitely affects the output of care rendered to patients, care is reduced because if we receive what we need to work with, we will work happily for the patients. But if we don't even have gloves to carry out baby's cord care, we get confused and don't know what to do. So, the care is reduced, and the quality of work too is also reduced because you are not getting the necessary things to work up to standard' (Site 2. NICU. NM. 4).

One participant felt there could be an impact on the hospital:

'..... the image of the facility will be tarnished in a way because once we provide poor quality of care it's the patients and family members that will experience it and subsequently report it to the community....' (Site 4. Paed. NM. 14).

Nurse managers' demographic information, such as religion, age and ethnicity were examined in relationship to the experience of moral distress. The experience of moral distress did not appear to be influenced by participants' religion, age, or ethnicity. However, it appeared that participants with less than 5 years working experience recounted more intense forms of moral distress particularly in study site 1 compared with sites 2, 3 and 4.

6.16. Summary of nurses and nurse managers experience of moral distress

A summary of the findings from the interviews with the nurses and nurse managers is presented here to provide an overview of how moral distress is experienced by nurses in Northern Ghana. A common theme that emerged from the data analysis of the accounts of nurses and nurse managers were both nurses and nurse managers experience morally distressing situations in NICU and paediatric wards. All 54 participants experienced distressing situations working in NICU and paediatric wards on daily basis, even though some had not heard of the term moral distress. The nurse managers experienced moral distress in two ways (experience of moral distress as a nurse manager and experience of moral distress as a nurse). Firstly, inability to ensure availability of basic instruments, equipment, consumables, and essential medicines for the care of patients and inability to support nurses experiencing moral distress. Secondly, nurse managers worked as nurses in times of staff shortages. For these participants generally the contributing factors to moral distress were, lack of nurses, lack of cooperation from family members of patients, poverty in family members, lack of teamwork on the wards, inefficient management of the hospital and religious and traditional beliefs of family members that interfered with patient care. Participants were compassionate in the care of patients which led to instances where nurses and doctors contributed money to arrange for transport for ambulance services, buy medicines or ensured laboratory tests were done for patients who needed them

but could not afford. As discussed in chapter 2, poverty levels in the populace in the Northern sector of Ghana is pronounced posing a difficulty for nurses in these sectors.

Another common theme that emerged from the analysis of the interviews was the impact of moral distress on nurses. The experience of moral distress impacted negatively on participants, for it affected their psychological and physical wellbeing. Although the experience affected nurses there were no formal support services available to nurses and nurse managers. These common themes between the nurses and the nurse managers are presented in table 21 below.

Table 21: Common descriptive themes for nurses and nurse managers

Themes	Description
Nurses and nurse managers experience morally distressing situations	- Nurses perceive and experience moral difficulties concerning patient care. - Nurse managers perceive and experience moral challenges working as nurses in times of shortage of nurses. - Nurse managers experience moral difficulties as a result lack of support from hospital management
Causes of morally distressing situations	- Lack of cooperation of patient's family members regarding patient care - Religious and traditional beliefs interfering in patient care - Poverty among family members - Lack of essential medicines - Lack of items and consumables
Impact of moral distress	- On nurses and Nurse managers - Patients and family members - Hospitals
No adequate support from hospital management concerning the management of moral difficulties	- No support for nurses and nurse managers

6. 17 Approaches for ensuring the rigour of the findings

Ensuring thoroughness and quality is an important part of any study (Tobin and Begley 2004), and trustworthiness of the data is important when determining the rigour of a study (Lincoln et al., 2011). It is useful and appropriate in qualitative studies to establish the accounts of

participants' experience of a particular phenomenon by objective analysis and precise presentation of their accounts. There are numerous frameworks of quality standards for qualitative research (Lincoln et al., 2011; Finlay, 2006; Tracy, 2010). However, five main criteria have been identified which are: objectivity, dependability, credibility, transferability, and application (Lincoln et al., 2011; Miles et al., 2014), and these can be applied to qualitative descriptive studies. In the quest to achieve trustworthiness in my study, I followed the principles of objectivity, dependability, credibility, transferability, and application.

6.17.1 Objectivity

Objectivity is theorized as 'relative neutrality and reasonable freedom from researcher bias's (Colorafi and Evans, 2016 pg. 23). Ensuring objectivity in a study involves describing the study's approaches and processes in a precise manner (Colorafi and Evans, 2016). The process of participant recruitment was carried out in a systematic manner as was data collection. The analysis of the data and report of findings are shared in a sequential manner to provide an audit trail in various sections of this study. To ensure objectivity all data collected from participants were used for the analysis. I made myself aware of my opinions/prejudices and was cautious to ensure they did not influence my approach to the data analysis as posited by Colorafi and Evans (2016). I acknowledged and documented my experience of moral difficulties, reminded myself of the study goals, reflected on participants' moral encounters, and concentrated on analysing participants' experience in the data analysis process. Participants were given the opportunity to recount their own experiences of moral difficulties in the care of patients, prompts were used to elicit more information when it was needed. At certain points in the dialogue, I asked for clarification of statements made by participants or when more information was needed on subjects. I set aside my knowledge and experience of moral distress to focus on the accounts of participants of moral distress.

6.17.2 Dependability

Dependability or reliability may be nurtured through uniformity in methods and techniques (semi structured interview questions) used with all participants over the period of study (Colorafi and Evans, 2016). Using semi structured questions produced an audit trail, representing a similarity in results in the participants (Bradshaw et al., 2017). I formulated interview questions based on the background literature and evidence of the experience of moral distress in nurses in developing economies. There were two different sets of interview questions, one set for all nurses and the other set for all nurse managers in all 4 study sites (Appendices D and E). I asked all participants the same set of interview questions in a similar manner, to show uniformity in gathering data. My role and status as a researcher in these study sites were described in the process of data collection. Furthermore, thorough description of procedures of data collection and the process of data analysis are included in chapter 5 for an audit trail to be followed by other researchers. The study design has been described extensively to enable evaluation of the degree to which suitable study procedures have been carried out.

6.17. 3 Credibility

Credibility or internal validity is described as accuracy of the study information 'Do the findings of the study make sense?' (Miles et al., 2014 pg. 312). In the quest to attain credibility of this current study, several actions were taken to ensure the credibility of the findings, these are 'establishment of rapport prior to commencing interviews, developed a trusting relationship (willingness to exchange information), express compassion and empathy during interviews, individual interviews suggesting a meeting with participants (Bradshaw et al., 2017). To ensure credibility of my study, ethical approval was sought from the University of Birmingham Research Ethics Committee and Navrongo Health Research Centre Institutional Review Board in Ghana. Further, approval was received from the hospital management of all four study sites

to carry out the study. I also had lengthy meetings with nursing management at all 4 hospitals and with study participants to enable me to acquire an understanding of health care in the study sites. This led to a relationship essential for the management and participants to volunteer to take part willingly and freely in the study. I spent 9 months in the Northern part of Ghana collecting data. Data collected were analysed in an inductive and systematic process that represented participants accounts of moral distress in NICU and paediatric wards. This was achieved through a comprehensive background account of participants and through interpretations that were grounded in the data (Sandelowski, 2004).

6.17.4 Transferability

Transferability or external validity is concerned with whether the results of the study have potential applications to other settings (Colorafi and Evans, 2016). In this study the participants were nurses and nurse managers who worked in NICU and paediatric wards in Northern Ghana. The background information provided on Ghana as a developing economy in chapter 2 may indicate that the results of this study could be applied to other developing economies.

6.17.5 Application

Study findings need to be utilized and applied (Miles et al., 2014). For Miles et al., (2014) the researcher must know what the study findings do for their participants.

The results of the study will be made available to the management of all 4 hospitals (study sites). Furthermore, a seminar will be held at all 4 hospitals to disseminate the findings to participants. A seminar will be organized for the academic community of the University for Development Studies, Tamale. A meeting will be held with the management of the Regional Health Directorate of Northern Region where the results will be disseminated. These are 'standard' dissemination activities to help ensure the findings of the work are applied. In addition, I am going to work with the management of the hospitals to increase the likelihood

of the findings being applied in the 4 study sites. Publications will also be carried out for wider dissemination.

6.18 Conclusion

The findings chapter provides a comprehensive account of moral distress in nurses working in NICU and paediatric wards in Northern Ghana. The findings show that nurses encountered morally distressing situations working in NICU and paediatric wards. In total there were seven major findings drawn from the interview data regarding the participants' descriptions and explanations of their experience of moral distress. The key themes that emerged from the analysis were: nurses experienced morally distressing situations working in NICU and paediatric ward, causes of morally distressing situations among nurses, impact of morally distressing situations on nurses, coping mechanisms of nurses who experienced morally distressing situations, recommendations by nurses to reduce the incidence of morally distressing situations, inadequate support measures available to nurse managers to address morally distressing situations among nurses and morally distressing situation not limited to only nurses; nurse managers experienced it too.

Most of the participants were not familiar with the term moral distress, however, once the term was explained participants immediately associated with it. It was experienced by participants working in NICU and paediatric wards. Participants' experience of moral distress was caused mainly by a lack of basic medical consumables such as disposable gloves, cotton, and thermometers. They reported that lifesaving items such as oxygen, nebulizers and essential medicines were often unavailable. Participants felt sad, hurt, frustrated, and wept when they could not carry out what they felt was best for the patients.

The experience of moral distress had a significant impact on the participants, and they reported a range of psychological, physical, and emotional effects.

Nurse managers' voices are not often heard regarding the causes of moral distress in the nurses. When nurses experience morally distressing situations, they adopt coping measures. Nurses reflect on morally distressing situations, and some nurses cope by praying to God to help them deal with the situation and make situations better for them.

Participants made recommendations to mitigate the effects of moral distress on nurses. For example, they identified the need for in-service training for nurses on ethical issues especially on moral distress. In addition, they felt timely procurement of instruments and equipment by the hospital management, employment of more staff, regular meetings with nurse managers about ethical issues, creation of ethical review committees on the ward, and education of caregivers concerning conditions of their ill children would all be helpful in alleviating moral distress.

The connections between the themes appeared to circle around systematic organizational challenges.

In chapter 7, the main findings of the study are discussed to examine the wider implications of the findings concerning moral distress among nurses working in NICU and paediatric wards in Northern Ghana.

Chapter 7: Discussion

7.1 Introduction

This study was carried out to determine if and how moral distress was experienced by nurses working in NICUs and paediatric wards in Northern Ghana. Individual interviews were carried out with 54 nurses and nurse managers. In this chapter, the findings presented in chapter 6 are discussed in relation to the existing evidence on the experience of moral distress in nurses. Seven overarching areas were considered for the discussion as I reflected on the study findings.

7. 2. Ghanaian nurses' knowledge about moral distress and experience of moral distress

In this study, it was revealed that Ghanaian nurses experienced morally distressing situations working in NICU and paediatric wards, even though 38 participants were unfamiliar with the term 'moral distress'. The notion of moral distress was conceptualized in the United States by Jameton in 1984, and subsequently arguments, discussions and knowledge of the concept have significantly increased in the ethics literature in developed economies. (Lützén and Kvist, 2012; Morley et al., 2017; Sanderson et al., 2019; Wilson, 2018). This has contributed to the increase in knowledge of the experience of moral distress in nurses. With the increasing number of studies (16) carried out in developing economies it was surprising to note that nurses and nurse managers in Ghana were not familiar with the concept, even though they could have read articles on moral distress published elsewhere to enhance their knowledge of it.

Over the years in Ghana, local nursing curricula have generally included little information about ethics (Donkor and Andrews, 2011). This in part explains why some nurses are completely unaware of the term moral distress. This seems to align with studies that reported that nurses were not familiar with the term before the investigation (Fournier et al., 2007; Häggström et al., 2008; Harrowing and Mill, 2010; Maluwa et al., 2012; Nasrabadi et al., 2018; Prompahakul and Epstein, 2020). However, my study highlighted the fact that participants

recognised the term once it was defined and explained. For the nurses and nurse managers, the experience of moral distress is feeling anguish in situations where provision of care was negated because of lack of equipment, lack of funds to pay for care and staff shortages. This result corroborates Morley et al.,'s, (2017 pg. 16) definition of moral distress as a combination of (a) the experience of a moral event, (b) the experience of psychological distress and (c) a direct causal relationship between (a) and (b). The finding tat nurses and nurse managers in Northern Ghana experience moral distress contributes to the development of the body of knowledge about the experience of moral distress in nurses.

Participants showed a profound awareness of who they are as nurses and nurse managers, what their professional beliefs and principles meant to them. Believing in their core responsibilities as nurses (caring agents), in circumstances where they did not have the consumables to work with, they continued to offer patients inadequate nursing care (Maluwa et al., 2012; Häggström et al., 2008; Harrowing and Mill, 2010). In such challenging situations, participants tried to manage the care of patients by either borrowing basic items from other wards or improvising, when possible. The challenge being that improvising might not be successful, yet nurses could not overcome it or gave up trying. This is consistent with the act of conscience (Cleary and Lees, 2019). Conscience involves "choosing morally according to the best of one's ability" (Sulmasy, 2008 pg. 135). Conscience in nursing care is seen as an act of responsibility (Jensen and Lidell, 2009). As a result, nurses must try to carry out their nursing duties even in difficult circumstances.

Though the different sites used for this study had different demographics including traditional and religious orientation, all nurses experienced morally distressing situations irrespective of the ward they worked on. Participants emphasised that the experience of moral distress occurs on daily basis consistent with Maluwa et al's., 2012 study in Malawi and Langley et al's.,

(2015) in South Africa. Nurses daily experience of moral distress could be suggestive of the careful moral engagement with their skills and professional practices that is inhibited, therefore unable to act in the best interest of their patients (Weinzimmer et al., 2014). Many neonatal and children's wards in Ghana have adopted a family centered care policy and as part of the policy children are managed as part of the family. Guardians can remain with their ill children while they are in hospital and can participate in the child's care and treatment plan. The difficulty here is that nurses feel morally distressed by situations where family members of patients request treatments that nurses believe are not in the best interest of the patients.

7. 3 Nurse managers' two-fold experience of moral distress

Nurse managers also known as 'ward in-charges' in Ghana, are entrusted to guide and supervise nurses in their ward. The quality of care provided for patients is determined in part by the moral environment of the ward which is influenced by the beliefs and actions of nurse managers (Wlody, 2007). The position of nurse managers in a ward is twofold; that is loyalty inherent to the role and responsibility of the nurse manager on one side and pressure between the desires of the hospital, needs of the nurses and patients and their family members on the other side (Gaudine and Beaton, 2002; Hardingham, 2004). This puts the nurse manager in a unique position. This study highlighted the fact that the experience of moral distress was not only limited to nurses, but also nurse managers, consistent with studies by Porter (2010), Mitton et al., (2011), Ganz et al., (2015), Kortje (2016), Nasrabadi et al., (2018), Nikbakht et al., (2018). Nurse managers experienced moral distress in a unique fashion, they experienced moral distress first and foremost as nurses and second as managers. The twofold experience lies in the fact that due to lack of nurses, nurse managers sometimes fall back to support their subordinates by carrying out duties on the ward. They therefore face the same issues as their subordinates. They experience at first-hand what their nurses experience daily. This contrasts

with Ganz et al's., (2015) study in which nurse managers were uninvolved with daily clinical care, because managers saw supervising nurses as their main responsibility.

