MONASH University

Moral Habitability in Nursing: An Interpretive Description

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ABSTRACT

In response to the wider implications of workplace adversity, there is a large body of nursing ethics research that focuses on the associations between adverse workplaces and the moral complexities of the everyday practice of nurses. While research has identified that the adversity nurses experience in their workplaces makes some environments morally *uninhabitable*, to date there have been no studies that directly explore or describe *moral habitability* in nursing.

The aim of this study was to provide an interpretive description of moral habitability in nursing, both conceptually and in practice. Using the methodology of interpretive description, a two-phase study was designed to accommodate this under-researched and under-developed concept. Phase One was conducted through a conceptual exploration of the nursing ethics literature related to the nursing workplace and the social roles and practices of nurses. Conceptual mapping and integrative literature review strategies were implemented to achieve the intent of this Phase.

The Phase One findings identified three focal areas of interest and eight concepts relevant to gaining an understanding of moral habitability in nursing: qualities *internal* to the nurse (the concepts of moral agency, moral identity, moral integrity and moral sensitivity); *context*, where the action takes place (the concepts of moral climate and moral community); and the *outcomes* of this action (the concepts of moral satisfaction and moral distress). This conceptual framework was used to direct the Phase Two field component of this study.

In Phase Two, the experience of moral habitability in nursing was explored through a particularly vulnerable subset of the nursing workforce, new graduate nurses (n=44). Data

collection took place over 12 months through focus groups (4), interviews (14), non-participant observation (12 episodes), and second interviews (8). Eight participants were involved in the data collection across the entire 12 months of their new graduate nurse programs. Using thematic analysis, five themes were identified: being a nurse, working relationships, insider/outsider, toughening up, and the influence of the working context.

Analytical synthesis of the findings of both phases of the research answered the overall aim of the study. From the interpretive description, moral habitability in nursing was found to be a dynamic interplay between the individual qualities of the nurse and the environment where practice takes place. Inter-relationships with patients and nursing staff, and the context of practice are pivotal. The concept of moral distress was found to fluctuate in the experiences of the new graduate nurses' moral habitability.

As implications from the findings, strategies to support moral habitability in the workplace are suggested. The associations between the theoretical concepts and experiences of the nurses provide a platform for research into the influence of the workplace on both new and more experienced nurses. Finally, the study's use of conceptual exploration synthesised with real world experience in a two-phase design, has implications for methodological approaches in other under-researched concepts of relevance to the nursing profession.

DECLARATION

I declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signature: 

Rebecca Anne Vanderheide

Date: 24 May 2017

THESIS INCLUDING PUBLISHED WORKS DECLARATION

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes one original paper published in a peer reviewed journal. The core theme of the thesis is moral habitability in nursing. The ideas, development and writing up of this paper in the thesis were the principal responsibility of myself, the student, working within the Faculty of Medicine, Nursing and Health Sciences, Monash University under the supervision of Susan Lee, Cheryle Moss and external supervisor Patricia Rodney.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapter 3, my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution	Co-author(s), Monash student Y/N
3	Understanding Moral Habitability: A Framework to Enhance Quality of the Clinical Environment as a Workplace	Published	80% Concept and collecting data and writing first draft	1) Cheryle Moss input into manuscript 10% 2) Susan Lee input into manuscript 10%	Yes

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature: [redacted] **Date:** 24 May 2017

The undersigned hereby certifies that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature: [redacted] **Date:** 24 May 2017

OTHER PUBLICATIONS DURING ENROLMENT

Musto, L.C., Rodney, P.A., Vanderheide, R. (2015). Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics*, *22*(1), 91-102, doi: 10.1177/0969733014534879

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Over the many years I was an intensive care nurse, I became increasingly interested in the moral component of nursing practice because to me, this aspect was often overlooked and undervalued. However, it is inseparable from every aspect of caring for our patients. Over time I realised that to fully realise morally-centred patient care, the profession needs to be particularly concerned about what can enhance the moral practice of the nurses providing this care. The experience of exploring moral habitability in nursing and the end result, this thesis, is part of my personal journey of supporting nurses in their quest to care for themselves and, most importantly, provide morally-based care for the patients under their watch.

Many people supported me through this work. This thesis would not have been possible without the following people, to whom I am deeply grateful:

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> *Your patience, encouragement, wisdom and (well-timed) firm words kept me on the right path, even during those periods when that path was hidden from me.*

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CHAPTER 1 INTRODUCTION

The nursing work environment can be difficult. Challenges within the contexts where nursing practice takes place include organisational constraints and interrelational issues, and can produce harmful outcomes for both nurses and patients (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken et al., 2014; Duffield et al., 2011). Enabling nurses to provide quality care for their patients and for the nurses themselves to remain healthy in the process, are important. This is true not only for the individuals involved, but for the healthcare system as a whole.

In response to the wider implications of the challenges nurses face in the workplace, there is a large body of nursing ethics research which focuses on the links between difficult work environments and the moral complexities related to the provision of care by nurses in everyday practice (Humphries & Woods, 2016; Rodney et al., 2002; Storch et al., 2009). An important concept related to this field of research is *moral habitability in nursing.*

Peter, Macfarlane, and O'Brien-Pallas (2004) were the first researchers to identify this concept in the nursing context. They achieved this through a secondary analysis of data drawn from focus groups related to the impact of work environments on nurses across Canada. The researchers identified that the adversity nurses experience in their workplaces makes some environments *morally uninhabitable*. The researchers offered an initial discussion of moral habitability, based on feminist theory, which particularly focused on the moral-social orders in the work environment.

What is evident from this discussion is that understanding the concept of moral habitability requires insight, both into factors associated with the environments where nurses practice

and into dimensions of the participants (i.e. nurses) within those environments. To date however, there have been no studies that have directly explored or described moral habitability in nursing. The absence of studies in this area is coupled with a paucity of methodological approaches in the nursing disciplinary literature aimed at enabling the exploration of under-researched concepts. However, based on research outcomes highlighting the difficulties that nurses experience in their workplaces and the impacts of that adversity, the study of moral habitability in nursing has the potential to offer highly significant value. This is because understanding what constitutes a morally habitable environment also requires the identification of the aspects of the workplace that enhance moral nursing practice.

This study is an interpretive description of moral habitability in nursing, both conceptually and in practice. It was designed to accommodate an under-researched concept and to have relevance to both nursing theory and practice. A subset of the nursing workforce, new graduate nurses, was used to generate practice data for the study. In this thesis the term 'new graduate nurse' refers to a registered nurse in their first year of practice post-completion of study (Malouf & West, 2011). Because they are new to the working environment, new graduate nurses are particularly vulnerable (Dwyer & Hunter Revell, 2016), and the moral aspects of this group's nursing practice are under-reported. Their experience of challenging and enhancing aspects of their practice within the workplace has implications for sustaining the future workforce.

This introductory chapter commences with some background to this research study. The impetus to the study is then outlined and the aim of the research is stated. A brief design overview is presented and this is expanded upon in Chapter Two. Finally, the significance of

the study is outlined and the chapter concludes with a synopsis of the thesis chapters to orient the reader to the design and implementation of the research overall.

Background

Nurses practice in increasingly complex, challenging and dynamic hospital environments. To respond to the needs of an increasingly acute patient population, an effective nursing workforce requires an elevated level of values-based decision-making skills. Within the nursing ethics literature there has been growing recognition that there is a moral dimension to most 'everyday' decision-making scenarios (Milliken & Grace, 2015; Storch, 2013). For example, an everyday decision such as prioritising the changing of an incontinent patient's soiled sheets in an environment where there are competing needs of multiple patients and constrained resources, has both moral and clinical features that are relevant to the nurse's decision-making and subsequent action. In this scenario, the moral aspect of maintaining the dignity of the incontinent patient is coupled with the clinical imperative of protecting skin integrity, while also balancing the priority of the moral and clinical needs of the other patients. Alternatively, decision-making of this nature in a less constrained workplace where, for example, there are sufficient resources, may have different outcomes. Being able to identify the moral component of everyday nursing decisions and acting on those moral responsibilities is increasingly referred to as moral agency in the nursing literature (Liaschenko & Peter, 2016; Peter & Liaschenko, 2004; Rodney & Varcoe, 2012).

Nurses' moral choices and the provision of values-based patient care through the enactment of moral agency occurs within the context of nurses' practices (Liaschenko & Peter, 2016). In light of the ageing demographic of hospital patients and the exponential increase in technological advancements and related expense, many Western countries have

initiated fiscal strategies to address mounting costs (Aiken et al., 2012). These changes have had significant impacts on nurses working in acute hospital environments, where reductions in staffing and increased workloads have caused workplace adversity for nurses (Weigl et al., 2016). These factors have been associated with challenges to nurses' moral agency (Rodney & Varcoe, 2012).

Outcomes of workplace adversity are considerable for nurses as well as for those whom they serve, with links to job dissatisfaction, attrition (Flinkman, Leino-Kilpi, & Salantera, 2010; Hayes, Douglas, & Bonner, 2015; Nantsupawat et al., 2017) and negative patient outcomes, such as falls and medication errors (Aiken et al., 2014; Duffield et al., 2011). Challenges to moral agency are also associated with the experience of moral distress for nurses (Rodney, 2017). Moral distress, as opposed to other forms of distress, occurs when nurses are unable to act according to what they perceive is the right action and can result in both physical and psychological consequences (Oh & Gastmans, 2015). Given that these consequences can be harmful to nurses, consideration of what may contribute to a workplace that is habitable rather than uninhabitable for nurses is required.

Setting the scene

The initial exploration of any facet of relevance to the nursing profession requires a comprehensive review of the pertinent literature (Polit & Beck, 2017). Given that moral habitability is an under-researched concept in nursing, exploration of a wide range of nursing literature that relates to the moral aspects of nursing practice was required. While the terms 'ethics' and 'moral' are etymologically different, some writers argue the terms are not philosophically different (Johnstone, 2016). Other writers support this stance, as these terms are used interchangeably in some aspects of the nursing literature, for example in

describing moral/ethical sensitivity (Grace, 2014). In the present thesis the terms are used synonymously.

Initial conceptualisation of moral habitability in nursing

Peter et al. (2004) produced the initial conceptualisation of moral habitability in nursing in a secondary analysis of data from a study related to Canadian nurses. The original study examined the impact of nurses' work environments on nurses (Baumann et al., 2001) and was not conducted with a focus on the moral aspects of practice. However, the authors found the data and implications of the data were often profoundly moral in nature (Peter et al., 2004). For example, the nurses' narratives expressed their experiences of challenges to their values, often on a daily basis, in not being able to advocate for their patients' needs due to organisational constraints (Peter et al., 2004). In light of their findings, the researchers conducted a secondary analysis drawing on the work of Margaret Urban Walker (1998), a feminist philosopher.

Walker (2003) positions moral epistemology in human social experiences and considers that morality subsists in practices of responsibility and accountability. These practices of responsibility involve commonly-shared agreements about which role is accountable for which task (Peter & Liaschenko, 2003). Therefore, from this position, morality is not a component somehow separate from other shared aspects of everyday life. In a healthcare environment where workplace adversity is experienced by nurses, this construct is important, since problems could be otherwise identified as practical rather than moral (Peter & Liaschenko, 2003). Peter et al. (2004) suggested that using this theoretical perspective highlights that the moral-social orders in the work environment are made clear

and examined for moral habitability. More specifically, in defining moral habitability Peter et al. (2004) stated:

> Morally habitable environments are those in which differently situated people experience their responsibilities as intelligible and coherent. They also foster recognition, cooperation and shared benefits (p. 358).

In their findings the authors of the secondary analysis detailed four key categories. The first category, *oppressive work environments*, highlighted a lack of power felt by the nurses in a practice context dominated by managerial and medical values. Many workplace adversity issues were experienced by nurses who were trying to manage a high level of patient care responsibilities. *Incoherent moral understandings*, the second category, emphasised the nurses' feelings of being overwhelmed due to an incongruence of responsibility and outcome expectations, in an environment with inadequate resources. The third category, *moral suffering*, described negative experiences such as feelings of emotional exhaustion and perceptions of a lack of respect by the organisation as an outcome of the values conflicts experienced. The final category, *moral influence and resistance*, detailed strategies used by nurses to maintain moral integrity within the context of workplace constraints. In light of their findings, the researchers concluded that the adversity nurses experience in their workplaces made some environments morally uninhabitable (Peter et al., 2004).

In the last two decades, analysis of the relational nature of the moral-social workplace has been reflected in the nursing literature through research and commentary promoting the need for moral communities. Moral communities in healthcare are those where mechanisms are instigated to enhance interaction between members of the community to influence better moral practice and avoid adversity (Austin, 2007; Hardingham, 2004;

Pavlish, Brown-Saltzman, Jakel, & Fine, 2014). Other aspects of a moral community include the call for strong moral leadership, accessible organisational resources such as ethics training and policy, and a willingness by practitioners to access these resources with an openness to discussing moral issues (Pavlish et al., 2014). Further commentary calls for the need for morally habitable environments as a response to difficult workplaces in which nurses experience moral distress (Beavis, 2013; Peter & Liaschenko, 2013).

While the theoretical influence of Walker can support the proposition of developing moral communities, it fails to fully capture the variety needed for research application in a nursing context. This is because, while focusing on the relationships between workers is imperative, for a wider grasp of moral habitability the emphasis also needs to be on the specific participant within the environment, their capacity to adapt and how the environment itself impacts the participant. Consideration of these factors influenced the theoretical and methodological choices for the design of this study. While acknowledging this work was one stimulus for this study into moral habitability in nursing, the influence of Walker was deemed too theoretically loaded and restrictive for the exploration of an under-researched concept relevant to nursing.

Challenges within the nursing workplace

There is an extensive body of literature focused on the challenges and adversity nurses experience in the workplace (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Leiter & Spence Laschinger, 2006; Van Bogaert, Kowalski, Weeks, & Clarke, 2013). Adversity for nurses can be experienced through organisational constraints, such as inadequate staffing levels where increased workloads create stress for nurses who feel unable to provide appropriate care (Van Bogaert et al., 2013). Research suggests that the consequences can include moral

distress with the result of nurses leaving the nursing workforce altogether (Dyo, Kalowes, & Devries, 2016; Woods, Rodgers, Towers, & La Grow, 2015). Research into this area also suggests that the outcomes of adversity in the workplace include increased staff turnover and attrition (Nei, Snyder, & Litwiller, 2015; Strachota, Normandin, O'brien, Clary, & Krukow, 2003), lack of job satisfaction (Khamisa, Peltzer, Ilic, & Oldenburg, 2016) and changes to worker wellbeing such as stress and burnout (Edward & Hercelinskyj, 2007; Khamisa et al., 2016). While challenges to nurses' wellbeing are an important area of concern, the nursing literature also reports that patient care can be eroded through workplace adversity, with higher morbidity and mortality reported as a consequence in studies undertaken in North America and Europe (Aiken et al., 2012) and in Australia (Duffield et al., 2011).

The nursing workplaces found to be morally uninhabitable by Peter et al. (2004) had many of the features of adversity experienced by nurses through organisational constraints. Because the consequences of adversity are significant, the impact of morally uninhabitable workplaces may also have consequences for nurses and patients.

Nursing work in all contexts is interdependent, particularly in acute hospital settings, with interactions among nurses, patients and other healthcare professions, all of which are a vital component of everyday practice. Interrelational aspects that challenge nurses within the workplace include conflicts with medical staff (Akel & Elazeem, 2015; Keenan, Cooke, & Hillis, 1998) and conflicts with and bullying by nursing colleagues (Ganz et al., 2015). In response to the identification of workplace aspects that challenge nurses' practice, there is an increasingly considerable body of nursing ethics research that focuses on the associations between the burden of tough workplace environments and the moral complexities of

everyday practice of nurses providing care (Rodney et al., 2002; Sauerland, Marotta, Peinemann, Berndt, & Robichaux, 2014; Storch et al., 2009).

The link to nursing workplace adversity appears relevant to the morally uninhabitable environments identified in the secondary analysis undertaken by Peter et al. (2004). However, a clearer understanding of what constitutes a morally habitable workplace may highlight the features of a nursing workplace that enhances rather than inhibits both nursing care and, the nurses' experiences within their workplaces.

Nursing workplace ethics literature

Traditionally, a bioethical approach that accentuates objectivity and impartiality has been the dominant ethical paradigm in healthcare (Johnstone, 2016). The lack of analysis of 'everyday' issues facing nurses through the dominance of a bioethical paradigm has prompted dissatisfaction in nursing researchers who are interested in the moral working life (Ulrich, 2016). This is evident in the last three decades, where there has been an increasing shift within the nursing ethics literature towards an ethical perspective that is more applied, addressing everyday moral issues and challenging the impact of organisational changes to nurses' workplaces (Peter et al., 2004; Rodney & Varcoe, 2012; Rodney et al., 2002; Ulrich et al., 2010). This field of research is significant, since it is consistent with the workplace adversity literature and includes findings which suggest that the impact of difficult environments can be detrimental for nurses' wellbeing. For example, as previously described, challenges to moral agency through workplace constraints can lead to an exacerbation of moral distress (Austin, 2012; Musto, Rodney, & Vanderheide, 2015; Pauly, Varcoe, Storch, & Newton, 2009; Rathert, May, & Chung, 2016).

Moral distress, initially identified by the work of Jameton (1984) was described as the negative psychological and physical outcomes that occur due to constraint of moral agency, often through organisational constraints. The concept of moral distress is attributed to many aspects of workplace adversity, such as workload issues and conflict with other staff (Musto et al., 2015) and remains of particular contemporary interest in the nursing ethics literature (McCarthy & Gastmans, 2015). The concept of moral distress raises questions related to the influence of nurses' moral agency, with regard to both the individual nurse and the context of practice they morally inhabit (Musto et al., 2015).