The nurse manager's second experience of moral distress stems from the responsibility and role as a manager, in the provision of scarce material and human resources. Nurse managers are key contributors to the work environment of nurses and play significant roles in creating an enabling clinical moral environment for the smooth effective management of patients by nurses (Hardingham, 2004). However, provision of essential material resources and advocating for more nurses for the smooth running of the ward has become a challenge for nurse managers in Ghana. Nurse managers in this study felt distressed because of non-availability of basic items and consumables for nurses because of its impact on the provision of the best care for patients. This is especially the case in settings where material resources are limited in supply. In a qualitative study, Mitton et al., (2011) and Ganz et al., (2015) reported that health care managers experienced moral distress because of limited budget allocations and management challenges. Many of the managers would have risen through the ranks to get to their current positions (Townsend et al., 2015). This may allow them to empathise easily and to appreciate the experience of distress in their subordinate (Kortje, 2016).

According to the Ghana Health Service (2005) job description for nurse managers, a nurse manager's position should be occupied by a senior nursing officer or a principal nursing officer. This was not the case in this current study for all study sites, the rank of nurse managers ranged from senior staff nurse to principal nursing officer. Although it is not uncommon to have lower ranked nurses as nurse managers on the wards in some faith-based and district hospitals in Ghana because of lack of senior nurses, lower ranked nurse managers may not be adequately prepared to manage and assist nurses who encounter challenging moral circumstances on the ward because of lack of experience and managerial skills. Ofei et al., (2018) recommended that nurses in lower ranks develop their managerial skills throughout their early years of practice in

preparation to take up managerial positions as senior nurses. As, nurses advance in age and experience, they may become conversant with challenges on the wards hence, placing nurses in a position to manage the challenges that come with being a nurse manager (Ofei et al., 2018). With the argument that managerial roles are multifaceted in the healthcare delivery system because they offer clinical and administrative guidance as well as retaining and developing staff (Thrall, 2006), nurse managers do not only need experience through their practice but also require formal training on managerial and advocacy skills. Further, role clarity through job description and formal appointments for nurse managers are essential and significant if nurse managers are to perform their work adequately (Meyer et al., 2009).

7. 4 The role of religion, tradition, and beliefs in making sense of and managing moral distress

The role of religion is known to influence decisions and actions made by society regarding care (Rumun, 2014). In a similar way, religious beliefs in Ghana affects decisions taken by many patients and their family members regarding their choice of treatment options (Nuhu, 2018). This issue for nurses can be particularly challenging when the religious and traditional beliefs of family members run counter to recommended medical action. In this study family members' religious and traditional beliefs made it morally difficult for nurses to care for their patients thus contributing to nurses' experience of moral distress. This has been identified as an important factor that influences nurses' experience of moral distress in other developing economies (Shoorideh et al., 2012; Maluwa et al., 2012; Langley et al., 2015). Miljeteig et al., (2019) found that in Ethiopia participants experienced difficulties in caring for patients and making decisions when the family had a different religious belief regarding care. For example, participants recounted the distress felt when patients and family members urged them to use 'herbs' or take the patient to a priest rather than accept medical treatment. Welfare systems that

are meant to protect and seek the welfare of patients are limited in Ethiopia in the capacity to provide adequate care for children (Miljeteig et al., 2019) making it a difficult situation.

In Africa, traditional medicines are usually favoured over orthodox medicine (Abdullahi, 2011). This inclination dates to the precolonial and colonial era in Ghana (Twumasi, 1979). Preference for herbal medicine arises from people's personal beliefs and values based on a presumption that it is harmless, gives quick results and is certain to bring positive results compared with orthodox medicine (Abdullahi, 2011; Agyei-Baffour et al., 2017). Another reason for its popularity is believed to be its accessibility to the people at low and flexible cost compared with orthodox medicine that is believed to be unavailable and expensive in developing economies (Cameron et al., 2008). The extensive use of traditional medicine could be linked to its accessibility and affordability. People who are considered wealthy are less likely to access traditional medicine compared to poor people (Agyei-Baffour et al., 2017). Though, nurses may not share the same views and beliefs of their patients, they are required to recognise and accept that beliefs are important to the family (Berlinger, 2017). It is important for nurses to educate family members of patients and explain the consequences and outcomes of some prevalent harmful traditional practices. In this case harmless beliefs that do not have significant harmful effects can be incorporated into health care for they entail the same skills that nurses have in the approach to patient-centred care (Rumun, 2014). These skills are underpinned by the principles of respect and collaboration. The principle of individualised care can be adopted by nurses by acknowledging the uniqueness of the patient and family members in their circumstance (Hawk et al., 2017).

The populace in Ghana is inclined to the belief in religion for hope and encouragement in all activities especially in challenging circumstances (Prempeh, 2021). According to Emmons (2003) religion helps people restore themselves following disturbing occurrences and provides a background for understanding the most difficult circumstances. Because of this belief in

religion, it was seen as a source of comfort for nurses when they experienced morally distressing situations in NICUs and paediatric wards. Nurses seemingly gained a sense of hope and believed that the challenging situation might improve. Nurses viewed 'God' and 'prayers' as a means of consolation because it strengthens them in challenging situations consistent with other studies (Nurasikin et al., 2013; Shoorideh et al., 2015; Langley et al., 2015). In one instance, Shoorideh et al., (2015) reported that belief in 'God' was a helpful reaction to moral distress situations in ICU nurses in Iran. Similarly, nurses in South Africa described prayer as a way of coping with the experience of moral distress and Nurasikin et al., (2013) found that stronger religious commitment was associated with lower levels of distress in Malaysia. In the United States, Čák (2012) reported the use of religious practices to reduce the experience of moral distress in nurses in NICU. Although nurses were comforted through their religious beliefs, complete reliance on it may prevent them from finding appropriate solutions or adequately resolving these challenges (King et al., 2013; Greenstreet, 2006).

Instead of nurses criticising self by using words like helpless, bad, and shameful, it is appropriate to feel a sense of self-compassion when one suffers, feels anguish, or feels inadequate in circumstances beyond one's control (Germer and Neff, 2013). Self-compassion comprises 'kindness, a sense of feelings of common humanity and mindfulness' (Germer and Neff, 2013 pg. 856). These factors commonly interrelate to produce a self-compassionate person. The significance of self-compassion is seen where individuals experience shortfalls and distressing situations beyond their circumstances (Germer and Neff, 2013) as seen with the participants in this study. Duarte et al., (2016) measured self- compassion using a Self-compassion scale in nurses in Portugal and concluded that self -compassion may protect nurses in situations of burnout. The relationship between the experience of moral distress and burnout has been documented in the moral distress literature as an emotional response to moral distress. Meltzer and Huckabay (2004) reported that the experience of moral distress accounted for 10%

of a variance in emotional burnout. The variances of burnout have been described by Leiter and Maslach (2005) as lost energy**,** lost enthusiasm, and lost confidence.

7. 5 The similarities/differences between moral distress in developed and developing economies

Moral distress in nurses has been studied extensively in developed economies (Wilkinson, 1989; Hanna, 2004; Oh and Gastmans, 2015; Prentice et la., 2016; Lamiani et la., 2017: Ulrich et al., 2018; Morley et al., 2019). In recent times its study is gaining ground in developing economies and it has been identified in nurses in Malawi, Egypt, Iran, Tanzania, South Africa, India, Uganda, Saudi Arabia and Israel (Fournier et al., 2007; Häggström et al., 2008; Harrowing and Mill, 2010; Maluwa et al., 2012; Shorideh et al, 2012; DeKeyser and Berkovitz, 2012; Shoorideh et al., 2015; LeBaron et al., 2014; Langley et al., 2015; Borhani et al., 2015; Ganz et al., 2015: Borhani, 2017; Robaee et al., 2018; Asayesh et al., 2018; Almutairi et al., 2019; Haghighinezhad et al., 2019). The results of this study suggest that the experience of moral distress in Ghana (a developing economy) is similar to what pertains in other parts of the world (Wilkinson, 1987; Oh and Gastmans, 2015; Prentice et al., 2016; de Boer et al., 2016; Sannino et al., 2015). The experience of moral distress therefore may have no geographical boundaries and nurses may experience it irrespective of the country they work. The code of ethics of the International Council of Nurses (ICN, 2012 pg. 1) states that 'nurses have four fundamental responsibilities in the care of patients: promote health, prevent illness, restore health and alleviate suffering'. This statement echoes that the moral concerns of nursing are universal irrespective of the background of a nurse.

Participants in this study were impacted by their daily experience of moral distress consistent with the findings of studies in both developing and developed economies (Wilkinson,1987; Corley, 2002; Gutierrez., 2005; McCarthy and Deady, 2008; Wiegand & Funk 2012; Maluwa

et al., 2012; Shorideh et al., 2012; Harrowing and Mill, 2010; LeBaron et al., 2014; Prentice et al., 2016). Nurses described a sense of sadness when faced with moral distress, others indicated that they felt guilty after the experience consistent with other studies (Maluwa et al., 2012; Forozeiya et al., 2019; Almutairi et al., 2019; Prompahakul and Epstein, 2020). Guilt and self-blame have been linked with moral injury, which is a permanent emotional, and experiential damage that ensues when an individual "perpetrates, fails to prevent, bears witness to, or learns about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, pg. 700). The common characteristics of moral distress and moral injury is that there is a psychological effect, however, the experience of the severity of the challenging circumstances makes the distinction (Čartolovni et al., 2021). The profound psychological effects associated with moral injury may be experienced by nurses in persistent exposure to moral distress. Moral injury is currently an emerging global issue linked to persistent exposure to moral distress (Papazoglou and Chopko, 2017; Ramos et al., 2016). Čartolovni et al., (2021) in a scoping review of the literature on moral injury in healthcare professionals reported that nurses' experience of moral residue may end with moral injury over time. Moral injury can lead to permanent changes in an individual's self-identity (Dombo et al., 2013) and may be long lasting (Litz et al., 2009). Even though moral injury was not investigated in this current study, it may be useful in future to study moral injury to gain a deeper understanding of this emerging concept linked to moral distress.

The experience of moral distress in nurses may continue long after the negative moral encounter. These lingering effects have been described by Webster and Baylis (2000) as moral residue. According to Webster and Baylis (2000) moral residue impacts on nurses psychologically, and results from this study highlight this concern. Participants struggled with emotional responses while sharing and reflecting on their experiences. These experiences are

also documented in nurses in developed economies (Oh and Gastmans, 2015; Prentice et al., 2016). Nurses need support as they navigate through problematic moral circumstances.

Nevertheless, there are some differences in the experience of moral distress in nurses that seem to resonate strongly with what has been observed in other developing economies (Fournier et al., 2007; Häggström et al., 2008; Harrowing and Mill, 2010; Maluwa et al., 2012; Langley et al., 2015; Prompahakul and Epstein, 2020). Resources and traditional factors influence the contributing factors differently. Lack of basic items, instruments and consumables seen in the health care delivery system in Ghana is largely due to less budgetary allocation to the health sector in general (Akortsu and Abor, 2011). Hospitals lack the funds necessary to purchase simple equipment and basic supplies for patient care (Akortsu and Abor, 2011). With lack of basic items nurses are constrained and unable to act on their moral responsibilities and attain their professional goals. For instance, the need to check the fasting blood sugar for every child diagnosed with severe malaria remained only theoretical, because of lack of items.

Lack of basic items meant that family members of patients were required to buy items out of pocket to care for patients. If a parent or family member cannot afford these the nurse cannot proceed further leading to the experience of moral distress. However, family members' inability to purchase medicines and consumables are directly attributed to widespread poverty in this part of the country (Amanor-Boadu et al., 2013; Cooke et al., 2016) making it challenging for nurses to provide quality care. Poverty among family members of patients was one of the major contributory factors to participants' experience of moral distress. The findings of this study mirror what is generally seen in developing economies where the general populace has a low standard of living (United Nations, 2020). The issue of poverty among the populace is not new and has been reported in many developing economies (Maluwa et al., 2012; Fournier et al., 2007; Häggström et al., 2008). Participants in this study recounted situations where

relatives of critically ill patients were unable to purchase fuel for an ambulance to transport the patient to a hospital in another region, necessitating nurses and doctors to contribute money for fuel to transport patients. Although some similar findings have been reported regarding lack of material resources in some developed economies such as United Kingdom, Canada, and United States (Austin et al., 2003; Whittaker et al., 2018; Morley et al., 2019), lack of basic instruments and care beds are more pronounced in developing economies, including Ghana.

The introduction of the NHIS in Ghana was envisioned to lessen inequities of health service provision between rich and poor, nonetheless, this realization has not been attained. With only 40% percent of the population in Ghana insured through the NHIS, many family members are required to make out-of-pocket payments for services in critical care areas such as NICU and paediatric wards. In a systematic review evaluating the impact of the national health insurance scheme of Ghana, Okoroh et al., (2018) reported that the uninsured patients paid 1.4 to 10 times more in out-of-pocket expenditures and probably incur high health expenditure than the insured. As, highlighted by participants of the present study, uninsured patients were unable to receive medications and carry out laboratory examinations because of inability to pay out-of-pocket. Family members were required to pay before care can be rendered to patients (Adua et al., 2017).

While inability to acquire medicines and carry out laboratory investigations contributed to participants experience of moral distress, nurses may also experience moral distress if they feel rich family members easily afford health care in comparison to poor family members. Even though this was not investigated in this current study, this has been documented elsewhere. For instance, some studies in the developed economies have shown that nurses experience of moral distress resulted from circumstances where family members demanded care nurses believed were futile and continued aggressive treatment that did not improve the patient's outcome

(Vincent et al., 2020). More studies can be conducted in this area to have a better understanding of moral distress in nurses and nurse managers.

With the challenges of the COVID-19 global pandemic lack of basic items may be more marked in developing economies. McMahon et al., (2020) reported that developing economies lack pulse oximeters, oxygen cylinders and bag-masks necessary for basic resuscitation in this pandemic era. The absence of these vital lifesaving items as suggested by Cacchione (2020), and Gallagher (2020) contributes to moral distress in nurses.

7.6 System issues including levels of support

A major challenge facing the healthcare system in Ghana is finance which can be partially attributed to the Government of Ghana's (GoG) low economic capability and obligation to health (Ghana Health financing strategy, 2015). To address this situation, African Union countries in April 2001, agreed to allocate a target of at least 15% of their annual national budget to advance the health sector (WHO, 2013). In 2015, the total health expenditure as a percentage of GDP was 4.62%, way below the agreed declaration to augment health care spending in Ghana (The World Bank Group, 2021a). This fell to 3.46% in 2016 and only increased slightly to 3.54 % in 2018 (The World Bank Group, 2021a). Twenty years after the declaration, many economies including Ghana are yet to achieve this target (Ministry of Health, 2015). As a result of low budget allocations, health care needs and requirements are usually not met (Schieber et al., 2012). This perhaps explains in part the difficulties nurses experience regarding lack of basic items and resources.

Public healthcare disbursements in developing economies, have remained quite low, notwithstanding the likely advantages that could be realised regarding positive health outcomes if expenditure were increased (Novignon et al., 2012). Even when health expenditure is very

high health outcomes for many, or some remain poor. The USA has a high healthcare expenditure, yet worse health outcomes are seen in some of its health indicators compared with developing economies. Although high healthcare expenditure does not necessarily lead to better health outcomes, in developing economies such as Ghana, low budgetary allocation has led to inability to provide the most basic items that will ensure effective and safe delivery of health services (Adua et al., 2017). Health care expenditure is essentially financed with inadequate tax revenues, internal and external loans as well as limited foreign grants. Although there are additional available sources such as private payments, private health insurance schemes (Novignon et al., 2012) these are not enough.