This shift to a more applied approach is also evident in an increasing body of knowledge associated with the 'everyday' moral experiences of nurses with a particular emphasis on the relational and contextual influences of nursing practice environments on moral practice (Chambliss, 1996; Hardingham, 2004; Lindh, Severinsson, & Berg, 2007; Rodney & Varcoe, 2012). More than twenty years ago, Chambliss (1996) extensively observed the moral aspects of working within an acute hospital context and concluded that the moral behaviour of nurses was indivisible from the setting in which they practised. That is, the nurses involved were influenced by the roles, the context where they worked and the relationships within that context. In the following decade, Hardingham (2004) addressed the impact of how this relational aspect of nurses' moral life influenced the development of moral integrity and found that if the influence is negative, moral integrity can be eroded by moral residue, defined as the residual distress from previous moral encounters (Webster & Baylis, 2000).

The importance of context is reflected in the nursing ethics literature through the concept of moral climate. Moral climate describes the values that are implicit and explicit within an

organisation and it forms part of the overall culture of an organisation (Rodney, Doane, Storch, & Varcoe, 2006). The tone of verbal and non-verbal communications at all levels is also a constituent of the moral climate (Rodney et al., 2006). The moral climate of an organisation can enhance, support or constrain aspects of the nurses' moral practice and is manifested through policies, procedures, codes of ethics and education. Like workplace adversity, influences of moral climate in nursing have also been linked to job dissatisfaction and staff attrition (Goldman & Tabak, 2010; Ulrich et al., 2007).

Given the potential for negative impacts, it is not surprising that contemporary ethical studies are focused on these aspects of practice, as well as on the environment in which nurses' practice and on the relationships within these environments. While research effort into the moral issues that exist for nurses in their everyday practice is gaining momentum in North America, Scandinavia and the United Kingdom (Bolmsjo, Sandman, & Andersson, 2006; Ulrich et al., 2007; Ulrich et al., 2010), especially in regard to the work environment, less research in this area has occurred in the context of Australian nursing.

A large body of the nursing ethics literature has focused on the negative impacts of adverse environments on nurses and there is far less focus on factors that enhance nurses' experience. What does exist, for example, how positive moral climates contribute to reduced incidence of moral distress (Silen, Svantesson, Kjellstrom, Sidenvall, & Christensson, 2011), is suggestive of a state of moral habitability in the workplace. However, the broader interactions of the individual within the workplace are not comprehensively addressed. This, together with the links evident in the literature between moral agency, moral climate and moral distress and how relationships within the working context influence these factors,

make the potential value of gaining a broader understanding of moral habitability in nursing clear.

One subset of nurses particularly vulnerable to difficult workplaces is new graduate nurses during the transition period from student to registered nurse (Dwyer & Hunter Revell, 2016). The influence of their work environment, especially in relation to the moral aspects of practice, is scant in the literature. However, interest in the interactions between new graduate nurses and their environments of practice, particularly in relation to moral climate, is gaining momentum (Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015a). Further understanding of the experience of this particularly vulnerable subset of nurses and their experience of moral habitability is warranted.

Particular vulnerability of new graduate nurses

New graduate nurses negotiate their work practices through relationships within their workplace with patients, their patients' families and other staff. The transition period for new graduate nurses is a time of a complex interplay between the internal characteristics of the new nurse, relational interaction and the context (Dwyer & Hunter Revell, 2016). These aspects of their experiences in their first year of practice occur contemporaneously with the development of clinical competence, making this period especially challenging for the nurses.

The transition period from being a nursing student to a registered nurse is considered to be the first 12-24 months (Parker, Giles, Lantry, & McMillan, 2014). During the initial socialisation period, trying to 'fit in' can be challenging, as the new graduate nurse adjusts to becoming a part of a new culture (Malouf & West, 2011). This can be made even more

difficult as new graduate nurse programs often include multiple rotations in different clinical contexts (J. Kelly & Ahern, 2009).

The development of clinical competence during transition is a primary focus and occurs while new graduate nurses are potentially being faced with workplace adversity, such as managing untenable workloads and experiencing horizontal violence (Chachula, Myrick, & Yonge, 2015). Horizontal violence has been described as bullying by co-workers, with subsequent negative consequences for both nurses and those they care for, and is reflective of the contextual features where they practice (Granstra, 2015).

The transition period for new graduate nurses has generated an extensive body of literature over the last four decades. In the mid-seventies, Kramer (1974) used the term 'reality shock' to highlight the tensions newly-graduated nurses faced when their values were incongruent with the 'real' workplace. Reality shock continues to be highly relevant today in studies focused on the organisational and personal factors which influence new graduate nurses' experiences of transition (Kramer, Brewer, & Maguire, 2013; Phillips, Kenny, Esterman, & Smith, 2014; Stephens, Smith, & Cherry, 2017). This focus on the context of practice and values coherence resonates with moral agency and moral climate research, but there is minimal research on these conceptual areas directly related to new graduate nurses.

A review of the new graduate nurse workplace literature identified both organisational factors and personal factors linked to positive or negative outcomes (Parker et al., 2014) for new graduate nurses. Organisational issues include the effect of workloads, leadership styles and educational preparation (Laschinger, Finegan, & Wilk, 2009), as well as personal factors, such as autonomy and congruence with organisational and personal values (Duchscher, 2009). It is also highly evident that new graduate nurses during transition are a

vulnerable and stressed group (Higgins, Spencer, & Kane, 2010; Phillips et al., 2014). In a well-cited study that specifically focused on the moral aspects of the new graduate nursing experience, Kelly (1998) identified that moral distress could be a consequence for new nurses trying to maintain moral integrity when confronted by environmental values inconsistent with their own.

The influences of relationships within the work context are particularly important for new nurses. For example, a key influence on how new graduate nurses perceive their environment to be either supportive or unsupportive, is the quality of the relationships with other staff within that environment (Laschinger & Read, 2016; Parker et al., 2014; Zinsmeister & Schafer, 2009). Work environments with a heightened feeling of community were found by J. Cho, Laschinger, and Wong (2006) to reduce the incidence of burnout and create a greater sense of commitment by the new graduate nurse to their organisation. Of particular importance is the notion of feeling welcomed and valued professionally (Chachula et al., 2015; Phillips et al., 2014).

Over the past twenty years, studies related to new graduate nurses have also particularly focused on context and personal factors in relation to retention and future career plans (Boamah, Read, & Spence Laschinger, 2017; J. Cho et al., 2006; S. Cho, Lee, Mark, & Yun, 2012; Rheaume, Clement, & Lebel, 2011). The interest in successful transition and retention is not surprising in the light of cyclical and predicted nurse workforce shortages in many western countries (Aiken et al., 2001; Buerhaus, Auerbach, & Staiger, 2009; Glasper, 2016; Health Workforce Australia (HWA), 2014). There is evidence both in Australia and internationally that poor experiences in the first year of practice can lead to work

dissatisfaction and attrition (S. Cho et al., 2012; Goodare, 2015; J. Kelly & Ahern, 2009; Rheaume et al., 2011).

While the nursing literature on transition to practice is extensive and consistently viewed as imperative to successful integration into the nursing profession, there is a distinct absence of the explicit use of the term 'moral'. Much of the commentary around new graduate nurses identifies moral aspects of the experience, although not overtly (Lynette, Echevarria, Sun, & Ryan, 2016).

For this particular subset of nurses, the context of practice, relationships within the work environment, and the ability to work within their personal values orientation are important for their ongoing satisfaction. The potential for moral distress within this group is also evident from the literature. It is therefore important to gather new insights into the new graduate nurses' experience. The particular vulnerability and features of new graduate nurses' experience through the dimensions of the workplace environment and their personal meaning in their social sphere are relevant to an understanding of moral habitability.

Impetus for the Study

The discussion above highlights the need for a study into moral habitability in nursing. It identifies how nurses' individual, interrelational and working environments influence their moral actions. The importance of this is not only for the support of individual nurses in providing the highest quality care, but also for the wider healthcare system. Challenges within the nursing workplace through organisational constraints and interrelational issues can produce harmful outcomes for nurses, patients and patients' families.

It is evident that there are no studies which directly explore or describe how nurses experience moral habitability within their work environments. However, related research into aspects of moral agency, moral climate and moral distress, demonstrates an imperative to create morally habitable environments to better support nurses through organisational policy and leadership. The links to concepts related to both the individual nurse and the context of practice within the nursing literature provides a basis for understanding the complex interactions of how moral habitability may be experienced. There is also a need for an understanding of how moral habitability is lived in the real world of practice. New graduate nurses constitute a particularly salient basis for inquiry, because they are a group particularly vulnerable to workplace challenges related to the moral aspects of their practice, and their experience in this regard is under-reported.

This research goal is combined with a need to find a methodological approach in the nursing disciplinary literature suitable for exploring under-researched but important concepts. To better comprehend moral habitability in nursing, identification of both the features that enhance and those that inhibit habitability are essential to the development of a robust understanding of the phenomenon.

Research Aim

The aim of this study is to provide an interpretive description of moral habitability in nursing, both conceptually and in practice.

Overview of the Research Design

In the contemporary nursing methodological discourse there has been a move away from strategic adaptions of traditional social science methodologies to a more applied approach

(Thorne, Stephens, & Truant, 2016). The concept of moral habitability in nursing is under-theorised and under-researched. The interest in this study is in theorising and researching moral habitability as a concept experienced in nursing, not as a general moral concept. As a result, the intent of this research product is to make a knowledgeable contribution and application to the discipline of nursing. A traditional social science methodological approach with a rigid external theoretical framework was therefore considered by the researcher to be not a good fit with this research aim. Alternatively, interpretive description was identified as having sufficient flexibility as well as rigour to support the exploration of moral habitability in nursing. It sufficed as a practical and logical approach and provided a disciplinary theoretical framework.

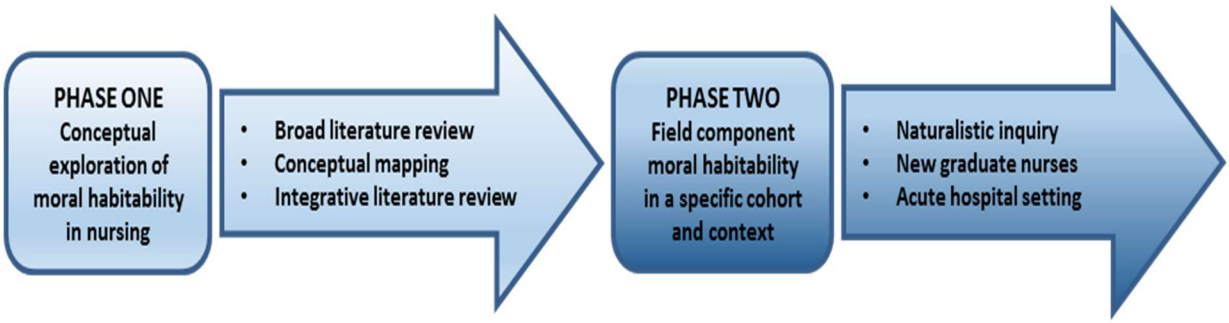
To achieve the study of moral habitability in nursing, an inductive two-phase qualitative study was designed to address the conceptual refinement and exploration of the phenomenon. The two distinct phases of the study are as follows:

> Phase One: An exploration and synthesis of the concept of moral habitability in nursing; and,
>
> Phase Two: A field study and exploration of the experience of moral habitability in nursing in the workplace.

The two-phase design of the study is consistent with the tenets of interpretive description. Interpretive description supported the further conceptualisation and description of moral habitability in nursing initially from the current knowledge within the nursing discipline, and then from the lived experience of a group of nurses (Thorne, 2008, 2016). Figure 1 provides a pictorial representation of the two-phase approach used for this study. The full rationale

for the choice of interpretive description as the appropriate methodology is discussed further in Chapter Two.

Figure 1. Two Phases of the Study Moral Habitability in Nursing



In a non-traditional thesis, conceptual framing can be a stand-alone finding rather than a background (Evans, Gruba, & Zobel, 2014). The overall objective of Phase One of this research was to explore concepts in the nursing ethics literature that describe moral habitability in nursing. The resultant conceptual exploration was achieved through examination of the nursing disciplinary ethics literature related to nursing practice environments and nurses' moral interactions and actions within the workplace. This conceptualisation was applied iteratively to influence the choice of methods used in Phase Two of the study in order to describe the experience of moral habitability in nursing by entering into the social world of one subset of nurses, new graduate nurses. The overall objective of Phase Two was to explore the experience of a group, new graduate nurses, to describe the moral habitability of their workplace.

Consideration of which participant group and context (field component setting) would be suitable for Phase Two of the study was guided by the following questions:

1. Why is it important to study this particular group in relation to moral habitability?

2. What is interesting about the context and features of this particular group in regard to moral habitability?

The following section further outlines why new graduate nurses in the acute hospital setting were chosen as the setting for Phase Two of the study.

Choice of focus for Phase Two

As indicated above, new graduate nurses were chosen as the focus and context for the second phase of the study because there are significant relevant features within this group. New graduate nurses, the future nursing workforce, are particularly vulnerable during the period when they are socialised into the workplace environment (Feng & Tsai, 2012). There is evidence that, through the socialisation process of the graduate year, new nurses may abandon their belief systems to ensure they 'fit in' (Ham, 2004), which may impact their moral agency. There is also evidence that this process may result in a crescendo effect, causing moral distress and the subsequent intention to leave the profession (Epstein & Hamric, 2009). These features are of particular relevance to moral habitability in nursing as they concern aspects of the individual nurse and the context of practice. Of particular concern is the high attrition within this subset of new nurses and consequent cost to the workforce (S. Cho et al., 2012).

The impact of the context in which new graduate nurses practice is powerfully exhibited in the nursing literature (Laschinger & Read, 2016; Numminen, Leino-Kilpi, Isoaho, & Meretoja, 2015b). In particular, the importance of relationships in the context of both positive and negative new graduate nurse outcomes is central in much of the new graduate nurse literature that was examined (Dwyer & Hunter Revell, 2016). Therefore, as argued earlier, understanding the qualities of the new graduate nurse and how their workplace and the

relationships within the workplace influence their experience, is important as this group is vulnerable to difficult workplaces. In addition, new graduate nurses are a highly salient group to study, as there are data indicating that they face significant moral challenges (B. Kelly, 1998) and yet there is very little literature specifically related to the moral aspects of practice.

Methods used in Phase Two

Data were sourced from new graduate nurses in the first year of their nursing practice through focus groups, interviews during the first six months and again in the final three months of their new graduate programs, as well as through non-participant observation of the new graduates practising in their workplaces. Each method of data collection was used to provide a different but complementary lens on moral habitability in the practice experience of new graduate nurses. By utilising multiple data sources, different lenses on the new graduate nurses' experience of moral habitability provided a rich data set (Thorne, 2016). The synthesis of the findings of both phases of the research provided a means to meet the overall aim of the study. Chapter Two provides a detailed discussion of the research design of this study.

Significance of the Study

Establishing an understanding of the concept of moral habitability is imperative for the discipline of nursing, because a nurse's ability to enact their moral agency and provide quality patient care can be enhanced or constrained by the moral aspects of their environment. Peter et al. (2004) offered an understanding of morally uninhabitable nursing workplaces and there is sufficient other literature in nursing regarding moral agency, moral climate and moral distress to suggest that moral habitability is itself an embedded or related

concept; however this has not been tested to date. No research has yet been undertaken specifically focused on moral habitability in nursing, and as an emergent concept, moral habitability in nursing is in need of further investigation. The outcome of this study, an interpretive description of moral habitability in nursing both conceptually and in practice, extends contemporary nursing knowledge and has implications for leadership, education and future research into the phenomenon.

The selection of new graduate nurses as the focus of this study is also of significance, given that they are a particularly vulnerable subset of the nursing profession. Through the implementation of the research design, contemporary knowledge of what shapes and challenges moral habitability for the new graduate nurse has been exposed. As an outcome of the interpretive description, education and management strategies to maintain and support a balance of moral habitability are suggested. In addition, while the strategies presented focus on new graduate nurses, this subset shares commonalities with broader nursing groups and points toward strategies that can be implemented across the profession.

Importantly, this study makes a contribution to the qualitative methodological discourse in regard to the design approach, particularly in under-theorised and under-developed concepts. Finally, this work will be of interest to researchers of healthcare workforce adversity, because some of the strategies suggested to make an environment more morally habitable can be utilised more generally within adverse nursing workplaces.

Thesis Outline

This thesis comprises eleven chapters. Given the under-development of writing and research about moral habitability and the view that it is an emergent concept, a two-phase approach to the design of this research was implemented. Chapter One has provided an

introduction to the research and a brief overview of the study design. In Chapter Two, the overall research design for the study and the theoretical foregrounding of the conceptual and methodological underpinnings of the study are detailed.

In Phase One of the study, a conceptual exploration of moral habitability in nursing was undertaken. Details of the methods used and the findings of this phase are contained within a published integrative literature review, which is presented in Chapter Three. Chapter Three concludes with an initial conceptualisation of the important concepts related to moral habitability in nursing as a framework for Phase Two. Chapter Four describes the methods and research processes used for Phase Two, the field component of the study.

In Chapter Five, the initial findings and the participant engagement over the 12-month study are presented. The five themes identified in the thematic analysis of Phase Two are presented in Chapters Six, Seven and Eight. Chapter Nine provides a synthesis of the findings of the two phases of the study in the form of an interpretive description of moral habitability in nursing. Chapter Ten presents a discussion of the key aspects of this research, the implications for nursing knowledge development of moral habitability, and the limitations of using a two-phase approach to research design. The final chapter presents a summary of the findings and concludes with recommendations for nursing research, practice, education and policy that arise from this study.

CHAPTER 2 RESEARCH DESIGN

In any form of inquiry, an argument for the approach to the research design is important because it provides a means of ensuring fit for purpose and rigour in the research, and an understanding of the researcher's decision making. As identified in Chapter One, moral habitability in nursing currently lacks utility for the development of nursing knowledge, because it is an under-described and under-studied phenomenon of nursing practice. There is no reported study that specifically describes an investigation into moral habitability in nursing. In addition, the concept of moral habitability in nursing has also not been fully described.

In light of the limited literature and research base on moral habitability in nursing, a practical and innovative two-phase inductive research design was developed and implemented. As identified in the previous chapter, this approach was adopted to address conceptual refinement and exploration of the phenomenon. The qualitative methodology of interpretive description (Thorne, 2008, 2016) was chosen to accommodate this approach. This methodology is appropriate when some depth and contextual understanding are useful in advancing nursing disciplinary knowledge and when the use of quantitative or other qualitative research approaches would be theoretically premature. These methodological features are consistent with the impetus and aims of this study.

Since coherent and logical details of design decisions provide a means of ensuring research rigour (Thorne, 2016), this chapter begins with a discussion of the arguments for the overall research design, the methodological choice and the associated paradigmatic alliances. The chapter concludes with an overview of the process of the two phases of the study.

Choices and Approach

While interpretive description was the methodological approach adopted for the study, several preliminary processes informed this choice. As previously detailed in developing the research design, the process included the selection of a paradigmatic and methodological framework to guide design decisions that would be consistent with the intent of the study. Selection was further informed by a critical review of the current state of knowledge in the field of nursing ethics and moral theory. This section details the sequence and decisions relating to the overall research design for this study.

In Chapter One it was established that moral habitability in nursing requires an understanding of the environment; and of the dimensions and personal meanings of the participants within that social environment. For instance, aspects of importance in this study in regard to the social environment include an understanding of moral agency within the context of practice and the potential implications for nurses when this agency is constrained. Therefore, an inquiry process that focuses on the social world requires a research approach that reflects how people understand their experiences within the context they inhabit (Holloway & Wheeler, 2010, p. 3). A qualitative approach was important for this inquiry as the research needed to take into account both the context and the participants as part of the phenomena (Welford, Murphy, & Casey, 2012).

Qualitative research

Qualitative research can be defined as a "situated activity that locates the observer in the world" (Denzin & Lincoln, 2017, p. 11). This means that qualitative researchers study phenomena in naturalistic environments. They do this while endeavouring to understand

the phenomena of interest by interpreting the meanings people convey through interacting in their particular social world (Denzin & Lincoln, 2017).

There are multiple qualitative paradigms. The term paradigm is defined by Denzin and Lincoln (2008) as a "basic set of beliefs that guide action" (p.245). The paradigm provides a structure with which to view or achieve an inquiry (Welford, Murphy, & Casey, 2011, p. 38). Characteristics of paradigms that influence how the research is done and how it contributes to knowledge are divided into three main areas: ontological, which questions the nature of reality; epistemological, which questions what can be known; and methodological, which questions how knowledge can be generated (Denzin & Lincoln, 2008; Guba, 1990). While the nuances of different qualitative paradigms vary, there are common features. Ontologically, the focus is on context and emphasises multiple realities (Creswell, 2014). Epistemologically, knowledge is subjective and generated inductively using multiple methods (Denzin & Lincoln, 2011). From an axiological perspective, where values are considered, qualitative researchers acknowledge the value-laden nature of inquiry (Denzin & Lincoln, 2011).

In researching the concept of moral habitability in nursing where there is little extant knowledge, using the general paradigmatic features of a qualitative approach provide a means to explore a complex concept in greater detail (Liamputtong, 2013). In qualitative studies, to gain understanding of the phenomena an inductive process of finding patterns or common elements in specific examples allows a move to a more general understanding of the phenomena (Morse & Field, 1996; Thorne, 2016).

Multiple methods are often employed to elicit data from the experiences of individuals, which can then be analysed to form a rich and contextualised description of an emergent

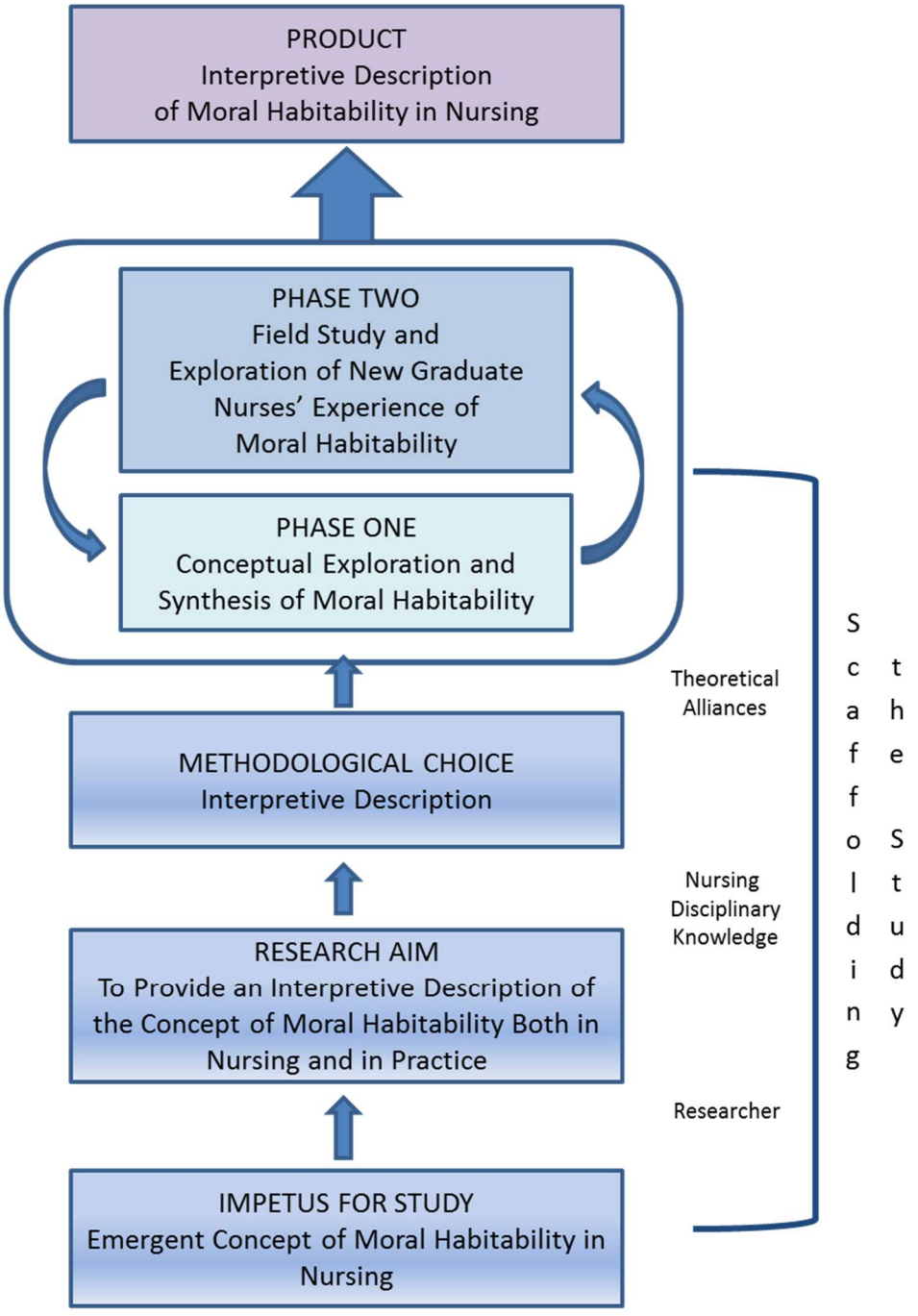
phenomenon (Polit & Beck, 2010). Denzin and Lincoln (2008) state that "objective reality can never be captured" (p.5), only represented. Therefore understanding is not static, and it is temporal and contextual. Finally, in this inquiry there was a need for practicality and flexibility, rather than a rigid approach, and this is consistent with a qualitative approach (Denzin & Lincoln, 2017; Liamputtong, 2013; Welford et al., 2012).

Two-phase approach

Initiating a qualitative inquiry requires carefully sequenced phases. The initial phase requires an orientation and an outline of the phenomenon under scrutiny and then an intensive examination of the phenomenon (Polit & Beck, 2017). As moral habitability in nursing is under-theorised and under-researched, an innovative two-phase qualitative study was developed that, through an inductive approach, would address the conceptual refinement and exploration of the phenomenon. Because conceptual exploration is necessary for the nascent concept of moral habitability in nursing, the classical literature review process (Pope, Mays, & Popay, 2007) prior to the design of the study (Evans et al., 2014) would not have been appropriate. Instead, as explained in Chapter One, this study was divided into two distinct phases: first, conceptual exploration, and second, a field component for further focused exploration of moral habitability in nursing in a workplace context with new graduate nurses. As introduced in Chapter One, Phase One of the study was conducted as a conceptual exploration through examination of the nursing disciplinary ethics literature related to nursing practice environments and nurses' moral interactions and actions in the workplace. The outcome of this process provided a basic framework within which to further examine the phenomenon in a naturalistic environment in Phase Two.

Figure 2 provides a visual representation of the overall research design of this study, noting that the impetus and aim were outlined in Chapter One.

Figure 2. Overall Research Design



In the following discussion on methodological choice, the 'scaffold' of the study and details of each phase are detailed.

Methodological choice

Because the overall approach is innovative, finding an appropriate methodology that would accommodate the exploration of the concept of moral habitability in nursing was very important. It was also essential as a means to address rigour (Liamputtong, 2013). Initially qualitative description (Sandelowski, 2000, 2010) was considered as an appropriate methodological approach. Sandelowski (2000, 2010) highlights that the traditional qualitative research approaches, for example grounded theory, phenomenology and ethnography, each use qualitative description as basic premises. The difference is that these theoretical approaches force the analyses of phenomena under scrutiny to deeper interpretive examination.

More specifically, qualitative description is considered to be the least 'theoretical' in the gamut of qualitative approaches in that researchers are less hindered by pre-existent obligations to certain theoretical and philosophical views (Sandelowski, 2000). Sandelowski notes however that no research is without some theoretical or disciplinary underpinnings (2010). Since moral habitability in nursing is an under-developed concept with minimal theoretical background, this gaining of significant interpretive depth would be unachievable, and a descriptive approach was therefore deemed appropriate.

After careful consideration, interpretive description (Thorne, 2008) was the methodology chosen for this study. While there are parallels between qualitative description and interpretive description in the influence of the more traditional methodological approaches, interpretive description departs from description alone (Thorne, 2008; 2016). This is because, while a deep interrogation of the data is not appropriate, there is an underlying assumption that nurses expect *some* exploration of meaning and direct application (Thorne,

2016; Thorne, Kirkham, & O'Flynn-Magee, 2004). This is consistent with the expected significance of this study which was outlined in Chapter One.

While Thorne (2008, 2016) believes qualitative description is useful to new knowledge development, interpretive description has other benefits. Interpretive description parallels not being restricted to a certain theoretical stance, and importantly for this study highlights focusing on extant nursing knowledge as a scaffold (Thorne et al., 2016). This methodology acknowledges and begins with a disciplinary conceptual framework which supports the use of methods outside their traditional context (Thorne, 2016). That is, using interpretive description as a methodological approach means the researcher is challenged to engage with the data and expand interpretive thinking (Thorne et al., 2016) from what is known to what also might be there. While gaining an understanding of moral habitability in nursing through an interpretive description was the primary aim of the study, an interest in the application of this knowledge to both nursing as a discipline and the context of new graduate nurses that ultimately lead to the use of this approach.

More specifically, interpretive description was chosen as the most appropriate methodology for this study for two reasons. The first was that, to further conceptualise moral habitability in nursing, an atheoretical stance driven by the current knowledge state within the nursing discipline was consistent with this methodology. The current knowledge state within the nursing disciplinary ethics knowledge could provide a sufficient disciplinary conceptual framework (Phase One).

The second was that, the articulated association with nursing clinical environments and the application of the findings to the social and political issues within these environments was consistent with the proposed outcomes of this study. Interpretive description as a

methodology provides a defensible approach to studying a specific cohort, new graduate nurses, in context (Phase Two) that will yield directly applicable outcomes for a particularly vulnerable nursing group.

Interpretive description

While interpretive description as a methodology provides a framework that will afford some interpretive depth, it is not intended to be a 'recipe book'. Rather, it offers a way to support qualitative design choices in keeping with the character of the nursing discipline (Thorne, 2016). This methodology supports the choice of methods used to achieve the aim and to demonstrate a logical audit trail. Interpretive description uses strategies derived from the "social science traditions applying them to the grounded and naturalistic conditions of the clinically derived disciplines" (Thorne et al., 2010, p. 748). Interpretive description was developed as a credible methodological alternative to address limits to the use of traditional qualitative approaches which were not always congruent with the clinical questions being asked by nurse researchers (Sandelowski, 2000; Thorne, 2008).

Working with two graduate students, Thorne, a major contributor to qualitative methodological dialogue (Thorne, 1994, 2000, 2014; Thorne & Darbyshire, 2005), published a paper outlining a non-categorical approach to qualitative methodology in the late 1990s (Thorne, Kirkham, & MacDonald-Emes, 1997). This was followed by a second paper and books which further developed the analytic process (Thorne, 2008, 2016; Thorne et al., 2004). Subsequently, interpretive description has been adopted as a methodology in nursing (Dickson, 2013; Reis, Rempel, Scott, Brady-Fryer, & Van Aerde, 2010) and other health disciplines (Hunt, 2009).

Interpretive description as a qualitative methodology is influenced by the general axioms of this form of research (Thorne, 2016). Specifically, there are key assumptions in using an interpretive descriptive methodology that guide the research design decisions and that are reflected in the design of this study. These assumptions are made explicit in the sections that follow. Thorne uses the term "scaffolding a study" (2016, p. 59) to explain the initial steps that underpin the design choices.

Scaffolding the Study

There are two essential elements of the 'scaffold'. The first requires the development of an understanding of the existing literature and knowledge in the field of inquiry (Thorne, 2016). The second element requires uncovering the theoretical and philosophical alliances influencing the study and situating the researcher "within the field and the theoretical world that surrounds it" (Thorne, 2008, p. 64). The following discussion explicates these elements and their application to the study of moral habitability in nursing.

Literature review

Thorne (2016) states that the three main purposes of a literature review are to ground the study with what is already known, critically identify what is not known and, offer a critique of the overall strengths and limitations evident in the overall knowledge. As the concept of moral habitability in nursing is immature and there is a limited literature base, in this study an innovative approach was designed to address this element of the scaffold. Exploration of concepts relevant to moral habitability in nursing was undertaken as Phase One of this inquiry. The findings and outcomes of this process, an integrative literature review, became a stand-alone product rather than merely a background. This is consistent with the purpose of the literature review in an interpretive description. However, it represents a fresh

approach that can be utilised more widely when faced with an emergent concept of relevance. The process for Phase One is detailed later in this chapter.

Theoretical forestructure

In considering how to answer the research problem presented by this study, a traditional approach is to establish the paradigm that is consistent with the investigative outcomes. In the discipline of nursing, different paradigms are utilised subject to both the state of current knowledge related to the topic under scrutiny and the kind of knowledge that is required for further understanding (Weaver & Olson, 2006). Interpretive description is located external to the traditional social science methodologies (Thorne, 2016) and therefore does not require a rigid or explicit paradigmatic view. However, clarification of the theoretical forestructure of the study locates the researcher and the theoretical alliances (Thorne, 2008) that influence the overall design of the study to meet the aim of the project (Houghton, Hunter, & Meskell, 2012). One of the key assumptions of using an interpretive descriptive approach is that it acknowledges the "socially constructed element of human experience" (Thorne, 2016, p. 82). This study is influenced by the paradigm of constructionism.

Theoretical alliances - Constructionism

From an ontological and epistemological perspective, constructionism is relativist, in that there is no absolute truth, but more a "tentative truth claim" (Thorne, 2008, p. 4) as an end product. Epistemologically and methodologically, these claims are generated by social constructions co-created through a transactional process in context between the knower (participant) and the researcher (Thorne et al., 2004). Weaver and Olson (2006) suggest that in constructing knowledge of a particular inquiry an important foundation is the assessment

of the theoretical base of contemporary knowledge. They suggest that this should be achieved through a critical appraisal of diverse and disparate studies (Weaver & Olson, 2006). Phase One was designed as a practical means using inductive and constructionist principles to develop the concept of moral habitability in nursing. The subsequent conceptual exploration provided a basic foundation of the state of knowledge development regarding the topic. Table 1 outlines key components of a constructionist approach applied directly to the study of moral habitability in nursing.