Further, although the National Health Insurance Scheme (NHIS) covers about 40% of the population of Ghana (chapter 2), hospitals do not receive prompt payment for services of people insured by the NHIS and delays can be 10 months or more (Akortsu and Abor, 2011; Sodzi-Tettey et al., 2012; Ghana Health Service, 2015). As a result, health institutions cannot sustain the medicine section of the health fund. Although, hospital management can collect and retain 100% of internally generated funds (IGFs) from sales and services of health care to supplement the NHIS payments, they are governed by the provisions of Ghana Health Service and Teaching Hospitals Act 525 of 1996 (Ghana Health Service and Teaching Hospitals Act 525, 1996) and the public procurement Act (Aberese-Ako et al., 2018) to ensure transparency and accountability of the procurement process. The public procurement Act 663 (Ameyaw et al., 2012) instituted in public hospitals may affect hospital management decision making on procurement of items and consumables. The challenge here is that the procurement team meets once a quarter to evaluate procurement needs and examine suppliers' bids for items and instruments needed, more frequent meetings may be helpful. Further, there are situations in the procurement process where lengthy bureaucratic procedures are followed affecting the timely procurement of items for emergencies and life-saving situations (Aberese-Ako et al., 2018).

The procurement process could be streamlined to allow for swift procurement of emergency items and services.

One significant role of a nurse manager is to ensure the availability of resources for nurses to care for patients. However, nurse managers in this study felt inadequately supported and empowered to support nurses. With lack of items and human resources, nurse managers are challenged and unable to support nurses in terms of providing instruments, consumables, and staff in the care of patients (Adatara et al., 2018). Participants' voices were not heard on issues regarding lack of basic instruments. The finding of this study support studies that have reported low organizational support in nurses in clinical care setting (Robaee et al., 2018; Haghighinezhad et al., 2019). However, this contrasts with Aitamaa et al's., (2019) who found nurse managers in Finland used various mechanisms to support nurses experiencing moral distress, including work arrangements and specific institutional instructions and principles.

There is a need for nurse managers to be supported and acknowledged in their managerial capacity. Nurse managers perceived that institutional management was unaware of the distressing situations that occurred within their wards. Lack of support from the institution could be because of the inability to perceive moral dimensions of care and the institutional culture whereby communication in general was poor (Van der Dam et al., 2013). Literature on organizational culture suggests the creation of a positive moral environment through which institutions offer support to enhance innovations through the creation of practices and policies (Pauly et al., 2009). Further, healthcare institutions should make it a priority to promote educational and supportive interventions intended to improve and enhance nurse managers' liberation, self-sufficiency, and moral knowledge (Kortje, 2016).

The challenges for nurse managers may be compounded in this COVID-19 pandemic era. For example, Newham and Hewison (2021 pg. 88) have reported that the pandemic is 'uncharted

territory' for all nurses, including nurse managers and they are likely to encounter new practical and moral difficulties in their work settings. Using professional codes of conduct may offer some direction to nurse managers to support nurses navigate the difficulties they encounter during these times of distress and uncertainty as well as an environment where time is taken to think through these moral issues (Newham and Hewison, 2021).

7.7 Workforce implications

Globally, the healthcare sector is severely affected by nurse turnover, and it is an increasing human resource challenge (Dewanto and Wardhani, 2017). Lack of nurses in the Northern parts of Ghana results in an increased workload for the few existing nurses. This constrains access to health services and impedes the realization of the national health goals (Association of Chartered Certified Accountants, 2013). Nurses are employed through a centralized system; as such, public hospital management are unable to freely employ nurses to the hospitals. The human resource division (HRD) of the GHS at national level recruits and allocates nurses to the regional health directorates. These nurses are then deployed to the districts and health facilities in the region. The number of nurses and other health professionals employed by the government depends on staff availability and government's capacity to pay salaries of nurses. Nevertheless, nurse managers can advocate for more nurses if quality of care for patients is a priority. Donkor and Andrews (2011), have identified the need for policy that will ensure an increase in local nursing education, collaborative training opportunities abroad and 'improve the welfare and retention rates of current staff' (pg. 223). These policies when instituted may increase the number of nurses as well as help retain the over stretched nurses in Ghana. The provision of quality health care is in part achievable if the wellbeing of nurses is safeguarded. It is essential for healthcare organisations to address moral distress in nurses to promote and maintain their mental wellbeing.

Nurses working in clinical care settings with low staffing levels are three times more likely to experience moral distress than nurses in well-staffed units (Berhie et al., 2020). This is also the case in many developing economies where the lack of nurses contributes to the experience of moral distress (also discussed in chapter 4) (Häggström et al., 2008; DeKeyer and Berkovitz, 2012; Shorideh et al., 2012; Maluwa et al., 2012; LeBaron et al., 2014; Langley et al., 2015; Ganz et al., 2015; Borhani et al., 2017). Inadequate staffing levels contribute to the highest intensity and frequency of moral distress in nurses in health care settings and leads to morally difficult and challenging situations where effective teamwork is reduced and nurses' relationships with patients are affected negatively (Corley et al., 2005), Bressler et al., (2017), Morley et al., (2019) and Prompahakul and Epstein (2020). This in turn limits nurses' ability to provide essential patient care in hospitals (Lake et al., 2015: Recio-Saucedo et al., 2018).

The challenge is that the needed care for patients is not carried out by nurses leading to increased patient anguish (Corley, 2002; Fournier et al., 2007; Häggström et al., 2008; Harrowing, and Mill, 2010; Prentice et al., 2016). Further, when nurses experience moral distress and are unable to perform optimally this could generally lead to low patient satisfaction. Over a period, patients and their family members may try to avoid a place where nurses are perceived as not providing their best. This is consistent with studies by Wilkinson (1987) and Corley et al., (2002). According to the WHO Organization for Economic Cooperation and Development (OECD) and International Bank for Reconstruction and Development/The World Bank (2018) guaranteeing quality health care for all is vital, for it helps prevents distress and improves economic output, the reverse is detrimental to economies.

Nurse managers in this study spent approximately 9 hours per shift with five shifts per week on the wards, cumulatively nurse managers worked for 45 hours a week. This is likely to cause fatigue, stress, and other health effects (Kokoroko and Sanda, 2019). The outcome of burnout

is detrimental not only to the nurse experiencing it but to patients, patient family members, members of the health care team as well the nurse's family members (Wlodarczyk and Lazarewicz, 2011). The link between burnout and moral distress has been investigated (Fumis et al., 2017; Wagner, 2015; Dalmolin et al., 2014) and Fumis et al., (2017) reported that the experience of moral distress in nurses contributed to the experience of burnout. This is because there are similar contributing factors that cause moral distress and burnout in nurses, such as inadequate teamwork and lack of nurses (Wagner, 2015).

7.8 Critique of moral distress

The concept of moral distress is not without criticism. One, particularly strong, criticism is that it should be abandoned (Johnstone and Hutchinson, 2015). It should be abandoned because the concept is flawed and the research about it and its purpose is respectively weak and unclear. Other critiques are less extreme in their recommendation but identify specific instances included in the broad criticism of Johnstone and Hutchinson (2015). For example, Newham (2020) focuses the idea of moral normativity and the conceptual and empirical concerns for measuring moral distress. Gallagher (2011) focuses on encouraging healthcare institutions to create supportive structures and understanding leadership that will improve moral courage in the work setting.

Johnstone and Hutchinson's (2015) criticism emphasises problems with the idea that nurses *know* the correct thing to do, that their inability to act is a 'special case' in healthcare, questioning whether *moral* distress exists and relatedly the credibility of the evidence.

Johnstone and Hutchinson's (2015) criticism emphasises the claim that nurses know the right thing to do, discussing the epistemology especially justificatory reasons for this explaining, rightly, that moral epistemology is very contested and thus questioning how it can be that nurses seem to have such knowledge. The criticism seems to be that rather than knowledge,

nurses are using opinion. Their claim is that moral judgements need critical thinking through the use of sound reasoning and not just opinion.

Another challenge argued by Johnstone and Hutchinson (2015) and Fourie (2015) is the assumption that there is a disparity between what nurses believe to be the right action and limitations or difficulties (internal or external) that inhibit them from taking such action. This is likely because most health institutions face challenges including shortage of nurses, lack of equipment, issues with management such as lack of policies, as a result all health professionals are constrained by these factors to various degrees. Therefore, nurses are not the only health professionals experiencing these morally challenging situations in their workplace, so the increasing investigation of moral distress in nurses is not warranted (Johnstone and Hutchinson, 2015). For, Johnstone and Hutchinson (2015), the continuing accounts of moral distress reinforce the view of nurses being helpless victims of the organization instead of them working to challenge and change the status quo. In any case it is not all the time that all nurses feel powerless to act for whether nurses feel constrained is an issue of personal character and ability, not other limitations (Johnstone and Hutchinson, 2015). As reported by Varcoe et al., (2004) nurses usually do find a way to manage moral problems they encounter through a combination of experience, courage, and resilience.

On a fundamental level, the concept of moral distress is the notion that such a state of distress in fact exists. Johnstone and Hutchinson (2015) argue that majority of studies conducted on moral distress comprise little more than an appropriation of normal psychological responses (sadness, frustration, anger, worry, displeasure) that nurses may feel when confronting problematic moral matters and disputes in their clinical practice. Whether these reactions necessarily constitute ‘moral’ distress, however, is debatable (Johnstone and Hutchinson,

2015). Further nurses' experience of anger, sadness and guilt may be more of manifestation of conscience, rather than moral distress (Johnstone and Hutchinson, 2015).

Johnstone and Hutchinson (2015) recommend that the idea of moral distress should be discarded while efforts should be directed towards studies that facilitate improving the quality and safety of moral decision- making, moral behaviour and moral impact in nursing and healthcare practice. Global concern about safety and quality in healthcare is increasing (Donaldson, 2002) and the World Health Assembly (WHA) recognised that the occurrence of avoidable adverse events is detrimental to patient care (WHO, 2002). Johnstone and Hutchinson (2015), suggest the need to focus on more useful studies by advancing a strong understanding of patient safety, and consequences of moral dispute in clinical care practice instead of more studies of moral distress. Further creating evidence-based responses for lessening moral dispute studying the nature and function of conscience in moral decision-making and action in healthcare practice.

Despite the criticisms of Johnstone and Hutchinson (2015) and others, the idea, and investigation of moral distress continues to interest nurse researchers. In a formal event organized to increase awareness of the concept moral distress, debate its meaning, and discuss its significance (Morley, 2016), Professor Gallagher itemised some of the problems that occur from an emphasis on moral distress: potential moral ineffectiveness and disempowerment and a possible distraction of consideration from institutional obligations. Professor Gallagher contended that the strengths of the idea of moral distress are: 1. moral facets of care practices can be identified, 2. it advocates moral compassion, 3. it focusses on challenges of moral care and 4. can enlighten the association of nurse's behaviour and institutional culture (Morley, 2016). Despite the problems associated with moral distress it is a valuable and beneficial idea (Morley, 2016). For it is precisely because of patient safety that more studies are needed on

moral distress so that it can be understood, and appropriate culturally accepted interventions instituted. As it turned out nurses in Ghana experienced moral distress and were impacted where it had not been conceptualized. The point here being that it does seem as though nurses are suffering distress at work, and it seems as though reasons given relate to moral events. More international investigators should continue to study moral distress in nurses (Ghana, Malawi, South Africa, Uganda) and draw attention to the significance of moral as pertained to nursing. Further, there is a need to move towards solution- based moral education according to Professor Gallagher (Morley, 2016).

Morley et al's., (2017) definition of moral distress is by far the broadest definition that encompasses a wide range of moral events and circumstances which was used in this study to determine whether nurses experience moral distress working in NICU and paediatric wards. Using this definition revealed that nurses experience moral distress in Ghana, an economy where the notion of moral distress was not conceptualized. As the findings of my study have shown, it is essential to foster strong qualitative studies that can be compared and likely combined, in different cultural and economic contexts as advocated by Prompahakul and Epstein (2020). This is especially the case for the cultural and economic context of Ghana where the concept was not originally conceptualized. As reported by Prompahakul and Epstein (2020) more studies are needed in less developed and developing economies to further enhance the holistic understanding of moral distress in nurses. Further, Gallagher (2011) acknowledges the difficulties of nurses working in clinical settings and has suggested the need to continue to understand these environments and an appreciation of the helplessness of nurses. Once nurses are appreciated and the complexities are understood healthcare institutions must create supportive structures and proactive leadership that will improve moral courage in the health care settings (Gallagher, 2011).

In summary, the current understanding of moral distress, supports and highlights the role of moral reactions in moral decision-making and shows various ways moral action can be executed or limited in institutional settings (Morley et al., 2019; Pauly et al., 2012; Corley, 2002). Though the conceptualization of moral distress may be ambiguous (Fourie, 2015; Campbell et al., 2016; Morley et al., 2017), it appears to enhance the understanding of nurses' moral difficulties working in clinical care settings. The reason for studying moral distress is to better understand its impact on the experience on nurses, the institutions they work in, and its effect on patient care (Prompahakul and Epstein, 2020). Once the detrimental effects are known appropriate interventions can be identified to help nurses lessen the experience of moral distress (Prompahakul and Epstein, 2020).

7. 9 Study implications

It is important to consider the implications of the study for nursing in the following areas: research, policy, clinical practice, and nursing education.

7. 9. 1 Implications for research

This study highlights the lack of research on moral distress in Ghana and the need for more studies in developing economies. The findings of this study have the potential to generate interest in research on moral distress in particular and ethics in general in Ghana.

While it may be unrealistic to expect that moral distress can be prevented, its negative impact on nurses in Ghana could be lessened. Interventional studies are needed to develop and test evidence-based and culturally appropriate coping mechanisms that support nurses to navigate the experience of moral distress. Further studies may be needed in the advancement and development of a moral distress scale for measuring the level of moral distress intensity and frequency as seen in Iran.

Further, other members of the health care team such as physicians, pharmacists, physiotherapists, occupational therapists, physician assistants are also likely to encounter morally distressing situations (Trotochaud et al., 2015; Hamric, 2012: Pauly et al., 2009: Austin et al., 2005) and so investigation of their experience is needed in developing economies. Recognition and investigation of the experience of moral distress as a multi-disciplinary phenomenon may provide useful insights on how to mitigate the problem. Such opportunities would enable those who feel powerless in certain situations to voice their views and opinions.

7. 9. 2 Implications for policy

The findings of this study show that nurses were affected psychologically by their experience of moral distress. The implication here is that nurses are more likely to leave the nursing profession in Ghana and migrate to developed economies where the perception is that nurses experience less moral distress. Migration of nurses is a challenge globally that has left Ghana and many developing economies with a lack of nurses which affects patient care. Lack of nurses is felt more in the Northern parts of Ghana where fewer nurses are found. Lessening of the experience of moral distress begins by providing adequate nurses in clinical care practice such as NICU and paediatric wards especially in the Northern sector of Ghana.

Mitigating the impact of moral distress is critical if we are to maintain a healthy working environment and lessening migration of nurses. To reduce the impact of moral distress on clinical nurses, there is a need to develop a system that recognizes moral distress and institutes measures that facilitate de-escalation (Goodman et al., 2020). These would include measures such as debriefing sessions as soon as clinical nurses experience morally distressing situations, where affected individuals could express what they are going through. Such sessions should be planned and should be held regularly. Another suggestion of de-escalation is the need to have ethics/moral committees tested in research that would among other things create an

environment that supports ethical practice but also helps address ethically challenging situations. In creating such committees, nurses should be represented in the planning stages to give their input (Hajibabaee et al., 2016).

7. 9. 3 Implication for clinical practice

Most of the difficulties participants of this study encountered in Ghana were lack of basic instruments and equipment comparable with what nurses' experience in other developing economies. According to the World Health Organization, between 50 to 80 percent of medical instruments in developing economies are non-effective (WHO, 2012). Lack of medical instruments is an obstacle to the ability of the health institution to offer quality services. Desirable patient outcomes are directly linked with the availability of medical instruments and devices of reliable quality, and same must be provided by health institutions (Moyimane et al., 2017). The regular procurement and availability of essential medicines, basic equipment and supplies are critical to lessen the experience of moral distress (Fournier et al., 2007; Maluwa et al., 2012). As a result, hospital managements need to comprehend and appreciate the moral component of the nurse managers role and responsibility, thereby facilitating for more basic instruments, equipment, and supplies as a measure of lessening moral difficulties on the wards (Mitton et al., 2010; Haghighinezhad et al., 2019).

In this study, participants indicated the need for in-service training on moral issues in general encountered in the wards and moral distress in particular, because the term moral distress was not known among participants until this present study was conducted. Formalizing training on moral issues and moral distress will enable more nurses and nurse mangers to appreciate and develop resilience (Monteverde, 2016). Although a challenge, this is particularly needed where nurses are generally unfamiliar with the term moral distress. Therefore, there is the need to introduce training programmes such as workshops, continuing professional development

(CPD) presentations and regular staff meetings on moral issues so that nurses can be familiar with them and better prepared to reduce outcomes that generate moral distress. In a comparative study, Powell (2012), compared nurses who had attended a workplace-based educational program on moral distress and nurses who did not attend this workplace-based workshop. This program was operationalized using a plan published by the American Association of Critical Care Nurses' program entitled the 4As to Rise Above Moral Distress (2005) as the intervention for a set of nurses in different hospitals in the United States. After data analysis Powell (2012) established that the nurses employed in magnet selected hospitals reported reduced post-test moral distress scores when compared to staff in the non-magnet hospitals indicating that workshops on moral distress are helpful for clinical nurses. Further, there is a need to facilitate supportive links among clinical nurses. The importance of supportive collaboration among nurses has been established in studies by deBoer et al., (2014) and Ozbay et al., (2007) albeit not specific to moral distress.

The findings of this study can be used by the management of health institutions to advance practical interventions to tackle the experience of moral distress in their staff.

Effective communication with all team members will go a long way to reduce disagreements regarding patient care that may lead to moral distress on the wards (Haghighinezhad et al., 2019). This is particularly important where nurses work with physicians who usually generate orders for nurses to carry out. It is imperative to have effective communication, including the need for physicians to listen to and empathise with nurses who carried out orders that generated moral distress (Vincent et al., 2020). Ultimately, the patients will also experience a more pleasant hospital ward environment. This fact should lead to a broad introduction of moral distress as a topic during nursing training and in-service training in Ghana.

7. 9. 4 Implications for nursing education

The nursing curricula developed by the Nurses and Midwifery Council (NMC) in Ghana generally include theoretical information about ethics. A review of the nursing curriculum in Ghana revealed that new courses such as supply chain management, relationship marketing strategy and entrepreneurship, French and Sign Language have been added to the curriculum (Zutah, 2017). However, there is no mention of moral distress in the section on ethics in the curriculum. Even though extensive studies on moral distress have been conducted in the developed economies, Corley (2002) suggests that the nurses' educational programmes do not sufficiently prepare new nurses to deal with moral distress that is encountered in practice. Vanlaere and Gastmans (2007), Pauly et al., (2012) and Sasso et al., (2016) contend that nursing students should be exposed to moral teaching that offers them skills they need to reflect on their practice. Therefore, a starting point in Ghana, could be to introduce student nurses to the concept of moral distress in their training which will help them develop interpersonal and coping strategies that might help them lessen experiences of moral distress in later practice (Curtis, 2014). The above studies, along with findings of the present study suggest there is a need to revise the sections of the curriculum that deal with ethical issues in general and to introduce material concerning moral distress into the curriculum of nursing in Ghana. This will improve awareness and motivate student nurses to prepare for clinical practice linked to moral distress.

As a result, nurse educators must recognise moral education as a main ingredient for clinical practice because education on moral difficulties may provide nurses with the knowledge and skills to lessen moral difficulties on the wards (Mullen, 2018). Nurse educators may also be called upon as resource persons for in-service training of nurses to develop their moral abilities. Junior nurses who begin their practice on the wards may require updated courses to enhance their understanding of moral distress and related moral issues. For experienced practicing

nurses there is the need to teach junior nurses coping mechanisms and moral resilience. Increased awareness of moral distress is needed for nurses in clinical practice to place nurses in a position to lessen moral difficulties.

Since some contributing factors were recounted in this study as disagreements and difficulties with medical officers regarding the care of patients, it will not be out of place to include medical officers and other health care professionals in the education on moral distress. Another form of lessening the experience of moral distress is to have a combined moral education of nurses, medical officers and other health care professionals that constitute the health team as suggested by Storch and Kenny (2007).

7. 10 Limitations of the study

Since purposive sampling was used to select participants from four hospitals in Northern Ghana, the study was limited only to nurses who heard and saw the advertisement for recruitment into the study. This meant that nurses who were on annual leave or sick leave were unavailable and so could not be included in the study.

Even though data saturation was realized with 54 participants, the findings cannot be generalised and applied to all Ghanaian nurses since sample selection was purposive.

The study was only limited to nurses working in NICU and paediatric wards as a result nurses working in other wards (adult care, maternity) aside NICU and paediatric wards were excluded in the study.

7.11 Recommendations

With the objective of the study being to ascertain the experience of moral distress in nurses working in NICU and paediatric wards in Northern Ghana, it is appropriate to present recommendations drawn from the findings of this study focussed on how the negative impact of moral distress on nurses can be managed. The following recommendations are proposed to

promote improvement in the quality of life in professional nursing and contribute to lessening the experience of moral distress in nurses and nurse managers. Some of these proposed recommendations have been identified from the section on the summary of strategies and responses to moral distress (4.11). These recommendations are also intended to be helpful to the wider profession, and for individual practitioners in nursing in clinical care in Ghana. The recommendations are examined under clinical leadership**,** regulatory leadership, future research, education, policy, and nursing practice.

Clinical Leadership

Participants suggested the need for the organization to offer management and leadership development education, a participant had this to say:

> *'We wish for in-service training on leadership and management skills to be able to handle our subordinates. If the hospital management organizes in service training for us it will go a long to improve patient care'* (SDA. NM. 13).

Leadership education has been demonstrated to contribute to lessening the daily difficulties that create the experience of moral distress for nurses (Haghighinezhad et al., 2019). Relevant preparatory and continuing leadership education programmes are therefore essential to support nursing leaders and managers as they strive to manage staff delivering patient care on the wards regarding. An example, of a form of leadership education is action centred leadership (Adair, 2006). The model consists of three over lapping circles, 1. achieving the task, 2. managing the group, and 3. managing individuals all in a balance (Adair, 2006). Although there is no evidence of its use in lessening the experience of moral distress in nurses, it has been used generally in leadership (Akparep et al., 2019). The approach could equip nurse managers and leaders to support nurses as they encounter complex moral problems during patient care in the Ghanaian context. Adair's model is widely used, easy to understand and applicable to a range of settings including Ghana (Akparep et al., 2019). Therefore, it could serve as a basis for leadership development in nursing in Ghana.

Frequent district, regional and national proactive nursing and nurse managers meetings for shared learning, planning, and responding to important community actions that affect the health care system could be helpful (AACN, 2004). These fora could serve as a means of building a repository of useful policies (AACN, 2004). Nurses and nurse managers should be included in these meetings, so when future events occur, those who lead are prepared with solid approaches to navigate difficult times (AACN, 2004).

As part of regional networking, organizations should also generate regular institution-wide networking opportunities through semi-annual or annual management professional days where executive leadership could interact with managers about strategic planning (American Society of Clinical Oncology, 2009). Nurses and managers would benefit from leadership seminars on current leadership issues and trends during these professional days. Such sessions may offer a chance for managers to form relationships that are fundamental in forming support systems that could assist in the care of patient and provide support to managers in their practice (Kolzow, 2014). This could give nurse managers in Ghana the opportunity to build capacity and active their innovative skills regarding moral best practices.

Regulatory Leadership

The findings of my study revealed that the knowledge of the concept moral distress was limited among nurse managers. A practical approach to lessening the experience of moral distress is through educating the professional bodies, and management of health institutions to hold expectations of leaders and nurse managers to resolve moral difficulties in the clinical work environment. As such it would be useful to ensure that all health care leaders and managers, for instance those at the top of the hierarchy and within government, are skilled and knowledgeable about moral distress, particularly in how they contribute to it, how they can

reduce it, and how it exists for them, so that knowledge, awareness, acceptance, and lessening of the experience of moral distress can occur (Haghighinezhad et al., 2019).

Considering the professional and organizational expectations of nurses and nurse managers to provide optimal patient care and to resolve moral difficulties in the health care environment, national institutions and policy makers in government could be well served to learn more about the current difficulties of the internal and external tensions encountered by nurses and nurse managers and the relationship of these tensions to moral action, constraints in agency, and the well-being of nurses and nurse managers in the health care system. For instance, the Ghana Registered Nurses and Midwives Association (GRNMA) has called for the government to employ 40,000 nurses and midwives in the health care sector, because of the shortage of nurses (Ghana web online, 2019 b). Although there has been an increase in the number of nurses for example, the ratio of nurses to total population was 1:1,084 in 2013, and 1:799 in 2017 (Ministry of Health, 2018) in 2018, the ratio of nurses to total population fell to 1: 839 (Ghana web online, 2019 a), meaning equity of access to, and high-quality delivery of health care is reduced. However, in a recent communication in Ghana, the Ministry of Finance has given authorisation for the recruitment of about 11,226 nurses **(**Okertchiri, 2021). This is welcome news as recruiting more nurses will improve and enhance quality of patient care. A technical report from the Ministry of Health on staffing norms for the health sector in Ghana recommends that regional hospitals with OPD attendances /Year below 100,000 and inpatient below 10,000 should have 121 minimum general nurses and 142 general nurses (Ministry of Health Staffing Norms for the Health sector in Ghana, 2018). Staffing norms can be enforced in various hospitals in Ghana.

Nurse managers should be resourced to consider careful planning for the purpose of ensuring available resources (nurses in terms of numbers and basic consumables and instruments) for nurses on the wards to work with, this is especially the case for under-resourced over-worked

environments seen in Ghana. For instance, although the WHO recommends 9.8 percent percentage of GDP allocated to health, in Ghana GDP ranged from 3 per cent in 2000 to 5.4 per cent in 2013 (Aikins and Koram, 2017), and decreased to 0.4 percent in 2020 (The World Bank Group, 2022). There is an urgent need for the Ghanaian government to increase the health care expenditure as recommended by the WHO. Further strategies should be put in place by the government to facilitate the increase in the health insurance enrolment, this will in turn increase the health revenue through NHIS premium (Schieber et al., 2012). Stakeholders (government, private enterprises) in the Ghanaian health care industry could explore innovative plans and motivational packages to retain nurses, nurse managers and other health care professionals (Adua et al., 2017). Incorporating these resources into management teams would create a culture of acceptance, trust, and support.

Future research

This qualitative research may stimulate interest for future studies of the experience and other facets of moral distress. Other members of the team such as physicians, pharmacists, physiotherapists, nutritionists, and others may also experience moral distress. They may also contribute to morally distressing situations among nurses, and the reverse could be true. Therefore, more studies are needed to explore these other groups of professionals to determine to what extent these assertions are true. Further studies are also needed on how nurses and other staff can be supported to cope, respond, and manage moral distress in their practice as suggested by Johnstone and Hutchinson, (2015).

Though this study has revealed that nurses working in NICU and paediatric wards in Northern Ghana experience moral distress, this cannot be generalized to maternity, medical and surgical wards. More qualitative studies are needed on the experiences of nurses and midwives working in adult medical and surgical care and maternity care settings to ascertain the factors that contribute to nurses' experience of moral distress and evidenced based mechanisms instituted

to assist nurses manage their experience. Further, a range of other dimensions that needs further investigation is age of nurses; religion of patients and family members; impact of the environment in relation to nurses' experience of moral distress.

A final recommendation for future research to enhance our understanding of moral distress is to conduct prospective and real-time longitudinal qualitative studies on the lessons learned during moral distress through nurses' perspective.

Education

In the wider literature education of nursing students about moral distress is reported to help them develop resilience to moral distress (Mæland et al., 2021; Reuvers, 2017; Krautscheid et al., 2017). Adding content about moral distress to the nursing curriculum should be considered in Ghana. An essential curriculum assessment and review to ensure an all-inclusive, sustainable method for teaching future nursing students how to lessen and manage moral distress is needed. This should focus on diploma and graduate level courses in nursing throughout the country. If student nurses are taught moral resilience, critical thinking, and communication skills during their training, they would be better equipped to understand and use individual and collective coping methods to manage moral distress (Reuvers, 2017). This training should be solution focussed moral education as recommended by Professor Gallagher (Morley, 2016).

Nurses may lessen the experience of moral distress by first recognising the moral issue and then by speaking up and advocating for the patient (Rushton and Kurtz, 2015). Nurse educators should use this study to develop, implement, and assess educational approaches such as Moral Distress Reflective Debriefs (Morley and Horsburgh, 2021), moral resilience (Rushton et al., 2015), critical reasoning and innovative skills aimed at assisting nurses to tackle complex moral issues concerning patient care. Moral action and efficient advocacy require knowledge of best practices, moral frameworks, conflict communication approaches, and personal formation of

both empowerment and resiliency. Another recommendation for education is introducing learning experiences such as problem-based learning, mental rehearsal, and role-play scenarios (Haghighinezhad et al., 2019; Krautscheid et al., 2017; Kälvemark et al., 2007). Moral dilemmas should also be included in simulation scenarios in the skills laboratory. The addition of moral dilemmas within simulation offers opportunities to practice and debrief moral practice, conflict communication approaches, and advocacy (Schaefer and Vieira, 2015). Such practices will help students acquire consistent psychological models of professional moral practice while also improving self-efficacy (Krautscheid et al., 2017). This type of teaching can be integrated in formal workshops for nurses in Ghana to provide challenging realistic situations that necessitate the need to explore new approaches, individually and in group level.

Educational workshops based on the 4A model discussed above in section (4.11) should be used for nurses working in the clinical settings to assist them reduce the incidence and experience of moral distress. This four-steps approach of ask, affirm, assess, and act was used by Molazem et al., (2013) to lessen the experience of moral distress in Iranian nurses' working in critical care units. The 4A approach has been used various authors to assist nurses manage complex moral difficulties (Rushton, 2006; McCue, 2010).

Educational programmes like the neonatal end-of-life educational program (Rogers et al., 2008) discussed in section (4.11) can be developed by nurse educators like myself that will encompass the essential coping response to moral issues and distress in nurses.

Policy

The data of this study suggests that institutions and governments might benefit from further understanding of the role difficulties of nurses and nurse managers and explore how institutions contribute to employee, nurses', and nurse managers' moral distress.