Ontologically, constructionism proposes that reality is constructed in relation to specific social locations as an ongoing, dynamic state of people acting on their shared understandings (Welford et al., 2011). Understanding is sought as to how individuals attach meaning to their actions and the consequences of these actions. Therefore, the second phase of this study is imperative to understanding what the constructed reality of moral habitability in nursing was within a local and specific group. The social constructions of the experiences of the participants, the new graduate nurses, cannot be taken out of the context, the clinical environment of practice, in which they occur. Finally, epistemologically and methodologically, constructionism is a collaboration between the researcher and participants. Constructionism is also emancipatory, but this emancipatory focus is not on the direct outcomes of the research, but the process of the research inquiry (Thorne, Kirkham, & Henderson, 1999).

To justify research design decisions and ensure rigour once theoretical alliances are located, the next component in developing a theoretical forestructure is situating the researcher within the disciplinary knowledge (Thorne, 2008).

Table 1. Constructionist Approach to this Study

	Constructionism	Moral habitability in nursing
Ontology		
What is the nature of reality?	Understanding from multiple perspectives to explain a concept.	**Phase One**: Conceptual exploration assessing the state of knowledge development.
	Constructed reality in a local and specific social location.	**Phase Two**: How new graduate nurses in an acute setting construct the reality and consequences of moral habitability.
	Communal production and transmission of meaning.	Focus on the social institution of nursing.
Epistemology		
What can be known?	Subjective.	The end product is an interpretive description.
	Multiple views within social institutions and attention to power within these social groups.	Views of new graduate nurses in multiple acute hospital settings. Attending to power interactions within these settings.
Methodology		
How can knowledge be generated?	Constructing and attaching meaning to a concept and finding ways to improve situations.	Interpretive description as a methodology that can combine multiple qualitative methods to construct and find meaning for the concept of moral habitability in nursing.

Note: In developing this table, the principles of constructionism were influenced by the writings of Denzin and Lincoln (2000) and Welford et al. (2011).

Thorne (2016) argues that the discipline of nursing should be considered as theory and by being aware of the role, disciplinary knowledge shapes the design choices; for example, what is observed. This is particularly relevant to this study in which a design approach directly drawing from the nursing literature as a framework is used for exploration in the field. Making explicit where the researcher is situated within the discipline, also affords better insight for the researcher when eliciting conclusions from the findings (Thorne, 2016).

Situating the researcher and nursing disciplinary knowledge within the study

Another key assumption of interpretive description is the influence exerted by the inextricable interactions of the researcher and the participant in the construction of the research product (Thorne, 2016). Situating the researcher in the study by making explicit the influences of experience and expertise which may influence the research choices and outcomes is imperative, since it lends integrity to the overall product. However, Thorne (2008) cautions that only what is necessary to position the research is revealed, rather than "overblown extensive personal reflections" (p. 72).

My initial curiosity about the moral aspects of practice was influenced by a clinical background in critical care nursing where the moral component of practice was often challenging. This led to studying ethics at a Masters level. My work as a university lecturer teaching ethics and law where discussions focused on everyday clinical practice, was also influential in my motivation to explore moral habitability in nursing. Thorne et al. (2016) suggest that in structuring a credible study, the disciplinary background is made overt and considered as theory as it gives an understanding of the choices made in the design and analysis. This study is situated in the discipline of nursing. The study is conceptually driven and therefore is atheoretical, however it is influenced by nursing knowledge, specifically the

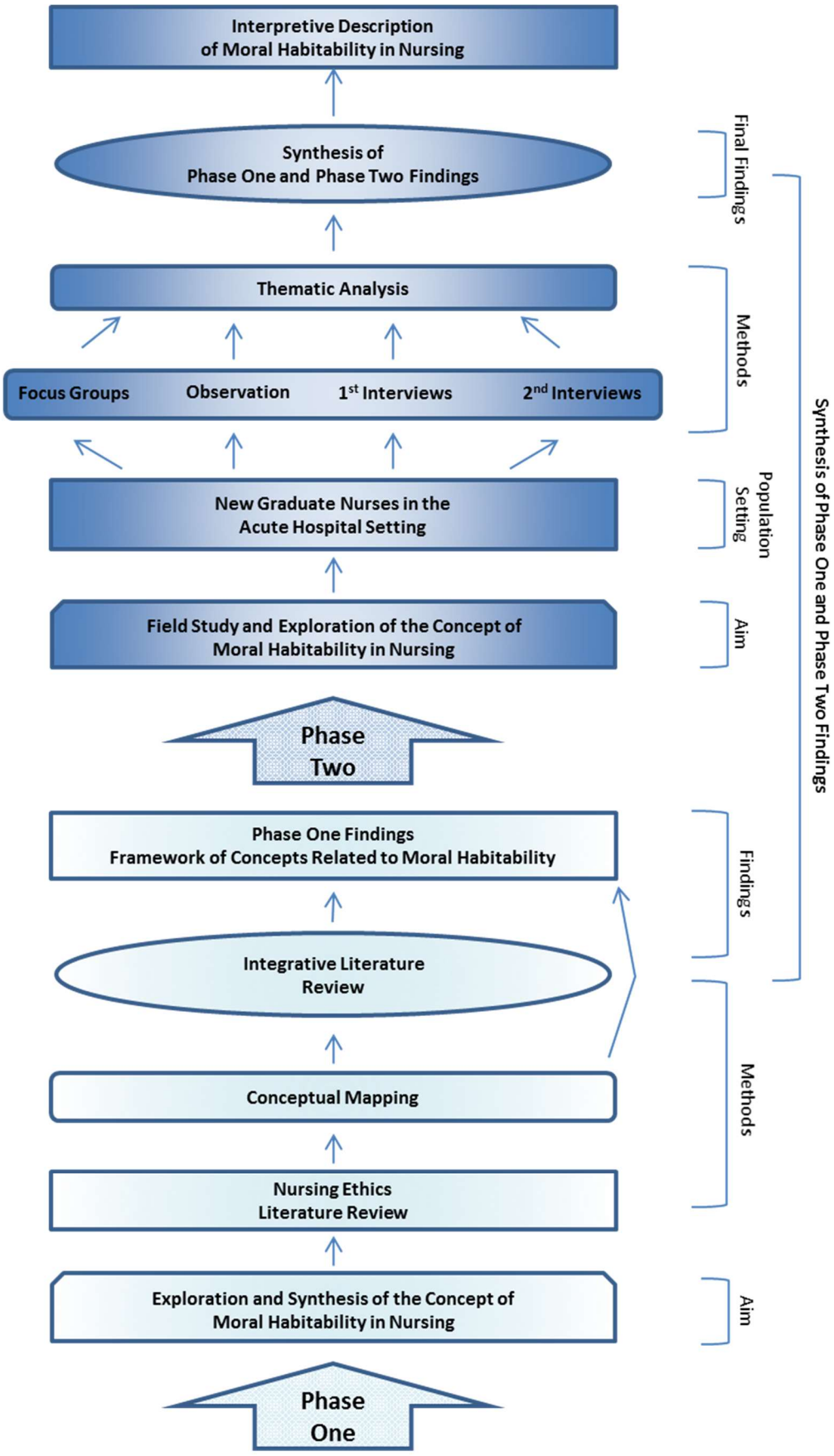
contemporary nursing moral literature, that may have theoretical components but is not in itself theory (Thorne, 2016).

The problem under scrutiny is moral habitability in nursing. An initial understanding of the concept was presented by Peter et al. (2004), who were influenced by a feminist philosopher (Walker, 2003). As a result, the scope of the initial moral nursing literature reviewed for Phase One was informed by feminist theory. This is what Sandelowski refers to as adopting the "hues, tones and texture" (2000, p. 337) of ideas rather than totally embracing a specific stance. Although Walker's work was acknowledged in Chapter One, the use of a feminist perspective with an ideological intent focused on gender and power was deemed too narrow for this study. Because the intent is to capture a broader description of the phenomenon of interest, a review of nursing literature relevant to the moral nursing environment and moral agents (nurses) was undertaken. This led to a wide view of the nursing moral literature related to nursing practice environments and the interactions and actions of nurses working within. As identified in Chapter One, early analysis of the moral literature in nursing supported the adoption of a wider view for Phase One of the study. That wider view initially encompassed concepts such as moral agency, moral distress, and contextual aspects such as moral climate. The specific details of the research design of the two phases are outlined in the next section.

Specific Details of Phase One and Phase Two

An overview of the methods used in Phase One and Phase Two of this study is provided in the following section of this chapter and pictorially represented in Figure 3.

Figure 3. Specific Details of Phase One and Phase Two



Chapter Three provides a comprehensive explanation of the methods employed for Phase One and, in addition to the findings, a published integrative literature review. In Chapter Four, an extensive outline of the methods used for Phase Two, the field component of the study, is presented.

Overview of Phase One

The intent of Phase One of the study was concept exploration. The use of concepts can "guide a discipline by forming the units that comprise and link theory, research and practice" (Weaver & Mitcham, 2008, p. 181). However, concepts that lack clarity and which are used with multiple meanings within a discipline, can weaken the result of subsequent research and theory development (Weaver & Mitcham, 2008). This view of the importance of concept clarification within nursing has been reflected by the increasing number of concept analyses in the nursing literature over the last decade (Dowling, Beauchesne, Farrelly, & Murphy, 2013; Fitzpatrick & McCarthy, 2016; Kulju, Stolt, Suhonen, & Leino-Kilpi, 2015; Numminen, Repo, & Leino-Kilpi, 2016).

What is a concept?

The lack of consensus regarding the term 'concept' provides a challenge to the utility of any work on concept development. The range of definitions reflects the historical diversity of philosophical views of the role of concepts and their link to knowledge development (Rodgers & Knafl, 2000, p. 30).

Acknowledgement of the complexity, contextual nature and diverse use of the term 'concept' is imperative to the use of this form of analysis (Beckwith, Dickinson, & Kendall, 2008). The complexity of the term 'concept', its defining characteristics, purpose, and association with the advancement of knowledge, is reflected in multiple theoretical

perspectives and this diversity of approaches is also mirrored in the nursing literature (Beckwith et al., 2008). It therefore seems unlikely that a 'one size fits all' approach to defining 'concepts' can be applied. However, there is potential for misinterpretation of the nature of the concept exploration if the approach to the use of the term 'concept' is not made clear (Beckwith et al., 2008).

Polit and Beck describe concepts as "abstractions of particular aspects of human behaviour and characteristics" (2017, p. 47). This description is consistent with an 'entity' theory of concepts that reflects much of the early philosophical literature (Rodgers & Knafl, 2000). This view defines concepts as objects that reflect an observable reality (Becker, 1983). The difficulty with this approach is that factors that influence a concept (entity) such as context, temporality and culture, are viewed differently by different individuals and groups. As a result, in the testing of the integrity of the concept, a logical outcome of an entity (object) approach is problematic (Rodgers & Knafl, 2000).

In contrast to the entity view of concepts, dispositional theories present concepts as practices or capabilities (Rodgers & Knafl, 2000). This theoretical perspective is more consistent with the approach for the present study since rather than providing a description of an 'entity', "dispositional theories emphasise the use of concepts and the behaviours that they make possible" (Rodgers & Knafl, 2000, p. 11). Medin's (1989) probabilistic view is indicative of a dispositional theory and emphasises that there is a focus on the probability of whether a cluster of characteristics or attributes is associated with the concept. That is, rather than attempt to find all the characteristics and attributes associated with the concept and apply them generally, there will be situations where they are more 'typically' associated (Rodgers & Knafl, 2000). In the emergent concept of moral habitability, a probabilistic view

which allows for the possibility of connections and associations is more valuable than a reductionist, definitive, context-free entity view. This is evident in the approach taken for the Phase One concept exploration.

Phase One concept exploration

Since there is sparse research and commentary specifically related to moral habitability in nursing, finding concepts that may be associated with the phenomenon and a literature review method that could combine disparate studies was needed. Initially, from a broad search for concepts related to 'moral habitability', nursing ethics literature was identified as being relevant to both the moral nature of the nursing workplace and the social roles and practices of nurses within these workplaces. The identified literature was then used to develop a concept map to frame the literature into specific key concepts. This concept map, presented in the next chapter, was developed to provide a visual representation of the literature search outcomes. To identify concepts that were contemporary and empirically supported was of key importance. Secondary concepts were those related to opinion or commentaries. The key concepts identified in the map were used as a framework to inform an integrative literature review, which is presented in the following chapter. Finally, the concept map and integrative literature review were used to develop an initial conceptualisation of moral habitability in nursing and provide a framework for Phase Two.

Overview of Phase Two

Another assumption that underpins an interpretive descriptive approach is conducting the research in a naturalistic environment with an emphasis on maintaining the ethical rights of the participants in a respectful manner (Thorne, 2016). The aim of Phase Two of this study, the field research component, was to further explore moral habitability in nursing through

an interpretive lens with a specific context, new graduate nurses in the acute hospital setting. Maintaining the participants' ethical rights was of foremost concern and the methods by which this was achieved are explained in Chapter Four.

There are multiple options for data collection when using interpretive descriptive methodology for resourceful researchers, with decisions as to the most appropriate options being driven by a critical analysis of which will yield the most credible results (Thorne, 2008). Denzin and Lincoln (2017) use the metaphor of a "methodological bricoleur" (p. 12) to describe the researcher as bringing together different strategies and materials to piece together a representation of what is being studied. If successful, the result is a non-sequential "montage" (Denzin & Lincoln, 2008, p. 5) of associations and contrasts that captures a representation of the phenomenon. To collect data for this phase of the study, multiple methods were used. Numerous data collection strategies were used to gain some 'snapshots' of different contexts and conversations about moral habitability in the new graduates' world that would form the final montage. This was not to capture objective reality, as this is not possible in qualitative research, but a meaningful representation (Denzin & Lincoln, 2008, p. 5) which reflects the assumptions underpinning interpretive description (Thorne, 2016).

Interpretive description seeks to capture the substance of the participants' experience by identifying patterns that contribute to understanding that experience (Thorne, 2016). Therefore, by obtaining multiple views of the experience, a more meaningful understanding may be generated. In Phase Two three strategies were used for data collection: focus groups, interviews and non-participant observation. Each strategy was used to provide a different lens on moral habitability in the practice experience of new graduate nurses. The

focus groups were used to consider social constructions, the interviews to examine language cues, and the observation considered actions within contexts (Thorne, 2008). In qualitative research, the researcher is located and active in the construction of data, and this requires ongoing reflection and justification of the intellectual processes to ensure the accountability of findings (Thorne, 2016).

Reciprocity between the two phases

In a 'standard' thesis, conceptual framing (the literature review) provides a background of prevailing theory and practice related to the research topic. This then provides a platform for positioning the study and subsequent design decisions. In addition, this background is used in synthesis with the study's findings to create a product to meet the aim of the study (Evans et al., 2014). In a 'non-standard' thesis, conceptual framing can be a stand-alone finding rather than a background (Evans et al., 2014). Due to the under-developed nature of the concept of moral habitability in nursing, in this study the findings of Phase One, the conceptual mapping and subsequent integrative literature review, provide a basic and flexible conceptual framework of concepts related to the topic. The interpretive descriptive methodology and this framework influenced the choice of methods used in Phase Two to construct a conversation by entering into the social world of one subset of nurses, new graduate nurses. The synthesis of the findings of Phase One and the context-laden findings of Phase Two provide a means to meet the aim of the study – an interpretive description of moral habitability in nursing.

Summary

In this chapter, an overview of the research design and theoretical alliances that scaffold the study has been presented. Interpretive description provides a methodology that

accommodates the innovative two-phase approach used in this study to explore an under-researched and under-developed concept. Phase One of this study was purely inductive and consistent with a constructionist approach to knowledge development, which is theoretically consistent with interpretive descriptive methodology. Phase Two focused on attending to and making meaning in a constructionist manner with participants in a highly salient group, new graduate nurses. Through the reciprocity of the two phases, a richer understanding of moral habitability in nursing is developed. The following chapter presents the findings of Phase One of the study in the form of a publication. The initial discussion and publication provide further comprehensive details of the methods employed for Phase One and includes an initial conceptualisation of moral habitability in nursing.