Health policies should comprise a standardized administrative process, available tools and resources, and reporting processes (Aberese-Ako, 2018). For example, health policies and acts of law on procurement of items and consumables should be adaptable to accommodate urgent procurement but with checks and balances to assist hospital managers in making timely decisions on essential materials such as drugs, basic medical supplies and equipment which is necessary for efficient health care delivery (Aberese-Ako, 2018). Further, this will support nurses in the care and management of patients and lessen their experience of moral distress.

Use of the formal priority setting approach programme budgeting and marginal analysis (PBMA) has been shown in Canada to make decision-makers more aware of the moral issues involved in assigning scarce resources (Gibson et al., 2006). PBMA approach consists of a consensual approach, open and transparent decision-making, increased use of evidence and mitigation of political interference.

A local policy could be that institutions consider instituting a document reporting system to record and detail workload and moral distress experiences. For example, workload management systems for nurses (WMSN) may be helpful for nurses in clinical care practice. A study WMSN which is based on direct and indirect nursing care study, prospectively categorises patients based on care needs and then determines staffing levels based on care workloads. The system monitored nursing personnel every 10 minutes for 8 hour shifts across nine facilities. The resulting 107,700 data points were analyzed to establish what percentage of time nurses spent in three categories: (a) direct care (24.5%), (b) indirect care (60.5%), and (c) non-productive time (15%). Molter (1990) chose 11 activities to determine the three categories above: direct care, charting/clerical, transport, communication, administration, personal, wait time, off-unit activity, supplies and equipment, conferences, and environment. This system is practicable and has provided data for objective staffing adjustments and validated staffing requirements (Molter, 1990). The information captured through a system like this would allow

further research into the experience of moral distress by recognising and measuring the experience, intricate variables of their work and the clinical environment and patterns contributing to the experience and finding mitigating factors. However, care must be taken so as prevent hinderance to nursing practice.

Finally, nursing associations ought to consider providing advisory direction on policies to their members who encounter moral distress, as these associations may have members with knowhow such as nurse ethicists in defining the principles for moral nursing in clinical practice environments. Though there is no known nurse ethicist in Ghana, nurses interested in this field of nursing can be identified by the professional nursing associations for further training in international settings.

Nursing practice

The experience of moral distress by the nurses and nurse managers in Ghana, reinforces the need for nurses to continue to act as advocates of their patients and family members and deliberate morally, particularly due to the continuing nature of nursing care. Nurses in practice must exhibit courage when acting in moral disagreements according to moral values and should be willing to take risks to protect patients and ensure quality nursing care (Black et al., 2014; Nunthawong et al., 2020; Taraz et al., 2019; Numminen et al., 2017). For instance, nurses are encouraged to use the following advocacy strategies; conversations between patients and physicians, suggest relevant resources to patients, educate patients and family members, communicate with the health team, advocate for legal choices or policy changes and minimize errors to help protect patient rights, keep patients safe and improve communities. However, as suggested by Gallagher (2011) for nurses to exhibit moral courage, healthcare institutions must create supportive structures and understanding leadership that will develop moral courage in the clinical care settings. This is a practical approach that can be instituted by the management of health institutions in Ghana.

A vital approach for creating support systems in nursing practice may come from nurses having formal leadership programmes. One recommendation for consideration is for health institutions to invest in the establishment of safe and respectful work environments where interpersonal support systems can grow (Pauly et al., 2009; AACN, 2004). The American Association of Critical-Care Nurses (AACN) has recognised six principles for a healthy work environment these are skilled communication, true collaboration, effective decision-making, meaningful recognition, appropriate staffing, and reliable leadership (AACN, 2004). This will foster the creation of a good working environment for all and improve patient care (AACN, 2004). Approaches for creating these support systems include designing formal mentorship programs for nurses, managers and leaders that purposively nurture professional relationship systems (AACN, 2004). Mentorship programs for nursing leaders and managers contribute to healthy organizational cultures because they provide opportunities for continued learning, create supportive relationships, promote the value of professionals throughout the institution, increase confidence, enhance decision-making, and augment job satisfaction (Jakubik et al., 2004).

A collaborative approach is an inter-disciplinary and multi-step action by a group of experts in various fields. For collaborative approach is valuable for further comprehending decision-making procedures in different disciplines in moral challenges and dilemmas and coping approaches with moral distress (Karanikola et al., 2014; Papathanassoglou et al., 2012). An example of an intervention with a collaborative approach is social work intervention. Browning and Cruz (2018) developed and tested a social worker-facilitated protocol called reflective debriefing for lessening the experience moral distress through regular debriefings with nursing staff on an intensive care unit. The response to the intervention highlighted the significances of interprofessional collaboration to effectively lessen moral distress in health-care workers (Browning and Cruz, 2018). Participants felt empowered to constructively confront other staff members about truth-telling in the care of patients (Browning and Cruz, 2018). Nurses'

response to the intervention was positive (Browning and Cruz, 2018). This would be particularly practical and applicable in the Ghanaian context where participants of this study recounted that lack of teamwork contributed to their experience of moral distress.

Another recommendation for nurses in practice is ethics consultation discussed in chapter 4. Ethics consultation that is linked to moral dilemma or moral uncertainty can be initiated to look for an appropriate patient-centred ethical resolution for nurses, other health care professionals as well as patient family members (American Society for Bioethics and Humanities Clinical Ethics Task Force, 2009).

It is also recommended that nurses experiencing moral distress utilize the Moral Distress Reflective Debriefing (MDFD) approach (discussed in chapter 4) to lessen the experience of moral distress on the wards. The five-stage approach can help nurses in manage discussions geared towards individual/group coping strategies, self-care and enhancing an emotional safe return to work. In the approach nurses are also given the opportunity to speak about their anguish where they are assured that the experience of moral distress is common, and they are not alone. This approach is particularly helpful because of the involvement of a clinical ethicist and a licensed social worker (Morley and Horsburgh, 2021). With the model of MDRD based on Morley et al's., (2017) broader definition of moral distress, which is also the definition used for my study, it can be a practical approach to assist nurses lessen their experience of moral distress working in hospitals.

Another recommendation for nurses working in clinical settings in Ghana, is the need for nurses to be given well-defined roles during decision-making about patients' care and treatment. Involving nurses more systematically, preferably before the treatment decision is made can reduce the experience of moral distress and improve the quality of decisions made by nurses regarding patient care (Stacey et al., 2008).

In conclusion, moral distress cannot be completely eradicated from nurses' experiences working in clinical settings in Ghana. However, these recommendations' when applied could go a long way to lessen the current experience of moral distress. With knowledge of what moral distress is and bearing in mind that some of the contributing causes of moral distress in Ghana are systems oriented, institutions can provide resources to assist nurses and nurse managers consider and address some of the system factors that tend to cause moral distress.

Chapter 8: Reflections and conclusion

8.1 Reflections

I began my doctoral journey, with the aim of exploring the experience of moral distress in nurses and nurse managers who worked in NICUs and paediatric wards in Northern Ghana. As a nurse working in NICU and paediatric wards, as an in-service training coordinator at the Regional Health Directorate in the Northern region and as a teacher at the University for Development Studies Tamale the idea to explore moral distress grew from a sincere interest, I had in moral difficulties nurses encounter in the clinical care settings. As I advanced through my doctoral studies, I examined a variety of thought-provoking and stimulating issues and in the process, I found that there was a paucity of studies on moral distress in developing economies. As a result, moral distress has not featured as a topic in the curricula of nursing training in many developing economies. Issues relating to moral distress are gradually being understood by the rank and file of nurses and nurse managers in Ghana and other developing economies, as confirmed by my study.

As I reflect on my study, I realise I was privileged to have a senior researcher from the University for Development Studies in Tamale with me during the initial interviews. The presence and guidance of the senior researcher in the interviews enhanced the rigour of the data collection process. The presence of the senior researcher did not affect the dynamics of the interview process, he was introduced to participants, and they were encouraged to respond freely. All study participants were asked the same set of interview questions. Participants were given the occasion to recount their own experiences of moral difficulties relating to the care of patients in NICU and paediatric wards. I acknowledged and documented my personal experience of moral difficulties as a clinical nurse and was mindful of its influence in the data collection process and analysis phase before the start of interviews.

In the analysis phase, analysis of the data and report of findings were carried out in a sequential way to produce an audit trail in the study. All data collected from nurses and nurse managers were used for the analysis. Trustworthiness of the study was ensured through the above discussions.

As a novice in qualitative research, I received practical guidance and coaching from my supervisors and attended lectures on the data collection processes.

The current study adds to the literature on moral distress in developing economies and offers new insights on the factors that contribute to moral distress in nurses and nurse managers in developing economies. The research results revealed the interplay of factors peculiar to Ghana and developing economies which led to the experience of moral distress. This study has added to the growing number of studies into moral distress from developing economies with particular attention to the differences of these settings from developed economies.

With the care of patients being paramount to nurses, it is distressing when basic items and equipment are unavailable for nurses to work with, this practical circumstance confirms my own clinical experience as a nurse. The pronounced and endemic nature of nurses' and nurse managers' experience of moral distress in NICU, and paediatric wards brought a new insight to my understanding of moral distress. As I ponder on the nature of their daily experience, the impact of their anguish - the value of the concept moral distress is evident. If nurses are impacted because of their experience of moral distress, it inevitably affects the quality of patient care. In recent times, there have been calls to address and safeguard nurses' psychological and mental health if quality of patient care is to be maintained in the health care system (Prompahakul and Epstein, 2020; Morley et al., 2019; Forozeiya et al., 2019).

An essential contribution of the study is the creation of a platform for further research into moral distress and the eventual development of a validated Ghanaian moral distress measurement instrument. The awareness created during the study will put moral distress at the

fore of nursing research and eventually will add significant information to the current knowledge. This current work may be viewed as sowing seeds for a flourishing branch of nursing training, research, and practice in developing economies such as Ghana.

8.2 Conclusion

In this chapter, I have discussed and explained the main findings of the current study in the Ghanaian context and related it to relevant literature. This study findings support reports of other research in developing economies. The main contributing factor to moral distress in nurses in Northern Ghana was the lack of basic items and consumables needed for patient care. It also emerged from the study that although the term moral distress was not initially known in nurses in NICU and paediatric wards, they experience it. Further, the study revealed that the voices of nurse managers are not heard nor considered, and no practical support is available to them to support nurses who experience moral distress. Nurse managers felt unsupported and ill-equipped in their role, as a result, participants experienced a sense of anguish, felt sadness and hopelessness because of inability to assist nurses navigate through moral distress.

Other significant factors contributing to the experience of morally distressing situations have been illuminated in the context of Ghana.

One of the main contributions of this study is its addition to the existing knowledge on the experience of moral distress. The awareness created during the study and the advocacy that shall follow in due course will add to our current knowledge.

Appendices

Appendix A: Participant Information Sheet

UNIVERSITY OF BIRMINGHAM

Participant Information Sheet
How is moral distress perceived and experienced in Northern Ghana? A study of neonatal intensive care and paediatric nurses.
Lead Researcher: Vivian Afoko, PhD student, University of Birmingham**.**
Supervisors: Dr Alistair Hewison, Dr Roger Newham and Dr Susan Neilson, University of Birmingham.

Why have I been approached?
You are invited to take part in this study because you work in a NICU or paediatric ward. Please read this information leaflet carefully to help you fully understand the reason for the research and what the study will involve.

Purpose of the study:
Moral distress has been studied extensively in many Western countries, the consensus is that moral distress is real and has negative effects on the wellbeing of nurses. However, little is known about moral distress in West Africa.

Do I have to take part?
No. It is your choice whether to take part in the study or not. If you do decide to take part, you can still withdraw at any time without giving a reason.

What will I have to do if I decide to take part?
If you agree to take part, you will be interviewed about your experiences of difficulties you may have faced in practice. The interview will take place in the hospital. It will be digitally recorded and will last approximately 60 minutes.

What are the benefits of taking part?
There are no immediate benefits to you by taking part in this study, although you may find the experience interesting. Also, the findings may be used to improve practice in the longer term.

What are the possible risks of taking part?
We do not expect this study to cause any significant risks, although some people might find it upsetting talking about an experience they faced. However, if you get distressed, or upset the interview can be stopped at any time.

What will happen with the information I give during the study?
All information will be anonymised when it is collected and securely stored on a university computer. You will not be identifiable. Information will be used for publications.

Who else is taking part in the study?
We hope to recruit 24 nurses and 14 nurse managers from four hospitals in Tamale for face-to-face interviews.

Will I receive any payment for my involvement?
Unfortunately, we are not able to provide you with any expenses or payments for taking part in the study. However, you will be given a drink and snack during the interview.

Who is organising this research?
I am doing this study as part of my PhD program at The University of Birmingham, U.K.

What do I do if I want to take part in the study?
If you decide to take part in the study, please contact Vivian Afoko on:
Email:
or
Telephone:
You will receive a reply within 24 hours.

Who to contact:
If you have any questions concerning ethical issues on this study, please contact,
The Chairman,
Thro' The IRB Administrator
Navrongo Health Research Centre
P. O. Box 114, Navrongo, UER
Email:
Tel:

Thank you for taking time to read this information sheet.

Appendix B: Participant Recruitment Sheet

UNIVERSITY OF BIRMINGHAM

Do you work on a neonatal intensive care unit or on a paediatric ward?

Are you a nurse or a nurse manager?

We wish to recruit front line nurses and nurse managers for a study exploring the experience of moral distress in Northern Ghana.

What will participation involve?

- One interview at the hospital (lasting up to 60 minutes).

To participate you must:

- Be a practicing registered nurse, a nurse manager (principal nursing officer, senior nursing officer, nursing officer, senior staff nurse, staff nurse)
- Currently working in the NICU or on a paediatric ward.
- Have over 6 months working experience at NICU/ paediatric wards of site 1, 2, 3, and 4.

What are the wider benefits of participating?

- Your information will help to provide a clearer understanding of how we can promote nurses' wellbeing in these areas. This study is part of a PhD in Nursing.

Date of commencement of the study: 26th November 2018.

To participate or for more information, please contact:

Vivian Afoko at [redacted] or on [redacted]

Appendix C: Participant Consent Form

UNIVERSITY OF BIRMINGHAM

Participant Consent Form

How is moral distress perceived and experienced in Northern Ghana? A study of neonatal intensive care and paediatric nurses.

Please write your initials in each box:

I confirm that I have read the participant information sheet and have had the opportunity to discuss the study.	
I understand that my participation in this study is entirely voluntary and that I am free to withdraw at any time without penalty and without giving any reason. Anonymised data will still be used.	
I agree to the digital recording of the face-to-face interviews.	
I understand that anonymised data will be used in dissemination of the findings.	
All data will be stored according to the University of Birmingham and the Navrongo Ethical Review Board guidelines.	
I agree to take part in the above titled research study.	

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

If you have further questions about the study, please feel free to contact Vivian Afoko at [redacted] or at [redacted] or my lead supervisor Dr Alistair Hewison at [redacted] or at [redacted]

When completed: one copy for the participant and one for the researcher.

Appendix D: Participant Demographic Survey – Nurse

UNIVERSITY OF BIRMINGHAM

The following general information about, age, origin, education is needed for the study. Please provide the required information and tick in the box where appropriate. This information will not be linked to individual participants' responses and will be used only for the purposes of describing the sample as a group. Providing this information is voluntary.