CHAPTER 3 PHASE ONE METHODS AND FINDINGS

As identified in the previous chapters, the two-phase design of this study specifically accommodated exploration of the under-researched concept of moral habitability in nursing. The focus of this chapter is the findings of Phase One, a concept map and integrative literature review. These findings informed the field component of this study, Phase Two. The findings are presented in the form of a peer-reviewed publication entitled '*Understanding moral habitability: A framework to enhance the quality of the clinical environment as a workplace'.*

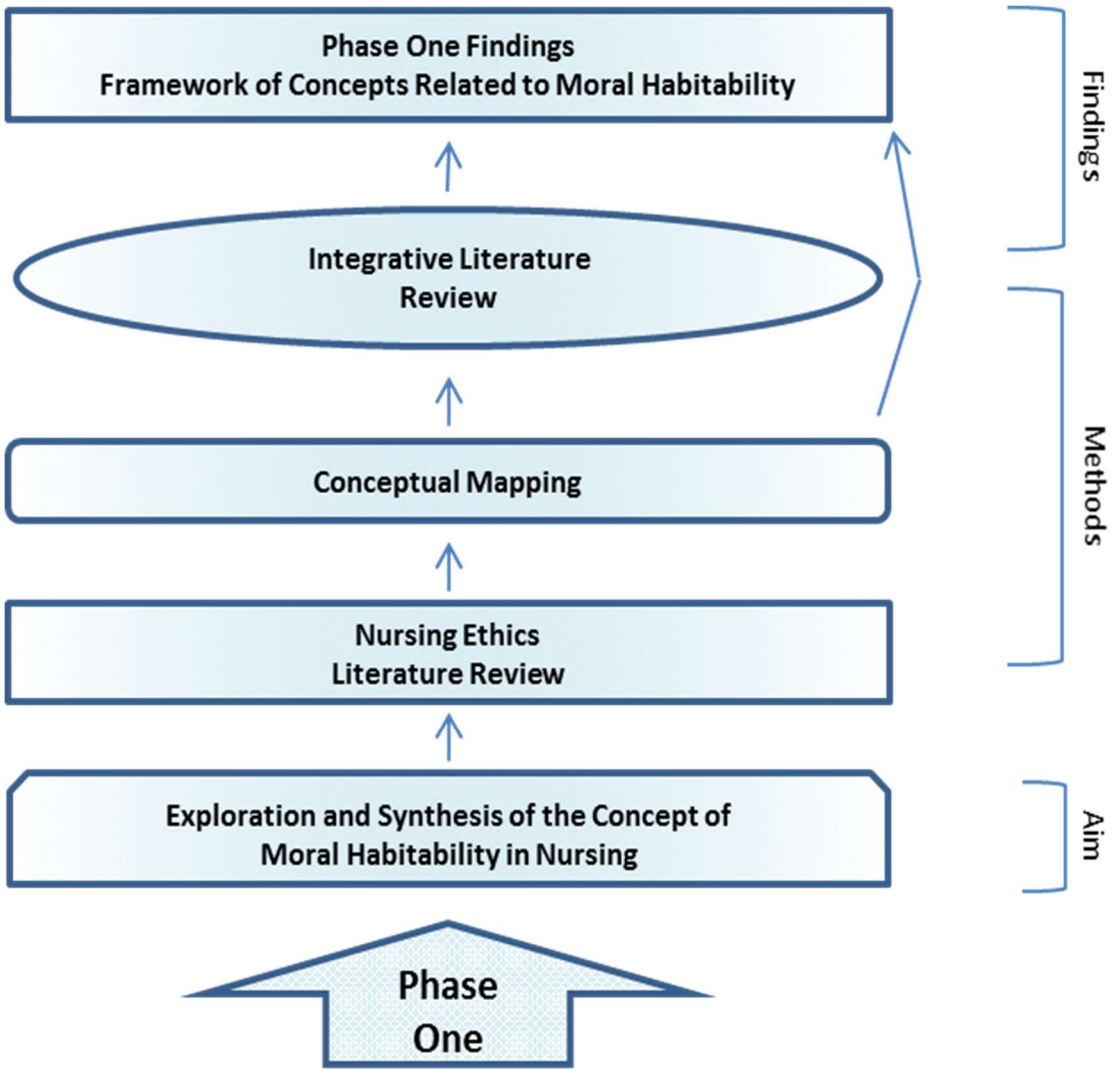
The chapter commences with a comprehensive discussion of the methods used to develop the concept map and integrative literature. This is provided because, while some aspects of the methods used for Phase One are addressed in the publication, the journal guidelines, including a restricted word count, hampered a thorough summary. Following the publication, a framework of the concepts identified to meet the intent of Phase One is outlined and an initial working definition of moral habitability in nursing is presented.

The integrative literature review which informed the Phase Two field component was published in 2013. Therefore, the literature in the publication is related to that timeframe. However, engagement with the literature continued throughout the study. In Chapters Nine and Ten of this thesis, the nursing literature published subsequent to the integrative review is incorporated into the synthesis and discussion of the combined findings of Phase One and Phase Two.

Methods Used for Phase One

As outlined in Chapter Two, in an approach to conceptually explore and synthesise contemporary concepts related to moral habitability in nursing, two methods were utilised. These two methods were concept mapping and an integrative literature review (Figure 4).

Figure 4. Phase One Aim and Methods



Initially a broad review was undertaken of the nursing ethics literature, focused on the moral aspects of the nursing workplace and the social roles and practices of nurses in the

workplace. In considering this focus, the following questions were developed to guide the broad review of the nursing ethics literature:

- What topics related to the moral aspects of the nursing workplace are examined empirically in the nursing ethics literature?
- What topics related to nurses' moral attributes or characteristics are examined empirically in the nursing ethics literature?
- What topics related to the outcomes of moral actions in the nursing workplace are examined empirically in the nursing ethics literature?

  And,

- What topics are generating commentary and opinion in the contemporary nursing ethics literature related to the moral aspects of the nursing workplace and nurses?

While the review focused on the contemporary nursing ethics literature from 1990-2012, seminal papers were also critiqued. This yielded a vast amount of relevant literature, and the use of conceptual mapping strategies offered a means to organise the findings. Next, a rigorous method to explore and create meaning of the disparate literature was employed in the form of an integrative literature review. The process employed for the conceptual mapping of concepts related to moral habitability in nursing and the subsequent integrative literature review is outlined in the publication. Owing to the journal's word limits, a comprehensive account of the concept mapping and integrative review methods in the article was not possible. The following discussion therefore provides supplementary commentary on the methods employed in Phase One.

Concept maps

Concept maps are two-dimensional graphic tools that assist in synthesizing and understanding the relationships between certain phenomena (Ghojazadeh et al., 2014). Novak (1998) introduced conceptual mapping as a strategy to enhance the integration of new knowledge and make it more meaningful. In the nursing literature, concept maps have been used to link theory to practice, particularly in developing critical thinking in nursing students (Chen, Duh, Feng, & Huang, 2011; Lee et al., 2013; Ozturk, Muslu, & Dicle, 2008), as an evaluative or planning tool in the clinical environment (McHugh Schuster, 2012), and also as an aid to the analysis of qualitative data (Thorne, 2016). In the present study, concept mapping techniques were used to organise the findings of the initial broad literature review.

As previously stated, the literature review focused on contemporary nursing ethics literature on nurses' moral practice and practice environments relevant to an understanding of moral habitability in nursing. This approach has been utilised by other researchers. For example, in the nursing literature Garcia-Dia, DiNapoli, Garcia-Ona, Jakubowski, and O'Flaherty (2013) used concept mapping to elicit the characteristics, precursors, consequences and empirical indicators of the concept of resilience as a way of analysing a complex concept which traversed many disciplinary arenas. In the business literature, Papaoikonomou, Ryan, and Valverde (2011) used conceptual mapping as a tool to integrate empirical evidence and guide further research in the area of ethical consumer behaviour, a topic that was new at the time and had complex and disparate literature associated with it. The researchers reviewed over 80 studies to identify trends in the business literature related to the topic that could then be used to guide further research (Papaoikonomou et al., 2011).

In the present study, concept mapping was used because it offered a pragmatic approach within an interpretive descriptive framework to meet the intent of Phase One: a conceptual exploration of moral habitability in nursing.

Two common methods used for conceptual mapping are hierarchical maps, where concepts and attributes are identified and created in descending order of significance (All & Huycke, 2007) and spider maps. Spider maps provide a tiered organisational representation of importance and also highlight the interrelatedness of the concepts and attributes (All & Huycke, 2007). An online concept mapping tool was used to develop a spider concept map of the key concepts related to moral habitability in nursing and this map is presented in Appendix 1 and in the publication. Following the conceptual mapping, the second stage of Phase One, the integrative literature review was undertaken.

Through the process of conceptual mapping using a spider map, a visual representation of the relationships between the concepts that had been identified was achieved. As the literature was analysed, the concept map was reviewed numerous times to further refine the depiction of the links between related concepts. This iterative mapping process allowed the integration of new insights, associations and interrelationships between concepts (All & Huycke, 2007) relevant to moral habitability in nursing. Following the conceptual mapping the second stage of Phase One, the integrative literature review, was undertaken.

Integrative literature reviews

An integrative literature review is a specific method which allows a summary of diverse literature from both empirical and theoretical sources to be developed, and which can then provide a more comprehensive understanding of a certain phenomenon of interest (Whittemore & Knafl, 2005). Integrative literature reviews can assist in building knowledge

which can inform research, practice and healthcare policy (Whittemore & Knafl, 2005). In nursing, this form of review has been used across a wide range of topics (Flinkman et al., 2010; Morgan, Pullon, & McKinlay, 2015; Pentland et al., 2011; Wechkunanukul, Grantham, & Clark, 2017). For example, integrative review methods have been implemented where conceptual development was limited within the discipline, such as Akerjordet and Severinsson's (2010) integrative review of the status of knowledge regarding emotional intelligence in nursing leadership. In Flinkman's (2010) study of nurses' intentions of leaving the profession, the integrative review method was utilised where there was a large empirical base of literature, supported by diverse methodological approaches.

Integrative literature reviews are predominantly used for topics that are highly researched or, as in this study, under-developed and under-researched, and where a "holistic conceptualisation and synthesis of the literature to date" (Torraco, 2005, p. 357) offers a new perception of the topic. The resultant conceptualisation can then be used for the subsequent refinement of a research design (Torraco, 2005). Cooper, a foundational and dominant author in regards to literature reviews, provides support for the use of this approach:

> Integrative reviews summarise past research by drawing overall conclusions from many separate studies that are believed to address *related* or identical hypotheses. The integrative reviewer hopes to present the state of knowledge concerning the relation(s) of interest and to highlight important issues research has left unresolved (Cooper, 1989, p. 13).

Through the process of reviewing, critiquing and synthesising related or representative literature, a new perspective can be gained (Torraco, 2005). In the present study, the

conceptual map of the contemporary state of the concepts in the nursing ethics literature relevant to moral habitability in nursing was used as a framework to guide the integrative review. This provided a practical approach to managing a large amount of relevant literature. Through the process of exploratory engagement that focused on concepts related to moral habitability in the nursing literature, papers were examined, excluded or retained. This narrowed the scope of the integrative literature review to a practical summary of disparate, yet linked, studies related to the concept. Specific parameters were developed to guide the selection of papers which were included and these are outlined extensively in the publication. This approach is consistent with Pentland et al.'s (2011) study of the key characteristics of knowledge transfer and exchange in healthcare, where they focused on the central literature relevant to the phenomenon under investigation, thereby yielding a vast amount of relevant literature.

While they have been cited over many decades as a valuable way to enhance disciplinary knowledge development (Aburn, Gott, & Hoare, 2016; Cooper, 1989; Kirkevold, 1997), integrative literature reviews are not without critiques. For example, the complexities of combining disparate, related or methodologically different studies highlights questions of rigour (Michael & Della, 2012). Phase One of this study was specifically designed to do "research of research" (Michael & Della, 2012, p.37) through conceptual exploration and therefore must meet the benchmarks of rigour, just as primary research must. To address rigour in the conduct of the integrative review of moral habitability in nursing, Whittlemore and Knafl's (2005) systematic approach was applied, and this is outlined in the following publication. This approach has been widely adopted by nursing researchers as a means to

ensure that integrative literature reviews present a rigorous representation of the concept under investigation (Aburn et al., 2016; Anthony & Jack, 2009).

Publication - Understanding Moral Habitability: A Framework to Enhance Quality of the Clinical Environment as a Workplace

Note: In the following publication the terms 'Phase 1' and 'Phase 2' were used as a means to demonstrate the process used to develop the integrative literature review. In the thesis, Phase One and Phase Two are related to the overall design of the project. The following publication presents the overall process and findings of *Phase One* of this research study.

Permission to use this paper was sought from the journal Contemporary Nurse and was approved subject to providing the following acknowledgement:

This is derived in part from an article published in Contemporary Nurse in August 2013 available online: http://www.tandfonline.com/10.5172/conu.2013.45.1.101

 Contemporary Nurse (2013) **45**(1): 101–113.

Understanding moral habitability: A framework to enhance the quality of the clinical environment as a workplace

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Abstract: *There is compelling evidence in the nursing literature that the workplace is experienced as morally uninhabitable for many nurses and yet the concept of moral habitability remains underdeveloped. An integrative review on moral habitability in nursing was undertaken. The findings reveal that the primary concepts by which nurses write and research aspects of moral habitability are moral climate, moral agency, moral sensitivity and moral distress. It is revealed that nurses in their clinical work experience adversity and moral distress through relational challenges and contextual difficulties that can challenge habitability and inhibit nurses' capacity to provide morally sensitive patient care. The primary concepts identified provide a framework for further development of the concept of moral habitability within nursing practice. The related data within the integrative review also highlights the need for further research into enhancing and sustaining morally habitable workplaces for nurses.*

Keywords: moral habitability, moral/ethical climate, nursing workforce, concept map, integrative review

The clinical workplace is demanding and at times a damaging work environment (Cline, Reilly, & Moore, 2003; Jackson, Firtko, & Edenborough, 2007). Nurses experience adversity through organisational constraints, reduction in staff ratios, escalating workloads, and where patient acuity is increasing (Jackson et al., 2007). This has an effect on the quality of patient care (Edward & Hercelinskyj, 2007) which can be further eroded by challenges such as abuse from patients and bullying from colleagues (Vessey, DeMarco, Gaffney, & Budin, 2009). In response to workplace adversity an emergent body of nursing ethics research focuses on links between the burden of difficult workplace environments and moral complexities of the everyday practice of nurses (Rodney et al., 2002; Storch et al., 2009b). These environments can be detrimental for both nurses and patients with research findings suggesting workplace adversity can lead to an exacerbation of moral distress (Austin, 2012; Pauly, Varcoe, Storch, & Newton, 2009), burnout (Edward & Hercelinskyj, 2007), increased staff turnover (Strachota, Normandin, O'Brien, Clary, & Krukow, 2003) and poor patient care (Cavaliere, Daly, Dowling, & Montgomery, 2010). In a large Canadian study researchers concluded that the adversity nurses experience in their workplaces made some environments '*morally uninhabitable*' (Peter, Macfarlane, & O'Brien-Pallas, 2004).

While understanding the moral dimensions of the workplace is intuitively important, simply declaring an environment 'uninhabitable' is problematic. Some nurses will have no choice but to inhabit these environments and either suffer adverse effects, or adapt through inhibiting their capacity to provide morally sensitive patient care (Peter et al., 2004). Alternatively, they may leave the workplace environment all together (Ulrich et al., 2007).

Conversely, enhancing or sustaining an environment's habitability is important because habitable environments may affect the shaping of the moral identity of participants (Hardingham, 2004; Laabs, 2011). Nurses' moral actions and moral identity influence care choices. It is also important to focus on the habitability of the environment as it may influence the ability to maintain a consistent workforce. Despite the evidence that many nurses experience the workplace as morally uninhabitable, this concept remains underdeveloped.

Conceptualising moral habitability

The term 'moral habitability' was first used in the nursing literature in a study by Peter et al. (2004) that described a large study examining the impact of Canadian working environments on nurses. Though the original study was not conducted with a moral lens, the researchers found

the data and implications were significantly moral in nature. A secondary analysis drawing on the work of Margaret Urban Walker (1998), a feminist ethical theorist, was conducted.

Walker locates moral epistemology in human social life and believes that morality exists in practices of responsibility which implement commonly shared understandings about which role is accountable for which task (Peter & Liaschenko, 2003). In this view morality is not socially modular – not a dimension somehow separate from other shared features of everyday life. In a healthcare environment under pressure, this construct is important as problems can be identified as practical rather than moral. Peter et al. (2004) suggest that using this theoretical perspective makes it imperative that moral–social orders in the work environment are made overt and scrutinised for moral habitability. The authors define moral habitability as:

> those [environments] in which differently situated people experience their responsibilities as intelligible and coherent. They also foster recognition, cooperation and shared benefits. (p. 358)

The relational nature of the moral–social workplace influenced by Walker has, in the last decade, been reflected in the literature through opinion papers purporting the notion of a 'moral community' where mechanisms are instigated to enhance interaction between members of the community to influence better moral practice (Austin, 2007; Hardingham, 2004). While the theoretical influence of Walker supports the proposition of developing 'moral communities' it does not capture the diversity needed for application in a nursing context. While it is important to address the relationships between workers, for a broader understanding of moral habitability the focus should also be on the individual participant within the environment, their capacity to adapt and how the environment itself impinges upon the individual.

Aims and objectives

The aim of this literature review is to provide conceptual understanding of moral habitability in nursing workplace environments and offer a framework for future research.

Specifically, this integrative literature review aims to:

(1) Identify the contemporary use of the concept of moral habitability in the nursing literature;
(2) Review literature related to the broader concept of moral habitability in nursing; and
(3) Synthesise this literature to a general position as a platform for future nursing research.

Method

As there is sparse specific research and commentary based on the term 'moral habitability', a method combining disparate studies was needed. A two-phased approach was implemented. In the first phase results from a broad search for concepts related to 'moral habitability' were used to develop a concept map (concepts were contemporary and empirically supported rather than opinion or commentary). In the second phase the concepts were used as a framework to inform an integrative review.

Phase 1 – development of the concept map

Concept maps are tools that assist in synthesising the relationships between certain phenomena. An online mapping tool was used to facilitate the development of a concept map related to moral habitability (Figure 1), and the links refined as the literature was analysed. This serial mapping process assisted in the integration of new knowledge and critical review of the organisational boundaries (All & Huycke, 2007).

The moral habitability concept map identifies concepts that have been established in the nursing literature. These concepts are represented in domains that are shaded (Figure 1) to depict the level of association with the overarching topic. In the first level there are four key domains; moral climate, moral agency, moral distress and moral sensitivity. Each of these domains has a recent or emergent body of nursing research and discussion papers associated with a specific concept. These concepts are directly relatable to the nature of the nursing workplace (moral climate) and the social roles and practices of nurses (moral agency, moral distress and moral sensitivity) within these workplaces, key components of Peter et al. (2004) description of moral habitability.

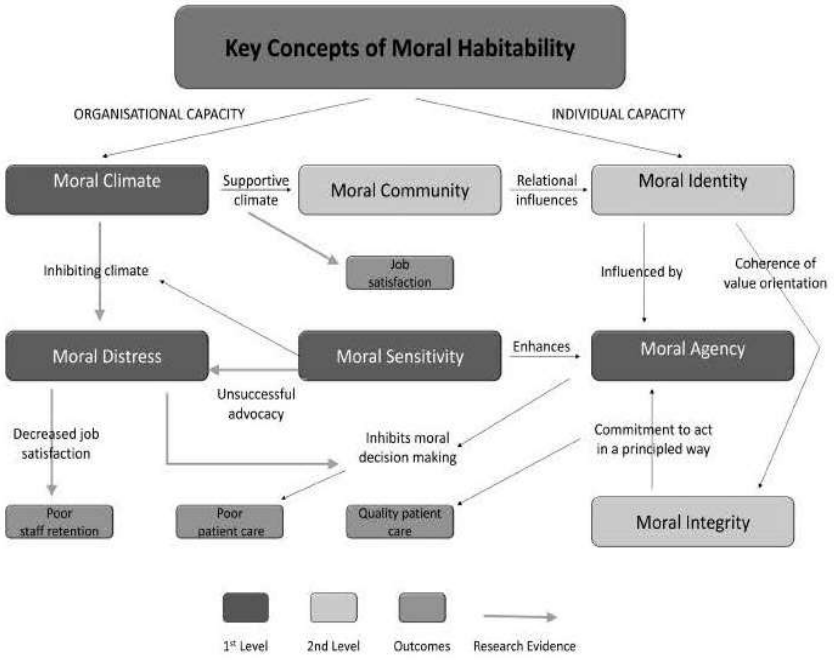

FIGURE 1: CONCEPT MAP OF MORAL HABITABILITY

The second level depicts relevant concepts that are associated with the first level domains. The nursing literature in this level is more opinion based, descriptive or theoretical. The second level domain consists of the concepts of moral community, moral identity and moral integrity. Relationship lines have been used to indicate the interrelationships between each domain. The nature of the relationship has been annotated to provide an explanation of the link. Some links have been further delineated with colour and directional arrows to represent association with research evidence. Finally, the outcomes of the interrelationships have been illustrated as end examples which are positive, related to quality patient care or negative, such as poor retention of staff and poor patient care. The use of this technique provided a 'visual representation of a unique perspective of the concept' (All & Huycke, 2007, p. 219) of moral habitability.

Phase 2 – process for the integrative review

In approaching a broad review of the literature of the conceptual ideas that are likely to be associated and/or related to moral habitability, a potential problem of a lack of analytic rigour needed to be addressed. Work by Whittlemore and Knafl (2005) was used to improve rigour and guide the review. They highlight that complexity in combining work from diverse empirical and theoretical perspectives can result in bias and an inaccurate summation of the phenomenon under review and suggest ways to counter this possibility. Their revised approach to integrative review has been adopted by many recent authors (Anthony & Jack, 2009; Pentland et al., 2011).

Based on the Whittlemore and Knafl (2005) systematic framework for integrative reviews, the relevant strategies that were adopted for this review are presented in Table 1.

Identification of literature

The reviewing of such diverse literature revealed some concepts had extensive literature bases while others were just emerging. Through the process of exploratory engagement, it was possible to identify relevance to the nursing environment and moral/ethical climate as an inclusion criterion (Pentland et al., 2011). The following

Table 1: Strategies to enhance rigour in an integrative review of the concept moral habitability

Stage	Strategy	Adaptation
Problem identification	Well specified review source from an explicit philosophical or theoretical perspective Kirkevold (1997)	Review source established through an initial literature search identifying the key concepts of an underdeveloped concept 'moral habitability' and subsequent concept mapping to develop a theoretical *guidance* framework for the review
Literature search	Difficulty in combining diverse methodologies can detract from the rigour of the review. To address publication bias, expect a success rate of only 50% by data base, thus need wider search strategies and clear documentation of inclusion and exclusion data	Search strategies based on key words from the primary concepts associated with the concept map. Primary databases used were Medline and CINAHL. Inclusion and exclusion criteria: • Peer reviewed articles • English language only • Published from 1990–2012 • Seminal papers if pre 1990 • Systematic reviews, qualitative and quantitative research and highly cited opinion papers Concepts used were directly relatable to the nature of the nursing workplace (moral climate) and the social roles and practices of nurses (moral sensitivity, moral distress and moral agency) within these workplaces. Based on initial searches and to refine the search of extensive literature a further inclusion criteria: • Research relevant to the concept of 'ethical/moral climate'
Data evaluation and quality appraisal	Assessing quality is complex; evaluate using historical research technique and theory analysis/ critique	Diverse research designs, weaknesses in design and theoretical perspectives, and the inclusion of opinion papers made the process of narrow quality scoring not possible. As focus of this review was broad and included range of wider sources the focus of the data was based on highly cited papers and the relevance to the overarching concept of ethical/moral climate
Data analysis and synthesis	Constant comparative method using an iterative process to see themes, patterns and relationships. Avoid premature analytic when drawing conclusions. Keep record throughout the process of hunches and puzzles	Data extracted from key conceptual areas and descriptive and methodological information summarised. Within each concept patterns were recorded as they emerged. Through comparative analysis of each of the concepts in regards to ethical climate, themes emerged
Presentation	Conclusions reported diagrammatically. Include details of primary sources, logical chains of evidence and methodological limitations	These have been utilised within this review

terms were used to search the Medline and CINAHL data bases supplemented by a manual search of references in papers that were included: ethical/moral climate combined with ethical/moral agency; ethical/moral distress; and, ethical/moral sensitivity. The literature was limited to only those papers that were relevant to nursing.

Search outcome and data abstraction

The results of the search process using the strategy outlined in Table 1 returned the following number of abstracts for review (Table 2).

Each of the concepts was initially reviewed for highly cited papers[1] to identify the state of the current

[1] Refers to highly cited papers that were reviewed.

Table 2: Literature search results

Search term	Database results	Combined with search 1	Manual search	Total
1 Moral/ ethical climate	136 (48)	–		
2 Moral/ ethical agency	1046 (37)	19	8	27
3 Moral/ ethical sensitivity	645 (55)	19	4	23
4 Moral/ ethical distress	239 (29)	12	14	26

nursing literature and to assist refinement of the concept map. Kirkevold's (1997) quality appraisal was then applied through a focus on representativeness of the contemporary nursing literature of each concept, and methodological and informative quality in relation to moral/ethical climate. Some papers referred to more than one parameter, for example: moral distress/moral sensitivity/moral climate (Lutzen, Blom, Ewalds-Kvist, & Winch, 2010).

Summary of results

The contemporary use of the term 'moral habitability' as a keyword in a title search within the nursing literature yielded only the Peter et al. (2004) paper. However, in the last 5 years that paper has been cited in 38 articles directly addressing topics that are related to the moral dimensions of work environments and the participants' actions and challenges within those environments. In situating the moral agent inhabiting this environment, the literature was reflected in conceptual mapping of moral agency and the agent's capacity for ethical sensitivity. Moral distress, as a consequence of the agent working within the environment, is a significant topic within the literature and viewed as a primary concept within the conceptual mapping process.

The environment – moral/ethical climate theory

Research into ethical climate developed as an empirical consequence to exposure of companies that have demonstrated unethical practices (Martin & Cullen, 2006). However, the impetus for ethical climate research is wider than just a retrospective response to dysfunctional practices. Gaining a deeper understanding of the influences of an organisation's *ethical* procedures, policies, and practices, rather than relying on overt public displays of espoused ethical codes and vision statements, can also have consequences for managerial practices, worker commitment and satisfaction and worker wellbeing.

In the late 1980s, Victor and Cullen (1988) introduced a theoretical framework and subsequent tool to describe five different types of ethical climates. This work is currently the most widely used and accepted measure of ethical climate and has been used in diverse disciplinary areas such as business, education and healthcare (Martin & Cullen, 2006).

Cullen, Victor, and Stephens (1989) focussed on providing a diagnostic tool that could be used by managers to implement strategies to mitigate risk of unethical behaviour within organisations. Consequent research findings identified affective outcomes in regard to employees' experience of their work within an organisation related to commitment to the organisation, job satisfaction, psychological well-being and a negative outcome of dysfunctional behaviour (Martin & Cullen, 2006). Affective outcomes hold particular resonance to healthcare organisations and the nursing profession where the nature of healthcare provision requires a focus on ethical decision-making and where the recruitment and retention of nursing staff remain ongoing issues.

Healthcare interest in ethical climate is a more recent phenomenon emerging in the nursing literature in the 1990s. Influenced by the findings from the business literature and in response to health workforce issues, relationships between ethical climate and job satisfaction (Goldman & Tabak, 2010; Hart, 2005) and, decision making and organisational commitment (Memarian, Salsali, Vanaki, Ahmadi, & Hajizadeh, 2007) have emerged. Other areas of correlational ethical climate research include the relationship with moral distress (Hamric & Blackhall, 2007) and ethical sensitivity (Lutzen et al., 2010).

Moral/ethical climate and moral agency

Ethical behaviour is the action result of the process of reasoning and making ethical decisions

(Goethals, Gastmans, & Dierckx de Casterle, 2010). The overall ability to make moral judgements and then act on those judgements can be referred to as moral agency. Peter and Liaschenko (2004) define moral agency as 'the capacity to recognise, deliberate/reflect on, and act on moral responsibilities' (p. 221). Both the individual nurses' values sets, knowledge, experience, relationships and, the context within where they practice influence their ethical practice (Dierckx de Casterle, Zumi, Godfrey, & Denhaerynck, 2008).

There is significant Canadian work regarding ethical practice and workplace influences (Hartrick Doane, Storch, & Pauly, 2009; Peter & Liaschenko, 2004; Storch et al., 2009a). A large qualitative study into ethical practice in nursing across four areas of Western Canada found enacting moral agency required working 'in-between their own identities and values and those of the organisations in which they worked' (Varcoe et al., 2004, p. 317). Participants often discussed grand narratives depicting the ideal nurse with conflicting values with the organisation causing tension. The ethical difficulties described issues with physicians, scarce resources, a context where a biomedical perspective is privileged, and lack of consistent good leadership. Varcoe et al. (2004) call for a shift from distant disengaged ethical approaches to contextual realities of nurses' moral experiences of practice.

While many researchers focus on the environmental factors that influence ethical practice (Ham, 2004; Hartrick Doane et al., 2009) specific links between ethical climate and ethical behaviour appear to be absent from the literature. In a study of ethical climate and teamwork in an acute care setting, Rathert and Fleming (2008) found that a benevolent ethical climate, a type of climate described by Victor and Cullen (1988), enhanced teamwork, implying that ethical behaviour would be influenced.

Austin (2007) in an opinion piece on everyday ethics reflected on the interaction of all players in a 'moral community' rather than ethical decision making. Austin and other authors (Hardingham, 2004; Thompson, 2003) believe that the dominance of a medical view in the development of bioethics has not provided a satisfactory theoretical analysis for addressing everyday issues facing practitioners. The notion of practice settings as moral communities is addressed by Hardingham (2004) who believes that the development of moral integrity is relational and deeply affected by the community where the person practices. Other authors (Peter, 2003; Thompson, 2003) cite power, social status, legislation and cultural institutions related to healthcare colleagues as being barriers to effective moral decision making and cite Walker (1998) in the urgent need to re-theorise an ethical perspective for healthcare.

Despite the plethora of research addressing the factors that influence nurses' ethical reasoning and behaviour, it is also reported as being challenged by a 'lack of clear conceptualisation and operationalisation of the terms "ethical reasoning" and "ethical behaviour"' (Goethals et al., 2010, p. 648). The outcome of difficulties in ethical decision making and the constraints of ethical climates that inhibit moral agency have been reported as contributing to moral distress.

Moral/ethical climate and moral distress

Ethical climate research in nursing has been studied with the concept of moral distress in an attempt to establish links between organisational ethical environments and moral outcomes for the individual (Corley, Minick, Elswick, & Jacobs, 2005; Lutzen & Ewalds-Kvist, 2012; Pauly et al., 2009). While the concept of moral distress has generated a lot of attention in the international nursing literature (Hamric, 2012) there is critique as to whether the concept is at best an 'umbrella term' to capture experiences by nurses in complex healthcare environments and has been used by nursing researchers to support claims for poor work conditions (McCarthy & Deady, 2008).

The concept of moral distress was first described by Jameton (1984), who categorised three types of ethical problems: moral distress; moral uncertainty; and moral dilemma. The category of moral distress was used to distinguish it from the concept of moral stress. Moral distress in Jameton's view is more profound, where the state

is described as a painful psychological imbalance when nurses are constrained to act accordingly and which can have lasting effects.

However, the delineation of moral distress and moral stress is not always evident in the literature and at times the term is used synonymously. In a synthesis of the concept of moral stress, Lutzen et al. (2010) include the notion of 'moral sensitivity' to the patient's vulnerability as being a component of moral stress. Lutzen and Ewalds-Kvist (2012) suggest a delineation of moral distress, which results in negative consequences, from moral stress, which can result in positive consequences.

Wilkinson (1988) substantiated Jameton's initial work through an exploration of the phenomenon of moral distress experienced by staff nurses in many clinical contexts. During the initial interview process of 24 nurses she identified that 11 were now not working in a staff nurse's role due in part to moral distress (1988). Wilkinson (1988) proposed that feelings of anger, anxiety and frustration coupled with ineffective coping mechanisms, could lead to poor quality patient care and possibly leaving the profession of nursing. Interestingly, while this is consistent with some of the outcomes associated with the nursing literature on 'burnout' (Severinsson, 2008; Sundin-Huard & Fahy, 2002) the differentiation remains underdeveloped despite claims that moral distress contributes to burnout (Meltzer & Huckabay, 2004; Pendry, 2007).

Like the consequences attributed to the concept of burnout, it is not surprising that there has been significant growth in both theoretical development and empirical studies regarding the phenomenon of moral distress. After the seminal work by Jameton (1984) and Wilkinson (1988), initial research focussed on nurses in acute settings using qualitative methodologies (Corley, 1995). Corley, Elswick, Gorman, and Clor (2001) then attempted to develop and evaluate a moral distress scale that has subsequently been used in many studies to measure the level of moral distress in nurses. The Corley et al. (2001) moral distress scale uses a questionnaire that proposes moral issues in everyday work in a critical care environment and a Likert scale from 0–7 that measures intensity of the nurses' distress. This scale has been used in multiple contexts and subsequently a range of mixed method approaches to moral distress research has arisen.

Nursing research into moral distress has been focussed on areas of culture and context. In a study by Ohnishi et al. (2010) the researchers used the Corley et al. (2001) tool to develop a scale for use in the context of Japanese psychiatric nursing. Further items were added to Corley's initial 32 questions based on a literature review specific to the psychiatric context. Their study found a relatively low level of moral distress in the specific context of Japanese psychiatric nurses. While the Corley et al. (2001) tool was developed with a focus on nurses in acute settings, other tools have been modified to address the needs of different disciplinary groups (Sporrong, Hoglund, & Arnetz, 2006), different cultural groups (Eizenberg, Desivilya, & Hirschfield, 2009) and to measure intensity and duration of the stress experienced (Hanna, 2004). Another focus is on specific groups. Kelly's (1998) qualitative research explored the preservation of moral integrity in new graduate nurses once they were in the 'real world' of hospital nursing. She identified that one consequence of this adaptive process may be moral distress (Kelly, 1998).

Despite the interest in moral distress, there appears to be a lack of critique and conceptual clarity (McCarthy & Deady, 2008). Commentary regarding the lack of critique and need for moral distress conceptualisation has been raised by other authors who suggest that it has been used by some nursing researchers to support a discourse of 'whinging' about nursing issues of medical oppression (Paley, 2004), or as a mask for nursing's discomfort with moral subjectivity (Repenshek, 2009).

Although the criticism for the concept of moral distress needs further consideration, the outcomes attributed to this phenomenon such as a lack of job satisfaction leading to leaving the profession and unsafe patient care warrants more work (Schluter, Winch, Holzhauser, & Henderson, 2008). Nurses practice within an organisation. The 'moral climate' of a health care

organisation has been defined by Rodney, Doane, Storch, and Varcoe (2006) as the implicit and explicit values that shape the care delivery. When an organisational environment is deemed 'ethical', the values that are explicit are in coherence with the participants (Webster & Baylis, 2000). Another view of an ethical environment is of a 'moral community' which has been defined as a place where values direct action, are clear, shared and a place where individuals feel safe to be heard (Storch, 2007). Moral distress has been attributed to a mismatch of values between the participants and the organisation or of organisational constraints that interfere with enactment of values (Zuzelo, 2007). It is therefore not unexpected that research into organisational ethical climate and moral distress has increased over the last decade.

As part of a broader Canadian study into nurses' workplaces Pauly et al. (2009) used the moral distress scale (Corley et al., 2005) and hospital ethical climate survey (Olson, 1998) to gain insight into British Columbian nurses' perceptions of ethical climate and moral distress. The small sample and poor response rate (22%) hindered the generalisability of the findings however, there was a correlation between more ethical climates and less intense experiences of moral distress. Further research is needed into how ethical climates can be enhanced to lessen moral distress.

Literature regarding moral distress has been mainly in the context of critical care nursing and end of life (Austin, Kelecevic, Goble, & Mekechuk, 2009; Hamric & Blackhall, 2007). Hamric and Blackhall (2007) explored this context in conjunction with physician/nurse collaboration, moral distress and ethical climate during care episodes of dying patients using a number of existing surveys (Corley et al., 2001; Olson, 1998) modified for multidisciplinary use. Their multi-site study found that medical staff perceived their ethical environment as more positive, had less incidences of moral distress and were generally satisfied with collaboration between the two professional groups compared to nursing staff (Hamric & Blackhall, 2007). Interestingly, the significance of moral distress when correlated with ethical climate varied in both sites with one negatively associated and the other with no significance.