Date: _____ ID NO**:**

Demographic information	**Required Answer of participant**
GENERAL INFORMATION	
My age is within:	1. 18-28 years: ☐ 2. 29- 39 years: ☐ 3. 40-50 years: ☐ 4. 51-60 years: ☐
I identify as:	1. Female: ☐ 2. Male: ☐
RELIGION AND CULTURE	
My ethnic origin is:	1. Grusi: ☐ 6. Ewe: ☐ 2. Mole-Dagbon: ☐ 7. Ga-Dangme: ☐ 3. Guang: ☐ 8. Mande: ☐ 4. Gurma: ☐ 9. Other Group……. 5. Ashanti-Akan: ☐
My religious orientation is:	1. Christian: ☐ 2. Moslem: ☐ 3. Traditionalist: ☐ 4. Other ……
CURRENT WORK	
How many hours do you work per day?	1. Below 6 hours: ☐ 2. 7 hours: ☐ 3. 8 hours: ☐

	4. 9 hours: ☐ 5. 10 hours: ☐ 6. More than 10 hours: ☐
I currently work in:	1. NICU: ☐ 2. Paediatric Ward: ☐
The hospital I currently work in is:	1. Site 1: ☐ 2. Site 2: ☐ 3. Site 3: ☐ 4. Site 4: ☐
I am employed as a:	1. Registered nurse: ☐
My rank/grade is:	1. Staff nurse: ☐ 2. Senior Staff nurse: ☐ 3. Nursing Officer: ☐ 4. Senior Nursing Officer: ☐ 5. Principal Nursing Officer: ☐ 6. Other.....
EDUCATIONAL BACKGROUND	
My highest level of education is:	1. Diploma: ☐ 2. BSc: ☐ 3. Post-graduate Speciality Training: ☐ 4. Masters: ☐ 5. Other…….
WORK EXPERIENCE	
I have been working as nurse for:	1. Less than a year: ☐ 2. 1-5 years: ☐ 3. 6-10 years: ☐ 4. More than 10 years: ☐
I have been working in my current unit/ward for:	1. Less than a year: ☐ 2. 1-5 years: ☐ 3. 6-10 years: ☐ 4. More than 10 years: ☐

Thank you for completing this information sheet.

Appendix E: Participant Demographic Survey – Nurse Managers

UNIVERSITY OF BIRMINGHAM

Participant Demographic Survey-Nurse managers.

The following general information about, age, origin, education is needed for the study. Please provide the required information and tick in the box where appropriate. This information will not be linked to individual participants' responses and will be used only for the purposes of describing the sample as a group. Providing this information is voluntary.

Date: _____ ID NO**:**

Demographic information	**Required Answer of participant**
GENERAL INFORMATION	
My age is within:	5. 18-28 years: ☐ 6. 29- 39 years: ☐ 7. 40-50 years: ☐ 8. 51-60 years: ☐
I identify as:	1. Female: ☐ 2. Male: ☐
RELIGION AND CULTURE	
My ethnic origin is:	1. Grusi: ☐ 6. Ewe: ☐ 2. Mole-Dagbon: ☐ 7. Ga-Dangme: ☐ 3. Guang: ☐ 8. Mande: ☐ 4. Gurma: ☐ 9. Other Group……. 5. Ashanti-Akan: ☐
My religious orientation is:	5. Christian: ☐ 6. Moslem: ☐ 7. Traditionalist: ☐ 8. Other ……
CURRENT WORK	
How many hours do you work per day?	1. Below 6 hours: ☐ 2. 7 hours: ☐ 3. 8 hours: ☐ 4. 9 hours: ☐ 5. 10 hours: ☐ 6. More than 10 hours: ☐
I currently work in:	1. NICU: ☐ 2. Paediatric Ward: ☐

The hospital I currently work in is:	1. Site 1: ☐ 2. Site 2: ☐ 3. Site 3: ☐ 4. Site 4: ☐
I am employed as a:	2. Registered nurse: ☐
My rank/grade is:	1. Staff nurse: ☐ 2. Senior Staff nurse: ☐ 3. Nursing Officer: ☐ 4. Senior Nursing Officer: ☐ 5. Principal Nursing Officer: ☐ 6. Other.....
EDUCATIONAL BACKGROUND	
My highest level of education is:	6. Diploma: ☐ 7. BSc: ☐ 8. Post-graduate Speciality Training: ☐ 9. Masters: ☐ 10. Other…….
WORK EXPERIENCE	
I have been working as nurse for:	1. Less than a year: ☐ 2. 1-5 years: ☐ 3. 6-10 years: ☐ 4. More than 10 years: ☐
I have been working in my current unit/ward for:	1. Less than a year: ☐ 2. 1-5 years: ☐ 3. 6-10 years: ☐ 4. More than 10 years: ☐
EXPERIENCE AS NURSE MANAGER	
I have been a nurse manager for:	1. Less than a year: ☐ 2. 1-5 years: ☐ 3. 6-10 years: ☐ 4. More than 10 years: ☐
My main managerial roles are:	1. Coordination of staff schedules (assignments regarding patient care): ☐ 2. Oversee staff performance regarding patient care: ☐ 3. Ensures nurses professional growth: ☐ 4. Provision of educational and career enhancement opportunities for nurses: ☐ 5. Provide needed support to nurses regarding patient

	care: ☐ 6. Make available logistics to nurses: ☐ 7. Disseminations of hospital policies/information to nurses: ☐ Other(s)..... 8. …..... 9. …..... 10. ….....
How many employees (nurses) do you oversee?	1. Less than 10 nurses: ☐ 2. 11- 20 nurses: ☐ 3. 21-30 nurses: ☐ 4. 31- 40 nurses: ☐ 5. 41- 50 nurses: ☐ 6. More than 60 nurses: ☐

Thank you for completing this information sheet.

Appendix F: Face to face Interview Schedule – Nurses

Face to face Interview schedule – Nurses

Preamble and consent - Interview – Debrief

Thank the participants for participating in the study.

The question guide covers areas on moral distress. Prior to starting the interview, the researcher will introduce herself and explain the purpose of the study. The researcher will assure participants of confidentiality. Participants will be asked to fill a consent form agreeing to take part in the study and agreeing to a digital recording before the start of the interview. Once the participant agrees, the researcher will begin recording. The researcher will give the participants an opportunity to ask questions concerning the study or interview.

Demographic Survey Information will be gathered from participants.

- Tell me what it is like working as a nurse in NICU/ paediatric ward?
- Can you tell me about an upsetting situation or an experience in which you find difficult to carry out your responsibilities as a nurse in NICU or paediatric ward?

Probe: It could be something related to the care of baby or child, or conflict related to your practice or inability to carry out a task for a patient, inability to execute a decision concerning patients.

- What were the problems that made executing the action difficult?
- Have you heard of the term moral distress?

No: (M.D is when professionals cannot carry out judgements, they believe to be morally appropriate because of constraints or barriers which makes them feel frustrated, angered and hopeless).

If yes, tell me what you understand by the term 'moral distress'?

Probe: So, do you see that the experiences or situations you shared can be related to this definition?

- As defined, would you say that you have experienced and continue to experience moral distress in your current ward? If so, can you describe the situation(s)?
- Can you describe what this experience (or these experiences) has been like for you, providing specific examples or illustrations?
- Can you tell me how your responsibilities as a nurse contributes to moral distress?
- Can you tell me if the example you gave is common among your colleague nurses?

How did the experience make you feel?
Probe: sad, hopeless, frustrated, indifferent, angered - psychological, physiological, social etc.

- What do you think led to it?

Probe: lack of staff, lack of instrument and equipment's, colleagues' and other health professionals' actions and inactions, personal values, organizational issues etc.
Has the work environment contributed to your experience of moral distress? In what ways?
Probe: working in NICU, paediatric ward, child health in general, patient relatives, and managerial issues: inadequate teamwork, lack of collaborations, organizational issues etc.

- Can you tell me how the experience disturbed you?

Probe: (Affected practice? Affected patient care? Affected colleagues?) Were there any short term or long-term i.e. consequences like time off work, personal ill health, frustration with self, potential impact on patients) examples? etc.

- Can you tell me how your experience disturbed patient care?

- Have you left or considered leaving a clinical position due to moral distress?

Probe: if yes which position, if no why not.

- Are you considering leaving your position now due to moral distress?

- Can you tell me how you navigated through the situation?

- What action, if any, did you take in the situation you described?

Probe: specific examples, situations (Managing methods utilized in managing moral distress)

- Tell me about any support available to help you navigate this situation? If yes, what are they?

Probe: Could you turn to someone or access organizational resources, personal strategies, organizational strategies (ability to provide care or not)

- Tell me who it was and what were their suggestions to you to overcome or deal with the situation or your reaction?

- Can you tell me if you felt vulnerable or safe disclosing that you were experiencing moral distress?

- Describe any assistance, resources or actions of others that could have helped or hindered this situation.

- Do you believe religion and culture can influence one's experience of moral distress? If yes, how has religion and culture influenced the experience of moral distress?

Probe: examples of cultural beliefs/religion.

- Did you perceive a morally difficult element of the situation? If yes, tell me what you perceive as the morally difficult element(s) of this situation for you and how did it make you feel?
- Can you tell me what factors assisted or prevented you in resolving the problem?
- Tell me the worst part of this ethical experience?
- What did you learn from the experience?

Probe: Was there a positive aspect of this experience.

- What consequence, if any, do you think moral distress has on patient care, nurses and the organization in this situation and other situations caused by moral distress?
- Do you distinguish moral distress as something different from or related to burnout, emotional distress? If so, explain.

Is there anything else you would like to tell me about or anything I have not asked?

Debrief

Thank you very much for participating in this interview.

Appendix G: Face to face Schedule – Nurse Managers

Interview schedule – Nurse Managers

Preamble and consent - Interview – Debrief

Thank the participants for participating in the study.

Introduction: The question guide covers areas of moral distress. Prior to starting the interview, the researcher will introduce herself and explain the purpose of the study. The researcher will assure the participant of confidentiality. Participants will be asked to fill a consent form agreeing to take part in the study and digital recording before the start of the interview. Once the participant agrees, the researcher will begin recording. The interviewer will give the participant an opportunity to ask questions concerning the interview and the study.
Demographic Survey Information will be gathered.

- Tell me what it is like working as a nurse manager in NICU / paediatric wards?
- Can you tell me if your subordinates (frontline nurses) face upsetting situations or experience ethical challenges?

Probe: It could be something related to the care of babies or children, or conflict related to nursing practice.

- Tell me how the issue is brought to your attention?
- How do you feel when you hear or witness such situations as a nurse manager?
- Have you heard of the term moral distress?

No: (M.D is when professionals cannot carry out a judgment, they believe to be morally appropriate because of constraints or barriers which makes them feel frustrated, angered, and hopeless).

- If yes, tell me what you understand by the term 'moral distress'?

Probe: As defined, would you say that your nurses experience moral distress in their current roles in NICU and paediatric wards?

- Are you usually informed by nurses on your ward concerning their encounter of moral distress? If yes tell me how?
- Can you tell me how it made them feel, and how it impacted them?

Probe: emotions, physical response, work out put etc.

- Can you tell me how it impacts on patient care?

Probe: quality care etc.

- How did you assist the nurses navigate through the situation?

Probe: give specific examples

- Can you describe the assistance you rendered as a nurse manager to help nurses to navigate this situation?

- Describe any assistance, resources or actions of others that could have helped or hindered the situation.
- Reflecting on the situation and your position in the ward, do you feel that those in managerial roles like you are well equipped to manage nurses in morally distressing situation? Please explain.
- Can you tell me the effect, if any, you think moral distress has on patient care, nurses and the organization in this situation?
- How would you describe the structures, policies, and practices of the hospital organization in fostering respect and support for nurses as they navigate through the complexities of ethical clinical issues?
- Have you ever felt as if your role as a nurse manager constrains you from helping nurses carry out their professional values? Please describe.
- In your role as a nurse manager, has your voice about situations triggering moral distress been heard?
- Can you tell me what organizational resources are in place to assist nurse managers in helping nurses deal with moral distress?

Probe: Are they effective, applicable, and useful?

- Tell me what approaches/resources you utilize and recommend mitigating the impact of moral distress among nurses?
- What approaches/resources will be useful for helping the organization and policy makers support nurse managers in supporting nurse cope with moral distress?

Is there anything else you would like to tell me about assistance to your nurses or anything I have not asked?