In a systemic literature review, Schluter et al. (2008) examined the relationship between decision-making, the moral distress that occurs when moral action is confounded by an inability to act, and the subsequent lack of recognition in the literature of how this affects nursing staff turnover. They concluded that as there is a suggested relationship between moral distress and staff turnover, further rigorous empirical research is needed. However, they fail to make explicit how moral sensitivity, as suggested in the title, relates to moral distress. Nevertheless, the authors recommend further examination of ethical climate and moral sensitivity in nurses in acute settings.

Moral/ethical climate and ethical sensitivity

A study that explicitly linked ethical climate with moral stress and ethical sensitivity was conducted by Lutzen et al. (2010) in the context of psychiatric professionals. Acknowledging the epistemological problems related to the concept of 'moral sensitivity' a conceptual framework of moral stress, moral climate and moral sensitivity were presented as the interactive process of moral agency. It was established in this small study that moral stress could be predicted by moral climate and/or by moral sensitivity.

The term moral sensitivity was described by Rest (1982), a psychologist, in an effort to conceptualise and empirically study a behaviour or ability to 'interpret … a situation by perceiving the potential influence of one's action on the welfare of others' (Rest, 1982, p. 31). Soon after, the use of the term 'ethical sensitivity' replaced 'moral sensitivity'. This was to be consistent with professional use of the term 'ethical' for example, 'where conduct may be guided by 'ethical' codes' (Bebeau, Rest, & Yamoor, 1985, p. 227). However, since the modern inception of the term, both 'moral sensitivity' (Lutzen, Dahlqvist, Eriksson, & Norberg, 2006) and 'ethical sensitivity' (Kim, Park, You, Seo, & Han, 2005) continue to be used with multiple definitions (Weaver, 2007), and tools (Begat et al., 2004; Comrie,

2012; Kim et al., 2005) across a number of health professions (Lutzen, Johansson, & Nordstrom, 2000). To address the variety of definitions and inconsistent use of the term Weaver, Morse, and Mitcham (2008) conducted a concept analysis.

In essence the concept of ethical or moral sensitivity relates to a person's ability to recognise the morally relevant aspects of a situation. Among nursing professionals, this recognition leads to the appropriate interpretation of the needs of those receiving care and subsequent response to those needs (Weaver et al., 2008). Weaver et al. (2008) describe ethical sensitivity as a type of 'practical wisdom' that can be used and developed by the professional to promote quality care. Their concept analysis resulted in a synthesised definition for the nursing profession:

> Ethical sensitivity is the capacity to decide with intelligence and compassion, given uncertainty in a care situation, drawing as needed on a critical understanding of codes for ethical conduct, clinical experience, academic learning and self knowledge, with an additional ability to anticipate the consequences and the courage to act (p. 610).

This definition reveals a number of components of the concept that could be developed by the professional such as academic knowledge and reflective critique of practice. The outcomes of developing ethical sensitivity included, preservation of integrity, growth, well-being and 'practical wisdom', for the professional, and patient care that is focussed on their needs. However, if care is not focussed on the patient's needs, the professional may experience dissatisfaction and moral distress with the potential to leaving the profession (Weaver et al., 2008).

Lutzen and colleagues conducted a study to further develop the concept of moral sensitivity in health care practice (Lutzen et al., 2006). The moral sensitivity questionnaire developed by Lutzen and Norden (1994) for use in psychiatric practice, was modified for developing a tool for health care professionals in various contexts. They highlighted the complexity of the concept as not only the cognitive capacity to 'distinguishing between facts, feelings and values' (p. 189) but also the need for a preconditioned moral motivation which for nurses is 'to care'(p. 189).

Lutzen et al. (2006) separate ethical and moral sensitivity by attributing ethical sensitivity to knowledge of theory and principles and the latter being related to relational aspects. The three primary factors identified by their analysis were a sense of moral burden, moral strength and moral responsibility. Moral burden was likened to moral stress and as in the Weaver et al. constructs (Weaver et al., 2008), a negative dimension that can be attributed to sensitivity. They question whether the factor of moral burden may actually be a positive aspect that is a prompt for moral action, rather than a negative problem to be avoided.

A comparative sociocultural study between an Eastern culture (Japan), and Western culture (Norway), was undertaken by Begat et al. (2004) into the relationship between perceptions of work environment and moral sensitivity. The results demonstrated a strong correlation between the work environment and the nurses' moral sensitivity in regards to moral stress that is experienced due to work place issues. There was a significant correlation 'between "physical and mental symptoms" and "moral conflicts" among the Norwegian nurses' (p. 193). This study's focus on the difficulty in enacting moral values through work environment constraints aligns with previously proposed consequences of a non supportive ethical climate.

In view of the positive outcomes proposed by Weaver et al. (2008) of either enhanced patient led care or the converse of professional dissatisfaction or moral stress which may result in leaving the profession, recent research has linked the individual component of ethical sensitivity to the organisational component of ethical climate. As in Lutzen et al. (2010) study with psychiatric professionals identified, there is an emerging empirical evidence to support the need for more research by questioning the link of context, agency and sensitivity.

Discussion

The concept of moral habitability is emergent, significant and previously undefined in nursing research. Understanding the habitability of an environment requires understanding both the environment and dimensions of the participants within that environment. Morally

habitable environments exist where there is shared understanding about differing levels of responsibility and shared cooperation, recognition and benefits (Peter et al., 2004). To understand this concept, both the values of the organisational environment and the participants that practice within it must be understood. While there is substantial nursing research that provides an insight into how nurses morally inhabit the clinical environment, there is a lack of robust evidence and conceptualisation to enable further understanding and research.

This review focussed on identifying the key influences and implications within each construct, identified through conceptual mapping, linked to a broader understanding of moral habitability. Ethical/moral climate was identified as having a direct relationship to the work environment that nurses inhabit. Although the impact of organisational ethical climate has been demonstrated in the business literature to influence behaviour and decision making of participants within that environment, it is underdeveloped in the nursing literature. Ethical climate is increasingly being linked to negative outcomes such as reduced job satisfaction and turnover (Hart, 2005; Shirey, 2005; Ulrich et al., 2007), however the impact of nurses' workplaces on nurses' understanding of responsibility, behaviour and decision making remains unsubstantiated. Some authors have suggested that nurses are working 'in between' the values of the organisation and their own values (Varcoe et al., 2004) but more understanding of how nurses successfully negotiate this is imperative since nurses are central to the delivery of care.

The increasing interest in the concept of moral distress needs more empirical support. A more robust identification of the antecedents and implications for patient care of this phenomenon is important as it will influence whether nurses can successfully negotiate their moral understandings and responsibilities. An integral component of nurses' moral understandings is in the 'recognition of the moral dimension of the care situation' (Weaver, 2007, p. 151) described as ethical sensitivity. Issues that are related to this construct include different definitions and an assumption that it is a positive quality. This construct is focussed on capacity of the individual nurses to successfully negotiate their environment. As the potential for increased levels of moral distress in difficult ethical climates has been attributed to a heightened sense of ethical sensitivity, it warrants further understanding.

Moral habitability and workplace adversity

The adverse workplace effects of practising within a complex social–moral clinical environment are evident and have been empirically demonstrated in many countries. As revealed by this review, the influence of ethical climate, ethical sensitivity and moral distress have been linked to adverse outcomes including burnout, job dissatisfaction and poor patient care. This reflects a growing concern for the moral dimension of workplace adversity. There is an implicit need to understand more about the environment and how workers can inhabit and adapt within this environment to minimise adverse effects.

Implications for nursing research

The current healthcare environment is demanding. This review demonstrates a growth in the field of nursing research linking moral climate with moral aspects of the nurses that practise within it. This review has highlighted areas that lack definition (ethical sensitivity), remain under tested or have ambiguous findings (moral agency and moral distress). There is a need for further research that focuses on the enactment of moral agency within different clinical contexts, with much of the current literature focussed on speciality areas and acute settings where nurses practise. There is also a need for further conceptual studies associated with the moral habitability of nurses and other health professionals particularly in light of adversity within workplaces.

Limitations of the review

A challenge in presenting this integrative review was the sparse specific research based on the term 'moral habitability' and, the ambiguous use of the nomenclature related to the

identified concepts. This has implications for the conceptual framing because moral habitability is untested. In light of the researcher's knowledge of the concepts under investigation and an intuitive sense of identification of the relevant literature associated with the emergent phenomena, this review forms the basis of early work into the moral habitability of nurses.

Conclusion

There is a need for a broader understanding of moral habitability within the clinical environments in which nurses' practise. Conceptually mapping and synthesising the literature related to moral habitability suggests a focus that encompasses the environment, individual participant within the environment, their capacity to adapt and how the environment impinges upon the individual. This provides a framework for future research to explore how workers within a stressed workplace can most successfully inhabit their environment.

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Key Findings of Phase One

The use of conceptual mapping and integrative literature review in the study of an under-developed conceptual field meant that disparate and representative literature related to moral habitability in nursing could be identified. As discussed in the publication, the concept map categorised both the primary and secondary domains of concepts relevant to moral habitability in nursing.

Primary and secondary domain concepts identified in the concept map

The primary domain concepts of moral climate, moral agency, moral sensitivity and moral distress, are directly relatable to the nursing workplace and the social roles and practices of nurses within these workplaces. They are also highly relevant due to the empirical nature of the literature base and were used for the integrative literature review.

The secondary domain concepts were not as prevalent or empirically supported at the time of the integrative literature review and were based on opinion and commentary. The secondary domain concepts identified in the broad nursing ethics literature review and subsequent conceptual mapping are moral integrity, moral identity, moral community and moral satisfaction. However, these concepts are also highly relevant to moral habitability in nursing, as they reflect the contemporary nursing dialogue centred on the moral aspects of nursing practitioners and the nursing environment. Therefore, in meeting the intent of Phase One through exploration and synthesis of the concepts relevant to moral habitability in nursing, both of these conceptual domains were considered.

The primary domain concepts were addressed in the publication. The secondary domain concepts, while not used in the published integrative literature review, are interrelated with

the primary concepts and therefore influenced the final framework for Phase Two of the study. The following brief discussion of the secondary concepts highlights the key components of these concepts relevant to the findings of Phase One of this study.

Moral identity and moral integrity

While there is a significant amount of literature in other disciplines related to moral identity (Aquino & Reed, 2002; Hardy & Carlo, 2005; Xu & Ma, 2015), in the nursing ethics literature at the time of the review, there was comparatively little which focused primarily on this aspect of moral practice. However, moral identity is an important concept with regard to an exploration of moral habitability because moral identity is closely linked to the enactment of moral agency in nursing practice and the context of practice (Doane, 2002; Peter & Liaschenko, 2013).

Moral identity is also linked to another primary concept, that of moral distress (Pauly et al., 2009). Central to an understanding of moral identity are coherence to values, beliefs and attitudes that influence and account for moral decision-making and therefore moral agency (Doane, 2002). The nursing literature predominantly described moral identity as a situated, dynamic and socially constructed (Doane, 2002; B. Kelly, 1998; Peter & Liaschenko, 2013) rather than as a rigid position of a set of personal values that are universally applied to any situation.

In a well-cited paper reviewing data from nurses involved in 19 focus groups in Canada, Doane (2002) found that moral identity is multifaceted. Moral identity is relational, expressed through narratives shaped by interaction with other nurses and, comparisons to nursing ideals, and internally critiqued through inner dialogue. Of significant relevance to

moral habitability, is the finding that changes to moral identity may occur through contextual influences (Doane, 2002).

Nursing is primarily concerned with patient care. Given the complexity of the care environment, it is reasonable to assume that in providing high quality care, good moral decision-making is crucial. Kelly (1998), in her influential paper on the moral outcomes of new graduate nurses, highlights how the ideals of patient care are central to the new graduate nurses' moral identities and, if compromised, may damage this identity. Attempts to maintain the personal and professional values in new graduate nurses, who are particularly vulnerable in entering a new context of practice, are viewed as strategies for maintaining moral integrity (B. Kelly, 1998).

Moral integrity in nursing is a dynamic relational concept, which encompasses preservation of moral identity, critical reflection on values, and coherence with these values (Hardingham, 2004). LaSala (2009) suggests there is a 'unity' in nurses maintaining moral integrity through mutually accepted standards. Moral integrity, as a secondary concept in a conceptual consideration of moral habitability in nursing, is significant because the social interactions within a context of practice can enhance or constrain moral practice, and therefore whether or not moral integrity is maintained (Yeo, Moorhouse, Kahn, & Rodney, 2010).

Moral community

More than twenty years ago, Aroskar (1995) proposed that nursing should be a moral community since the everyday working relationships within communities of practice can "shape and misshape" (p.135) practitioners, and thus patient care. Since then, a focus on the relational nature of the moral-social workplace has been reflected in the literature. This

has primarily been through commentary proposing the concept of a 'moral community' where strategies to enhance interactions between members of the community can influence better moral practice (Austin, 2007; Hardingham, 2004; Schick-Makaroff, Storch, Newton, Fulton, & Stevenson, 2010; Wilson, 2009).

Strategies to foster a moral community include the provision of safe spaces for open dialogue about moral issues and concerns (Scott, Marck, & Barton, 2011). However, minimal empirical evidence was identified as being directly focused on moral communities. Austin (2007) states that research into moral communities is imperative as workplace issues are similar across clinical settings and, strategies to deal with issues have not been sustainable. In particular, the focus of research into moral communities should be their moral climate (Austin, 2007). This is consistent with other authors' views of developing the concept of moral community as a way of addressing change to moral climate (Rodney, Buckley, Street, Serrano, & Martin, 2013). It is evident these two concepts are intimately linked and valuable to an exploration of moral habitability in nursing.

Moral satisfaction

In the conceptual map, outcomes of the identified primary and secondary concepts relevant to moral habitability in nursing have both positive and negative connotations. Inadequate patient care and reduced staff retention have long been empirically linked and discussed as being relevant to the primary concepts of constrained moral agency and subsequent moral distress (Hamric, 2012). The positively associated outcomes identified are quality patient care and job satisfaction. Outcomes of a supportive moral climate are empirically linked to job satisfaction (Ulrich et al., 2007) and the secondary concept of moral community is

suggested as a means of supporting moral agency (Scott et al., 2011) and quality patient care.

The primary focus of nursing is the provision of quality patient care and this promotes satisfaction (Pask, 2003). Through a process of exploratory engagement and reflection on the data, the concept of moral satisfaction was identified as being important to a further understanding of moral habitability in nursing. While moral satisfaction as a direct entity is undetermined in the empirical nursing literature, it remains an important concept, due to the potential links with satisfaction with enacting moral agency through quality patient care. Therefore, it warranted attention in Phase Two of the study. Drawing on the outcomes of the conceptual mapping, for the purposes of the present study, moral satisfaction is defined as: the experience of nurses when they are satisfied with their moral choices and feel they are able to act appropriately in their care for their patients.

Reflections on the nursing literature examined in Phase One

In considering the literature on the moral experiences and practices of nurses reviewed in Phase One, it became apparent that the contemporary nursing disciplinary literature is predominantly influenced by a critical theory approach, particularly in relation to feminist and relational ethics theory. This awareness was important, as the Phase One outcomes were designed to provide a framework for the methods used in Phase Two of the study and additionally makes overt the theoretical alliances that scaffold this study (Thorne, 2016).

Ontologically, critical theory views reality as being virtual, structural, based on power struggles and shaped by socio-political values over historical periods (Denzin & Lincoln, 2013). Epistemologically, research is driven by "the study of social structures" (p.103) with a belief that the outcomes of the research are transformative and emancipatory (Denzin &

Lincoln, 2013). Methodologically, it is dialogic and dialectical (Lincoln, Lynham, & Guba, 2011).

Historically and contemporaneously, nursing is predominantly a female profession and it is therefore not surprising that theoretical positions that consider gender, power and dialogue within relationships dominate (Peter & Liaschenko, 2013). The secondary analysis by Peter et al. (2004), which identified a state of morally uninhabitable environments, was theoretically informed from a feminist perspective. Central tenets of this view are that there are no universal moral truths, since understanding is historical and contextual (Peter & Liaschenko, 2013). Individuals are seen as connected, not atomistic, influenced by others with differing levels of power and privilege and this emphasises vulnerability (Peter & Liaschenko, 2013). Feminist ethics is focused on transparency and the quality of relationships (Austin, 2007). This is also the focus of a relational ethic, where dialogue with differently situated people that is respectful and celebrated assists in understanding, examining and enacting morality (Bergum, 2013).