Debrief

Thank you very much for participating in this interview

Appendix H: Attributes of Nurse Participants

Attributes of Nurse Participants	Age	Current work place	Current work place exp	Ethiic origin	Gender	Highest level of education	Hours of work	Rank	Religious orientation	Working experience as a nurse
Cases\\Site 4. Paed. 40	29 -39	Paed. ward	1 - 5 years	Ewe	Female	Diploma	7 hours	Senior Staff nurse	Christian	1 - 5 years
Cases\\Site 4. Paed. 38	29 -39	Paed. ward	6 - 10 years	Ashanti-Akan	Female	Diploma	7 hours	Staff nurse	Christian	6 - 10 years
Cases\\Site 4. Paed. 39	18 -28	Paed. ward	1 - 5 years	Other - Kusasi	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	1 - 5 years
Cases\\Site 2. Paed. 30	29 -39	Paed. ward	Less than a year	Mole-Dagbon	Female	Diploma	7 hours	Senior Staff nurse	Muslim	1 - 5 years
Cases\\Site 2. NICU. 12	29 -39	NICU	1 - 5 years	Other- Dagare	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	6 - 10 years
Cases\\Site 2. NICU. 13	18 -28	NICU	Less than a year	Mole-Dagbon	Female	BSc. Nursing	7 hours	Nursing Officer	Muslim	1 - 5 years
Cases\\Site 2. NICU. 14	29 -39	NICU	Less than a year	Other- Dagare	Female	Diploma	7 hours	Senior Staff Midwife	Christian	6 - 10 years
Cases\\Site 2. NICU. 15	29 -39	NICU	1 - 5 years	Ashanti-Akan	Female	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 2. NICU. 16	29 -39	NICU	1 - 5 years	Ashanti-Akan	Female	Diploma	7 hours	Senior Staff Midwife	Christian	More than 10 years
Cases\\Site 2. PAED. 31	29 -39	Paed. ward	Less than a year	Mole-Dagbon	Female	Diploma	7 hours	Staff nurse	Muslim	1 - 5 years
Cases\\Site 2. PAED. 28	29 -39	Paed. ward	1 - 5 years	Ewe	Female	Diploma	7 hours	Senior Staff nurse	Christian	6 - 10 years
Cases\\Site 2. PAED. 29	18 -28	Paed. ward	1 - 5 years	Mole-Dagbon	Female	Diploma	7 hours	Staff nurse	Muslim	1 - 5 years
Cases\\Site 1. NICU. 1	29 -39	NICU	1 - 5 years	Mole-Dagbon	Female	Diploma	7 hours	Staff nurse	Muslim	1 - 5 years
Cases\\Site 1. NICU. 10	18 -28	NICU	1 - 5 years	Frafra	Female	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. NICU. 11	29 -39	NICU	6 - 10 years	Other- Waala	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	6 - 10 years
Cases\\Site 1. NICU . 2	29 -39	NICU	1 - 5 years	Ewe	Male	Diploma	7 hours	Senior Nursing Offic	Christian	6 - 10 years
Cases\\Site 1. NICU. 4	18 -28	NICU	1 - 5 years	Grusi	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	1 - 5 years
Cases\\Site 1. NICU. 3	18 -28	NICU	1 - 5 years	Other- Dagare	Male	BSc. Nursing	7 hours	Nursing Officer	Christian	1 - 5 years
Cases\\Site 1. NICU. 5	29 -39	NICU	6 - 10 years	Other-Hausa	Female	Diploma	7 hours	Senior Staff nurse	Muslim	6 - 10 years
Cases\\Site 1. NICU. 6	29 -39	NICU	1 - 5 years	Guang	Male	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. NICU. 7	18 -28	NICU	1 - 5 years	Ashanti-Akan	Male	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. NICU. 8	29 -39	NICU	1 - 5 years	Mole-Dagbon	Male	BSc. Nursing	7 hours	Nursing Officer	Muslim	6 - 10 years
Cases\\Site 1. NICU. 9	18 -28	NICU	1 - 5 years	Other - Kusasi	Male	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. PAED. 16	29 -39	Paed. ward	6 - 10 years	Ashanti-Akan	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	6 - 10 years
Cases\\Site 1. PAED. 26	29 -39	Paed. ward	1 - 5 years	Ewe	Male	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. PAED. 25	29 -39	Paed. ward	1 - 5 years	Mole-Dagbon	Female	Diploma	7 hours	Senior Staff nurse	Muslim	1 - 5 years
Cases\\Site 1. PAED. 27	29 -39	Paed. ward	1 - 5 years	Ashanti-Akan	Female	BSc. Nursing	7 hours	Nursing Officer	Christian	6 - 10 years
Cases\\Site 1. PAED. 17	29 -39	Paed. ward	1 - 5 years	Buili	Female	Masters	7 hours	Senior Nursing Offic	Christian	6 - 10 years
Cases\\Site 1. PAED. 18	29 -39	Paed. ward	More than 10 years	Mole-Dagbon	Male	Diploma	7 hours	Senior Nursing Offic	Muslim	More than 10 years
Cases\\Site 1. PAED. 19	29 -39	Paed. ward	1 - 5 years	Mamprusi	Male	BSc. Nursing	7 hours	Nursing Officer	Christian	6 - 10 years
Cases\\Site 1. PAED. 20	29 -39	Paed. ward	1 - 5 years	Ga-Dangme	Male	Diploma	7 hours	Staff nurse	Christian	1 - 5 years
Cases\\Site 1. PAED. 21	29 -39	Paed. ward	1 - 5 years	Wala	Female	BSc. Nursing	7 hours	Nursing Officer	Muslim	1 - 5 years
Cases\\Site 1. PAED. 22	29 -39	Paed. ward	6 - 10 years	Grusi	Female	Diploma	7 hours	Senior Nursing Offic	Christian	6 - 10 years
Cases\\Site 1. PAED. 23	29 -39	Paed. ward	6 - 10 years	Bumla	Male	BSc. Nursing	7 hours	Senior Nursing Offic	Christian	6 - 10 years
Cases\\Site 1. PAED. 24	29 -39	Paed. ward	1 - 5 years	Ashanti-Akan	Female	BSc. Nursing	7 hours	Senior Staff nurse	Christian	1 - 5 years
Cases\\Site 3. PAED. 32	29 -39	Paed. ward	1 - 5 years	Kasina- Nankani	Male	Diploma	7 hours	Senior Staff nurse	Christian	1 - 5 years
Cases\\Site 3. PAED. 34	29 -39	Paed. ward	1 - 5 years	Ashanti-Akan	Male	BSc. Nursing	7 hours	Nursing Officer	Christian	1 - 5 years
Cases\\Site 3. PAED. 33	18 -28	Paed. ward	1 - 5 years	Mole-Dagbon	Female	BSc. Nursing	7 hours	Senior Staff nurse	Muslim	1 - 5 years
Cases\\Site 3. PAED. 36	29 -39	Paed. ward	1 - 5 years	Dagaara	Male	Diploma	7 hours	Senior Staff nurse	Christian	1 - 5 years
Cases\\Site 3. .PAED.34	29 -39	Paed. ward	1 - 5 years	Grusi	Female	BSc. Nursing	7 hours	Senior Staff nurse	Christian	1 - 5 years

Appendix I: Attributes of Nurse Managers

NM Paricipant Attributes	Age	Current work place	Ethnic origin and backg	Experience as a nurse	Experience in current work	Gender	Highest level of ed	Hours of work	How many employees do you ov	Managerial roles	Number of years as a NM	Rank or grade	Religious Orientation
Cases\\Site 4. NURSE MANAGER. Paed.	29 -39 years	Paed. ward	Mole-Dagbon	6 - 10 years	1 -5 years	Male	BSc. Nursing	8 hours	Less than 10 nurses	Provide needed support to nurses	1 -5 years	Nursing Officer	Muslim
Cases\\Site 4. NURSE MANAGER. Paed	29 -39 years	Paed. ward	Gurusi	6 - 10 years	1 -5 years	Male	Diploma	8 hours	11 - 20nurses	Provide needed support to nurses	1 -5 years	Senior staff nurse	Christian
Cases\\Site 2. NURSE MANAGER. NICU	29 -39 years	NICU	Gurusi	6 - 10 years	1 -5 years	Female	BSc. Nursing	8 hours	21- 30 nurses	Ensures professional growth	1 -5 years	Senior staff nurse	Christian
Cases\\Site 2. NURSE MANAGER. Paed.	29 -39 years	Paed. ward	Mole-Dagbon	1 5 years	Less than a year	Male	BSc. Nursing	8 hourshours	21 - 30 nurses	Coordination	1 -5 years	Nursing Officer	Muslim
Cases\\Site 2. NURSE MANAGER. Paed.	51 - 60 years	Paed. ward	Mole-Dagbon	more than 10 years	1 -5 years	Female	BSc. Nursing	8 hours	21 - 30 nurses	Coordination	6 - 10 years	Principal Nursing Officer	Muslim
Cases\\Site 2. NURSE MANAGER. NIC	29 -39 years	NICU	Dagaati	more than 10 years	6 - 10 years	Female	Masters	8 hourshours	21 - 30 nurses	Coordination	6 - 10 years	Senior nursing officer	Christian
Cases\\Site 1. NURSE MANAGER. Paed	40 - 50 years	NICU	Mole-Dagbon	more than 10 years	6 - 10 years	Female	BSc. Nursing	8 hourshours	41 - 50 nurses	Coordination	1 -5 years	Principal Nursing Officer	Muslim
Cases\\Site 1. NURSE MANAGER. Paed	40 - 50 years	Paed. ward	Ewe	more than 10 years	6 - 10 years	Female	Masters	8 hours	21 - 30 nurses	Dissemmination of hospital policies	1 -5 years	Principal Nursing Officer	Christian
Cases\\Site 1. NURSE MANAGER. Paed	29 -39 years	Paed. ward	Dagaati	6 - 10 years	6 - 10 years	Female	BSc. Nursing	8 hours	31 - 40 nurses	Provide needed support to nurses	1 -5 years	Senior nursing officer	Christian
Cases\\Site 1. NURSE MANAGER. NICU	29 -39 years	Paed. ward	Ashanti-Akan	1 5 years	1 -5 years	Female	BSc. Nursing	8 hours	41-50 nurses	Coordination	Less than a year	Nursing Officer	Christian
Cases\\Site 1. NURSE MANAGER. NICU	29 -39 years	Paed. ward	Builsa	6 - 10 years	1 -5 years	Male	BSc. Nursing	8 hours	31 - 40 nurses	Coordination	1 -5 years	Senior nursing officer	Christian
Cases\\Site 1.NURSE MANAGER. NICU	40 - 50 years	NICU	Mole-Dagbon	more than 10 years	1 -5 years	Female	BSc. Nursing	8 hourshours	41 - 50 nurses	Coordination	1 -5 years	Senior nursing officer	Muslim
Cases\\Site 3. NURSE MANAGER. Paed.	29 -39 years	Paed. ward	Mole-Dagbon	6 - 10 years	6 - 10 years	Male	BSc. Nursing	8 hourshours	41 - 50 nurses	Provide needed support to nurses	1 -5 years	Senior nursing officer	Muslim
Cases\\Site 3.NURSE MANAGER. Paed.	40 - 50 years	Paed. ward	Mole-Dagbon	more than 10 years	1 -5 years	Female	Masters	8 hours	41 - 50 nurses	Coordination	1 -5 years	Principal Nursing Officer	Muslim

Appendix J

Summary of Findings of Nurse Participants from site 1, 2, 3 and 4.

Forty nurses working in NICU and paediatric wards in site 1, 2, 3 and 4 participated in the study in Ghana. All participants experience distressing situations working in NICU and paediatric wards. Thirty-two nurses had not heard of the term moral distress. Meaning only 8 nurses had heard of the term moral distress. However, after I explained and followed up with examples all 40 nurses identified with experience of moral distress. Those familiar with md had heard of in articles they read. The type of cases seen and managed on the ward are respiratory distress, birth asphyxias, malnutrition, meningitis, severe malaria and encephalitis, retino blastoma, leukaemia cases and Burkitt's lymphoma.

All participants recounted experiencing upsetting situations working on the wards because of demands of patient's family members, poverty among caregivers, many could not afford imaging, neurosurgeries and laboratory request, these delays patient care and prolong recovery, most essential drugs are not captured under the health insurance scheme, even if they are captured, they are most often not available. These situation makes it difficult for nurses to make certain decisions and act on patient care. Their responsibilities are limited due to some of the upsetting situations they encounter.

There are many instances where nurses and doctors have to contribute money to arrange for transport, buy medicines and ensure laboratory requested are done. Many caregivers from the North are from rural and poor areas of the country, many of them are farmers and cannot afford drugs, laboratory requests, imaging, fluids and gloves, and strips, this makes it distressing for the nurses to work. Although they involve the social workers but not much is done for the patients. It's such a worrying situation that sometimes they can't help but watch patients die slowly.

Experience of moral distress: descriptors of moral distress by all participants makes the nurses feels sad, break down and weeps, feels hurt, feel helpless, feels for the patient because of emotional attachment with pts, feels very depressed, feels frustrated about the situation, feels demoralized immediately after experiencing the distress, depressed especially when a patient dies as a result of some constrains, feels very helpless, the feeling of powerlessness, feels angry.

All participants experienced moral distress quite often on the ward. All participants believe that their colleague nurses also experience moral distress. They discuss issues during handing over and at work.

The perceived causes of moral distress

Disagreements with medical officers concerning patient care, medical officers' delays in seeing the patients

Family members cultural beliefs and practice contributes to moral distress.

Lack of cooperation of caregivers - many caregivers are ignorant, and illiterate, have difficulty understanding the medical team

Poverty among caregivers, many cannot afford imaging, neurosurgeries and laboratory request, most essential drugs are not captured under the health insurance and not available at the hospital

Systematic issues of the hospital - inefficiencies of the hospital management

Language barrier (difficulty communicating with patient relatives)

No resting place for mothers whose babies is on admission (physical structure) so caregivers are always hanging around the ward and interrupting the care of the patients.

Lack of logistics – leads improvise of care to the patients- lack of instruments

Inadequate staff leads to increased workload

Frequent electricity outage

No protocols on patient care on the wards to facilitate care

Impact on nurses
All participants shared the impact the experience had on them.
Psychological effects
Blame self, lack of interest in the nursing work, comes to work late because these distressing, lose confidence, absenteeism, it affects family life of the nurse, feels like abandoning nursing, nurse displace their frustration on care givers. The nurse stops advocating for their pts after futile advocacies. Although the nurse still tries to do the best for the pt.
Physical effects
Goes home and cannot eat, loses appetite

Only a handful of participants stated that they will leave the ward because of moral distress. when an opportunity arrives.

More than half of the nurses will not leave the ward despite experiencing moral distress because of gratification, loves working at NICU and paediatric wards. Others believe the distress is everywhere in the hospital, therefore they will stay and continue to advocate for their patients.

Participants only neglect pts because of lack of logistics to work with.

Effects on patient care
Delay of care rendered to patients, it affects patient care, and a nurse can make a mistake when experiencing these distressing situations, make the nurse displace his/her anger on the pts.
Quality of care is not rendered appropriately to the patients.
Patients and relatives feel bad about the situation, worried and angry
Negative perception of nurses

Half of the nurses claimed they were used to the situation of lack of logistics to work with, because of constant lack of logistics on the ward. They also believe it is part of the nursing profession because nurses have to work with ill patients and caregivers, so there are bound to be difficulties. Nurses have become numb, because of the usual experience of morally distressing situations. With time the nurse realizes that the situation is normal.
Only a few participants knew 1 or 2 nurses who left NICU and paediatric ward as a result of the experience of moral distress
Coping with moral distress
Though it is difficult to cope with these situations. All participants had their own measures of coping with the distress. Participants hangs around family and friends when off duty to help cope.
Plays music, plays table tennis, watches movies
Some nurses walk away immediate after the experience to a different cubicle just to cool off
Others call other staff to help with the situation if need be
Others believe in the faith of God to help with coping with the distress
Console's self
Reflects and think of their maker (God)
Prays to God to forget the ethically challenging problems
Sit down for a while, calm self, tell self it will pass, it's just a passing moment.
Also uses the services of a counsellor (a Rev. Priest) when it affects the nurse psychologically.
Tries to forget about everything at work, goes off duty to cool off a bit
One participant stated that he does not really keep distress at heart for too long, because she needs to move on and try and help pts, griefs a bit and lets it go until she comes across the situation again.

Tries to brainstorm to solve the challenges

Some participants report issues of moral distress to the nurse managers- but the impact is not felt because not all nurses report the challenges.
Many participants do not feel exposed or vulnerable when they complain about morally distressing situations to the nurse managers. Speaks their mind freely because achieving results is what is needed for better care of the patients.
The voice of the nurse managers is not heard most of the time concerning issues of moral distress. Nurse managers tries their best though, gives feedback and keeps nurses informed about what is done to solved challenges.
Support from nurse managers
Nurse managers supports nurses to solve challenges on the wards. The give information about issues that are being solved.
Few nurses sometimes feel vulnerable when complaining to the nurse managers concerning morally distressing problems. Sometimes not sure if it is safe and advisable to inform the in-charge of the problem. Does not go to the in-charge to complain about care issues because the nurse believes others are favoured more than this nurse and believes that the issues will not be dealt with if the nurse complains.
There are no formal structures that helps to resolve issues
No known policies that go contrary to the nursing professionals' values
Religious influence
The Muslim religion teaches that whether good or bad one should embrace it, so with this orientation they expectations of patient recovery is 50/50. When things happen, the way they do (either bad or good) it's the will of Allah. Participants feels God heals so whatever happens if they try their best to care for the patient and its challenging is God's will.
All participants are able to perceive ethical situations in the care of pts concerning moral distress.
What participant has learnt from morally distressing situation is to ensure teamwork in the process of patient care.
Knowing what to do yet can't do it for your patient is very distressing to participants.
Recommendations
In-service training for nurses on ethical issues
Items and logistics should be available on the ward.
Nurses should be given the plate form to tailor their grievances and issues that affect the care they render to pts. There should be frequent meeting where the staff meets as a department to deliberate on issues.
The nurse recommends that nurses should do more to educate caregivers to understand some of the challenging the nurses experience regarding patient care. Also, education is needed for the caregivers to understand the conditions of their children and cooperate with the nurses.

Appendix K: Terms used to describe the psychological effects of moral distress by participants.

Terms used to describe the psychological effects of moral distress by participants.

Psychological effects on participants	Participants
'Dampens your spirit'	Site 1. NICU N. 4
'Feel upset'	Site 1. NICU N.10
'Distressed'	Site 3. Paed. N. 34
'Very anxious'	Site 1. NICU N. 3
'It keeps haunting us a lot'	Site 1. NICU N. 4
'Not stable'	Site 1. NICU N. 7
'Lot of frustrations'	Site 3. Paed. N. 36
'Affected me negatively'	Site 1. Paed. N. 23
'don't feel comfortable'	Site 2. Paed. N. 30
'I don't feel fine'	Site 2. NICU N. 31
'confused'	Site 1. NICU N. 5
'It makes me feel as if I'm 'dumb or something'	Site 2. NICU N. 15, 28
'Not comfortable'	Site 2. Paed. N. 30
'Very hurtful'	Site 2. NICU N. 15, 28
'So moody'	Site 2. Paed. N. 31
'You become so sad'	Site 2. NICU N. 14
'it's painful enough'	Site 2. NICU N. 15
'Emotionally I don't feel ok about it'	Site 1. NICU N. 6
'One time I went home, and I was crying'	Site 2. NICU N. 16

Appendix L: Summaries of findings from nurse managers in site 1, 2, 3 and 4 hospitals.

Fourteen nurse managers working in NICU and paediatric wards of sites 1, 2, 3 and 4 were recruited to participate in this study. Participants had worked as nurse managers between less than a year to more than 10 years. All participants recounted their experience of being a nurse manager; it is challenging because they supervise nurses on the nursing care they render to patients, make sure nurses are available to discharge their duties and also that they are doing so diligently and effectively. So, they carry out a 24-hour monitoring which is done shift by shift. In this process, they collaborate with the multidisciplinary staff that are in the wards ranging from prescribers, doctors, nutritionist in other to deliver quality care that for their clients.

8 participants not familiar with the term moral distress
6 participants have heard of the term moral distress
After I explained with examples, they identified with moral distress
Experience of moral distress.
Feels bad, it's frustrating because you want to do and you can't do or you want to help and you can't help or you are handicapped in a way so it's frustrating, feels unhappy, feels sad and demoralised, distressing situation, personally witnessed them weep and weep.

Nurse managers experiences moral distress quite often, they sometimes witness because apart from the supervision they also do work on the ward. They also complain to then nurse. Nurse managers have realised that lack of items does not increase their productivity because it hinders their work, they are constrained on how much care they can give to patients. It reduces output because if a nurse is supposed to give medication and there are no syringes available at that time it will be difficult to administer the drug at that time. And because they normally give the treatment with time, if that time is up and there is no syringe to give that particular medication.
The subordinate nurses also experience moral distress.
They do face a lot of ethical challenges because of the nature of the work in NICU. We deal with caregivers, because of the family centred approach in NICU and paediatric wards, people who are culturally inclined especially where we are located (Northern Ghana). So sometimes they will meet parents or even family members who will let them deviate from the nursing ethics.
Causes of moral distress.
Inefficiencies of hospital management
Cultural and religious beliefs of caregivers interfering with nursing care
Lack of logistics: oxygen, nebulizer, syringe, glucometer, strips, sucking machine, thermometers, blood pressure apparatus
Caregivers do not have money to buy medicines
In adequate staff- increased workload - By the end of the month we can get 65 to 70 babies in a month. 65 to 70 babies in that small place, site 2 NICU
Believes that majority of the nurses do not have passion for nursing care.
Lack of cooperation of caregivers and language barrier.
Basic medicines and laboratory examinations not covered by the NHIS
Impact on nurses
Feels bad, it's frustrating because they want to do it and yet they can't, feels unhappy, feels sad and demoralised. They become discouraged, it normally brings their spirit down, they don't always feel comfortable, some will even just say they don't feel like coming to work, emotional torture, they all feel bad about the situation, reduced care output, some throw their hands in the

air, some will bring suggestions, some will withdraw and sit down. Most nurses now are having apathy because after when they come to work the items for working is not available.
Some nurse managers believed that the more the nurses experience this distress it becomes a routine for the nurses which compromise the quality of care that they render to patients.
Impact on patients
Increases child mortality, which is not good, however they try their best to prevent and have full recovery of their patients. They are supposed to provide quality care to patients but if basic logistics are not available (glucose strips, oxygen, gloves, cotton wool) it amounts to poor service. Because the logistics are supposed to be in place in other to help the child recover and, in a way, providing quality service. It affects the patient as well and delays the recovery of the patient. It's not a healthy thing to have inadequate or shortage of logistics because at the end it is the patient who is going to suffer, meanwhile nurses are supposed to help patients recover.
Support to nurses
Subordinate nurses are counselled and share their experiences of morally distressing situations. Continuously talks to the nurses, encourages the nurses. Understanding a problem as they say is part of its solution. Reassure them; tell them that management is working on it, they are working with the management and so they should exercise patience and let's see if management will help. Sometimes diversional tactics is used, try to crack jokes and then play around with them to release these things. Tells them they can manage it, e.g. I will just be praising them, you do your best, God is watching you, whatever you are doing God is in control so you do your best and see what management will do. Nurse managers encourage nurses who experience distress. Colleagues support the nurses to cope with the situation Encourage them to use other alternatives, e.g., write medications for caregivers to go and buy.
Meetings are held on the wards during the meetings they remind themselves of their duties towards each other and duties towards the clients. Whenever there is a complaint of any ethical issue it worries them a lot.
Nurses bring their suggestions of how we should handle some morally distressing issues.

Encourage nurses and medical officers to contribute to buy medicines for needy patients
Roles of the nurse manager
NM are the first to contacted when the nurses have challenges regarding patient care. If it is beyond NM, then they will move to the next level of authority.
They voice are not often heard regarding issues causing distress among the nurses. The Deputy Director for Nursing Services is their contact point, and they pass their grievance through the matron.
They also try to make items are available at to nurses to work with in the ward. As nurse managers they do work on the ward as frontline nurses when they are short of staff
As a nurse manager it's my role to ensure that there is adequate logistics available as I said earlier to help the work to go on in the ward. And I also make sure that every morning I check through the items that are available and the ones that are not available. And I write out the ones that are not available in the requisition book so that they can go and get them from the supply officer. And I also make sure the staff on duty are all on the ward, like those supposed to be on a particular shift are in at work so that they can also help the work go fine in the ward.
Nurse managers acknowledged there have been times when they do not have a particular item to work with, in such cases they forward it to the higher management to investigate it. They try and request for them so that if they can get them to the wards for use. Feels helpless they complain to management, but nothing is done about the issues they face on the wards.
All nurse managers believed that their roles help nurses carry out and realise their professional values.

All nurse managers feel they are not sufficiently equipped to manage and address morally distressing situations. Reflecting on the situation and your position in the ward, do you feel that those in managerial roles like you are well equipped to manage nurses in morally distressing situations.

No support on address of ethical challenges on the ward
Need to further equip themselves on how to address and solve ethically challenging issues at work. There is no formal structure that helps to address morally distressing issues.
1 nurse manager complained that nobody even sees him as the in-charge of the ward. Only the substantive nurse manager attends meetings and few workshops
There are no known policies that supports them to assist nurse navigate through moral distress.
A nurse managers wrote a letter to Human Resources, to Chief Executive Officer, he followed up a couple of times nothing was done (site 1)
Their voices are not heard
Recommendations
The needed logistics should be made available for the nurse at the ward level.
Nurse need specific training directed to equip nurse managers to address such morally disturbing situations, and help nurses cope with the situation, they don't have such capacity. They only rely on their nursing experience. They try to offer the best support they can for their nurses.
They need job descriptions when made a nurse manager.
A committee in the facility that will basically be assisting nurses in the form of counselling or just a resource person in the facility that will help nurses when they have some of these issues.
The organisation itself needs some sort of education or some sort of awareness creation with regards to the importance of density of combating moral distress the awareness needs to be created and the necessity of combating it should be emphasized to them so that even though they are already doing something with regards to that it should give them the clue that extra attention extra efforts should be looking at that aspect owing to the negative impact that it has on the output of the nurses.
Update us on the code of ethics and then provide the necessary resources for them to give to my staff to work with.
Creating our own support group for instance between ranks, if there are Senior Nursing Officers, should have a support group that things like that they meet to discuss on how to go about it.
There should be in-service training and workshop for those things. Training on ethical issues.
Creation of protocols and put in place to help nurses overcome such distressing situations.
Regular training of staff will also help, regular training and clinical presentations in the wards will also help update themselves. Because most at times things are changing there is the need to also update themselves whiles things are changing
Motivational activities like workshops and all that it can boost their morale, so it can also help.

Appendix M: Application for Ethical Review ERN_18-0934

Susan Cottam (Research Support Group)

Fri 02/11/2018 13:58
To:
Alistair Hewison (Nursing);
Roger Newham (Nursing)
Cc:
Susan Neilson (Nursing);
Vivian Afoko (PhD Nursing FT (B700))
Inbox
Dear Dr Hewison and Dr Newham

Re: "How is moral distress perceived and experienced in Northern Ghana? A study of neonatal intensive care and paediatric nurses"
Application for Ethical Review ERN_18-0934

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available athttps://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards

Susan Cottam
Research Ethics Officer
Research Support Group
C Block Dome
Aston Webb Building

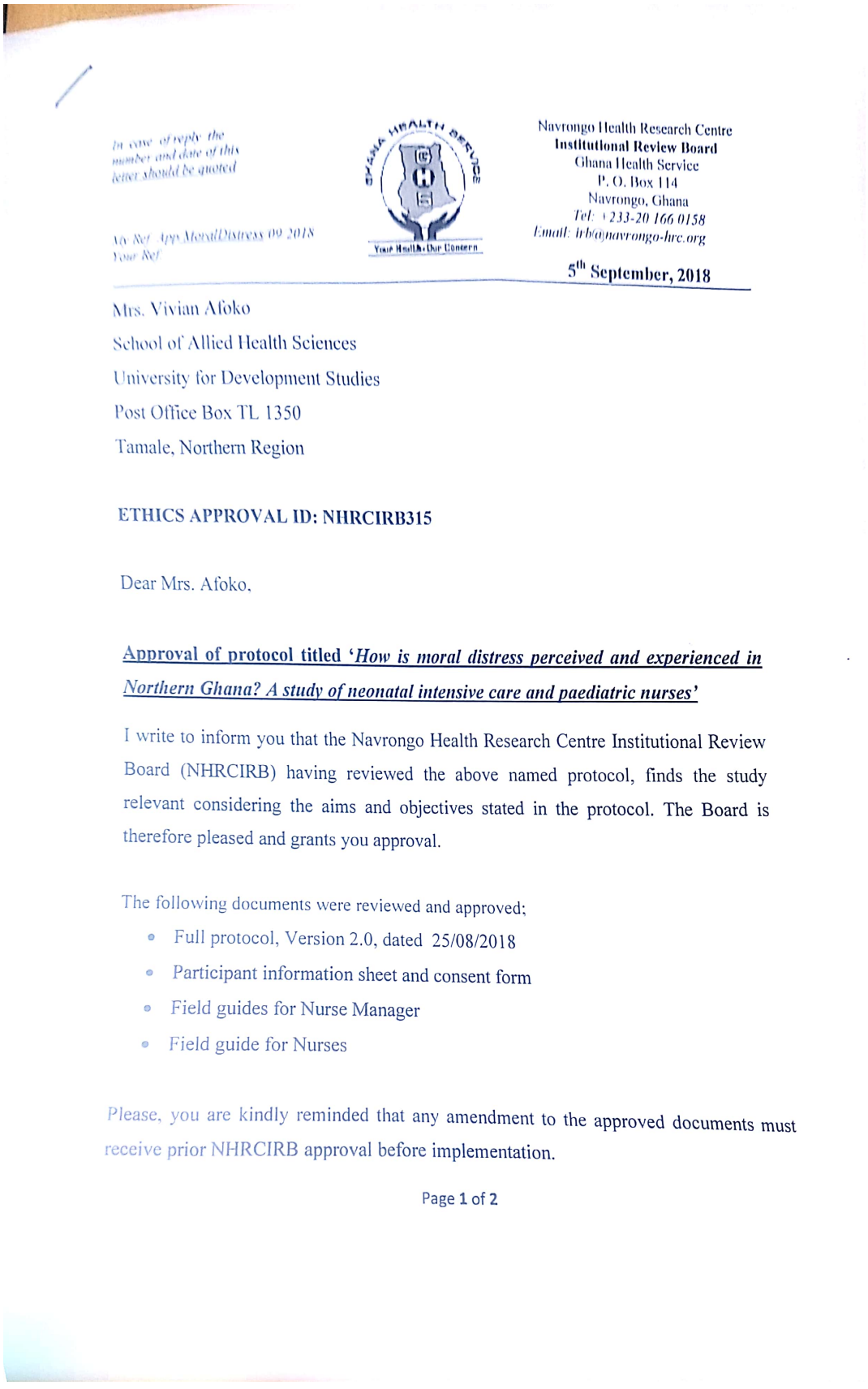
University of Birmingham
Edgbaston B15 2TT
Tel:
Email:
Web: https://intranet.birmingham.ac.uk/finance/RSS/Research-Support-Group/Research-Ethics/index.aspx

Please remember to submit a new Self-Assessment Form for each new project.

You can also email our team mailbox ethics-queries@contacts.bham.ac.uk with any queries relating to the University's ethics process.

Click Research Governance for further details regarding the University's Research Governance and Clinical Trials Insurance processes, or email researchgovernance@contacts.bham.ac.uk with any queries relating to research governance.

Appendix N: Ethics approval from Navrongo Health Research Centre Institutional Review Board



In case of reply the number and date of this letter should be quoted

My Ref: Apps/MoralDistress/09/2018
Your Ref:

Navrongo Health Research Centre
Institutional Review Board
Ghana Health Service
P. O. Box 114
Navrongo, Ghana
Tel: +233-20 166 0158
Email: irb@navrongo-hrc.org

5th September, 2018

Mrs. Vivian Afoko
School of Allied Health Sciences
University for Development Studies
Post Office Box TL 1350
Tamale, Northern Region

ETHICS APPROVAL ID: NHRCIRB315

Dear Mrs. Afoko,

Approval of protocol titled '*How is moral distress perceived and experienced in Northern Ghana? A study of neonatal intensive care and paediatric nurses*'

I write to inform you that the Navrongo Health Research Centre Institutional Review Board (NHRCIRB) having reviewed the above named protocol, finds the study relevant considering the aims and objectives stated in the protocol. The Board is therefore pleased and grants you approval.

The following documents were reviewed and approved;

- Full protocol, Version 2.0, dated 25/08/2018
- Participant information sheet and consent form
- Field guides for Nurse Manager
- Field guide for Nurses

Please, you are kindly reminded that any amendment to the approved documents must receive prior NHRCIRB approval before implementation.

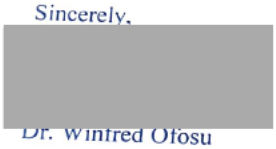
Page 1 of 2

The Board would expect a report on your study, annually or at the close of same, whichever comes first. Should you require a renewal of your approval, a progress report should be submitted two (2) months before the expiration date.

This approval expires on the **4th September, 2019.**

The Board wishes you all the best in the study.

Sincerely,



Dr. Winfred Ofosu
(Board Chair, NHRCIRB)

Cc: The Director
NHRC, Navrongo

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