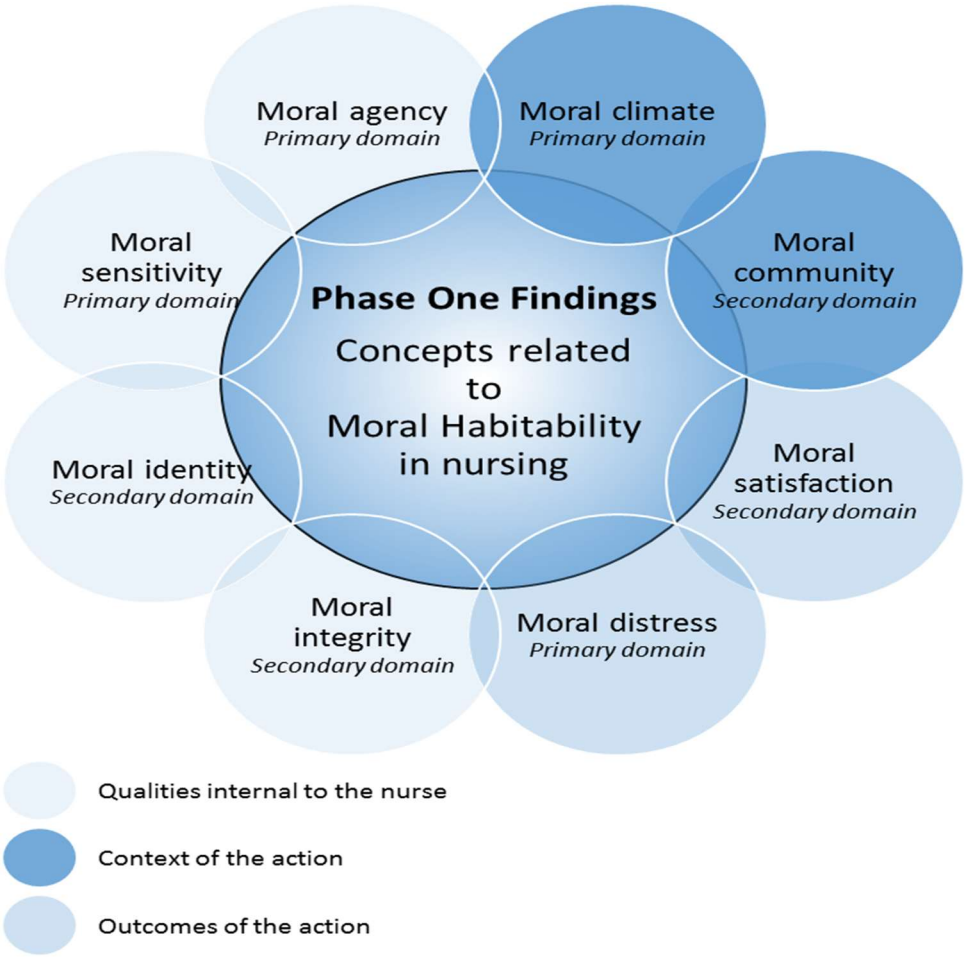
The use of only a feminist theoretical basis for this study was argued earlier in this thesis as being too restrictive. However, the use of a conceptual approach which draws directly from the field means that elements of the theoretical underpinnings of the nursing literature need to be made overt. Therefore, the influences of critical theory in the nursing literature had a bearing on the outcomes of Phase One, in particular, highlighting the interplay between the individual and the context of practice.

Framework of Concepts Related to Moral Habitability in Nursing

It was evident through immersion in the literature related to the moral practice of nurses, that an interplay between the nature of the organisation and the social roles and practices

of nurses working within practice environments is required for an understanding of moral habitability. Figure 5 presents a visual depiction of this framework, the level of evidence (primary or secondary domain) of each related concept to moral habitability in nursing and, the associated focal areas that were identified.

Figure 5. Framework of Concepts Related to Moral Habitability in Nursing



In this interplay three focal areas were identified in the literature: moral qualities internal to the nurse; the context of where the moral action takes place; and, the outcomes of this moral action. Through exploration and synthesis of the concepts identified as being relevant to moral habitability in nursing, a framework was developed that was used to inform Phase Two of this inquiry.

The first focal area is related to the characteristics internal to the nurse and is represented by the nursing literature related to moral agency, moral sensitivity, moral identity and moral integrity. The second focal area is related to the context where the action takes place and is represented by the nursing literature related to moral climate and moral community as a strategy to enhance moral climate. The third focal area is related to the outcomes of the action and is represented by the nursing literature related to moral distress and moral satisfaction.

Each of the concepts identified in Phase One are multifaceted, and while theoretical influences such as feminism and relational ethics exist, a single theoretical approach would be untenable. Instead, the design approach implemented in the current study provides a background scaffolding of interwoven possibilities of what nurses may encounter in the workplace and concepts relevant to this inquiry. The findings of Phase One provided a rich foundation of contemporary nursing knowledge as a theoretical underpinning to an initial conceptual exploration of moral habitability in nursing.

Another aspect that was dominant in the reviewed literature, was the call for further research into both morally habitable environments and each of the primary concepts identified. This consolidated the need to do fieldwork, and in light of these findings and the high relevance to contemporary nursing practice, data collection through a field component was imperative to further explore the concept of moral habitability in nursing.

Initial Working Definition of Moral Habitability in Nursing

Finally, to capture a tentative conclusion related to the findings of Phase One, an initial working definition of moral habitability in nursing was developed as follows:

Morally habitable environments are a space where internal and external constraints to action by the nurse are minimised, difference is embraced and moral wellbeing is promoted through shared understandings of responsibility.

This definition was subsequently published in a collaborative publication focused on moral distress, *'Towards interventions to address moral distress: Navigating structure and agency'* (Musto et al., 2015) which is attached as Appendix 2. In this definition, internal constraints were identified as those related to the individual nurse such as attitudes, beliefs and behaviours that limit optimal moral action. External constraints were identified as being organisational such as work policies and procedures, or relational, such as interactions with other nurses and managers.

Summary

An initial broad review of the nursing literature related to the moral aspects of nurses practice and work environments resulted in a large amount of relevant literature. Conceptual mapping provided a method of organising this literature, and an integrative literature review synthesised the disparate literature of relevance to moral habitability in nursing. By using these methods it was possible to achieve a framework of interlinked concepts related to moral habitability in nursing.

Eight concepts were identified and focused on three areas: qualities internal to the nurse (moral agent); the context of where the moral action takes place; and the outcomes of this action. The resultant conceptual framework provided a platform for the Phase Two field exploration of moral habitability in nurses' workplaces. The following chapter details the methods used for the second phase of this study.

CHAPTER 4 PHASE TWO AIM, QUESTIONS AND METHODS

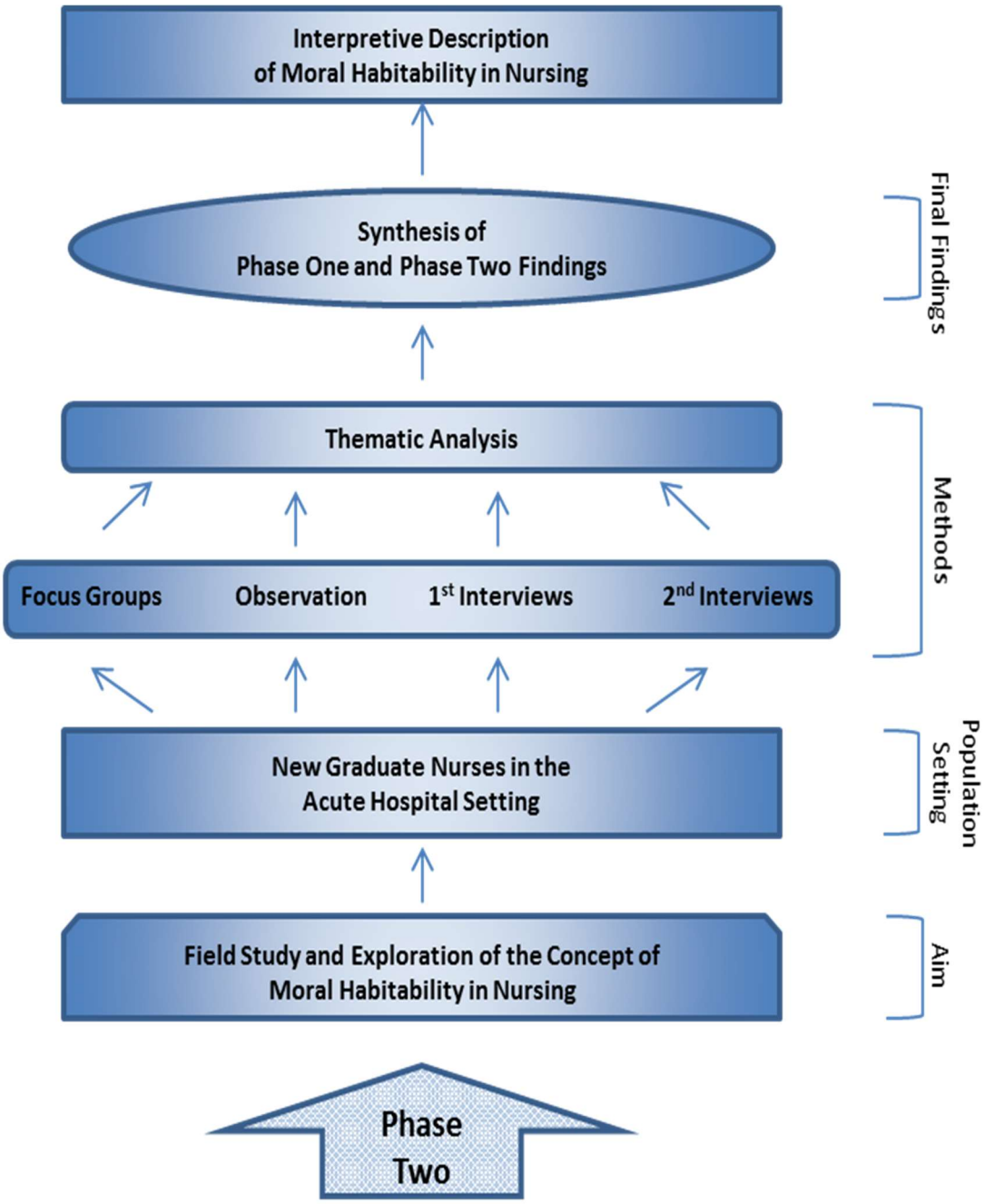
The integrative literature review included in the previous chapter was published in 2013, but exploration of the relevant concepts was not a static process and continued over the subsequent years through ongoing engagement with the literature and reflection on the nuances. Both the findings of Phase One and the ongoing engagement with the nursing literature highlighted the imperative for further data to be drawn directly from the field. In response to this need, Phase Two was developed to inductively explore moral habitability in nursing within a specific group and context, new graduate nurses. As previously detailed, new graduate nurses were chosen as a highly salient cohort since they constitute a particularly vulnerable group of nurses inhabiting an often challenging environment.

In this chapter, the aim, questions and methods used for Phase Two are comprehensively detailed. Interpretive description underpins the choice of strategies used for Phase Two of the study and the demonstration of a logical audit trail. The chapter concludes with a discussion of rigour and the ethical considerations related to this phase of the study, the field component.

Phase Two Aim and Research Questions

The overall aim of Phase Two was to explore and describe moral habitability in the nursing workplace using a specific and highly relevant subset of the nursing workforce, new graduate nurses. Figure 6 graphically represents the features of this phase of the inquiry.

Figure 6. Phase Two Aim and Methods



In the previous chapter the concepts identified in Phase One were discussed in detail and three focal areas were identified: concepts related to the qualities internal to the nurse; concepts related to the context of where the action takes place; and, concepts related to the outcomes of the action. Informed by the conceptualization developed in Phase One, the following exploratory questions were developed to guide this phase of the study:

- What qualities of new graduate nurses affect their moral habitability?
- What strategies do new graduate nurses use to sustain moral habitability?
- What are the characteristics of a morally habitable workplace when experienced by new graduates in an acute setting?
- How do contextual (relational) features in the new graduate nurses' world affect moral habitability?
- What are the outcomes of moral habitability for new graduate nurses in the acute setting?

The following section outlines the methods used to meet the aim of Phase Two.

Methods

Methods are the strategies used to generate and analyse data that are coherent with the assumptions that underpin the methodological approach (Richardson-Tench, Taylor, & Kermode, 2014). Interpretive description, the chosen methodological approach, influenced the methods chosen to achieve the aim of Phase Two of this study (Richardson-Tench et al., 2014). As highlighted in Chapter Two, interpretive descriptive studies are conducted in naturalistic contexts, acknowledge that experience is "socially constructed" (Thorne, 2008, p. 82), are generated through interaction with the participant and researcher, and seek to uncover commonalities and individual expressions of the phenomena under scrutiny (Thorne et al., 2016). These assumptions influenced the choice of methods discussed in the following section.

Population and setting

The population for Phase Two of the study was new graduate nurses working in an acute hospital setting. Typically in Australia the term new graduate nurse is applied to newly

registered nurses in their first year of practice who are employed by either a public or private health service and are accepted into a new graduate program of up to one year in duration (Parker et al., 2014). To gain employment in a new graduate program, nurses must have successfully completed a minimum of bachelor level nursing education, usually a three year program, accredited by the Nursing and Midwifery Board of Australia (NMBA) and be registered to practice as a nurse in Australia with the Australian Health Professional Regulation Agency (AHPRA). New graduate programs are work-based and designed to provide transitional support and professional development opportunities (Missen, McKenna, Beauchamp, & Larkins, 2016). Transitional programs of this nature are used in many countries as a means to support newly graduated nurses to become functioning safe practitioners (Beyea, von Reyn, & Slattery, 2007; Rush, Adamack, Gordon, Lilly, & Janke, 2013).

To elicit data related to moral habitability in nursing, two sites were chosen for this phase of the study. The sites were in different metropolitan health services within Melbourne, Australia. In 2015, Melbourne had a population of over 4,500,000 (Australian Bureau of Statistics, 2016). The two sites were separated geographically by more than 50 kilometres and both sites were acute hospital settings, had a population of new graduate nurses, and both provided new graduate programs. These particular health services were chosen because the new graduate educational programs differ and the economic and cultural communities served by the healthcare facilities also differ. This diversity was considered desirable to enable a potentially wider range of new graduate nurse perceptions and the exploration of their work environments and to create more options to identify key nuances of the phenomena.

The first site is a health service that serves a region of the outer metropolitan population of Melbourne over more than eight locations. While both sites provide services to a population with a wide range of demographic features, this service provides care to a region with an overall lower socio-economic profile than the other site. Consistent with other health services in Melbourne, there is a large tertiary teaching hospital. New graduates are rotated through three clinical experiences of four months duration in a diverse group of wards including medical, surgical and specialty units. Medical wards, geriatric, oncology, palliative care, gastroenterology, neurosurgery, vascular and general surgery are examples of possible placement sites for the new graduate nurses. They can also be placed in critical care units, including coronary care, intensive care, operating theatres and the emergency department. Some of the new graduate nurses also have a four month placement in a smaller regional hospital which is part of the health service. The new graduate program at this site was over a 12-month period and educational support included a two-week orientation and supernumerary period, ongoing mentorship and formal education sessions of one to two hours on a fortnightly basis for the duration of the program.

The second site is a health service that serves an inner region of the metropolitan population of Melbourne, provides speciality services across the state of Victoria, and involves a number of campuses and research affiliates. The service includes a large tertiary teaching hospital where the new graduate program is situated. New graduates in this service also rotate through three different clinical experiences of four months' duration. This involves a diverse range of wards similar to the first site and also includes trauma and cardio-thoracic units. New graduates in this health setting do not work in critical care units. While this site also has a 12-month new graduate program, it differs in that the orientation

period is two days and the educational and mentorship is only for the first three months. Access to twice weekly one hour formal education sessions continues over the whole period. In both sites, the wards/units where data collection was conducted were determined by the allocated placement of the consenting participant.

Sample selection and size

While quantitative researchers strive for a representative sample, Thorne (2008) highlights the complexity of representation in qualitative research and cautions researchers to ensure the sampling procedure is logically transparent. Rather than being technically representative, the sample will "reflect a certain kind of perspective built from an auditable set of angles of vision whose nature and boundaries we can acknowledge and address" (Thorne, 2008, p. 89). Purposive sampling is utilised as a technique to capture a certain perspective of an experience (Thorne, 2016) in a particular group to assist in understanding the phenomenon under scrutiny. The inclusion criteria were for the nurses to be employed by the health service involved, and to be currently undertaking their new graduate program. There were no exclusion criteria, as participation in a new graduate program was the key component of the context identified for the fieldwork.

Another challenge for qualitative researchers is in determining the sample size (Morse, 1998), since it is often difficult to predict at the inception of the study. An interpretive description can be achieved based on any size of sample, but justification of the size needs to be consistent with the aim of the research (Thorne, 2008). The aim of this phase of this research study was to gain further understanding of the complex concept of moral habitability by eliciting data in the specific context of the experience of new graduate nurses across two sites. To sample a range of views within these sites, an initial sample size of 30-

40 new graduates was proposed. This number provided an opportunity to gain a wide range of views and was achievable, based on the number of new graduate nurses employed at both sites.

Ethics approval

Once the sites had been identified and prior to commencement of the field component, ethical approval was sought from both health service ethics committees and the university. Full ethical approval was granted by the Human Research Ethics Committees (HREC) in October 2013 for site two and February 2014 for site one. In a memorandum of understanding with the two sites the university HREC granted approval in January 2014 (Project number CF14/26 – 2014000008). The certificate of approval is provided in Appendix 3.

Participant recruitment and consent

In qualitative research one means to gain access to recruit participants is through the use of 'gatekeepers' (Øye, Sørensen, & Glasdam, 2016). Gatekeepers function as conduits between the researcher and potential participants (Clark, 2010), who can regulate the pathways between possible informants (Øye et al., 2016). After ethical approval was granted, recruitment took place through the use of gatekeepers at each site, the new graduate program coordinators. The new graduate coordinators are responsible for the orientation program for new graduate nurses. Since orientation is a compulsory component of the new graduate program, this represented a mechanism to gain access to all new graduate nurses working in the organisations. Both new graduate program coordinators supported research access to their orientation programs and agreed to advertise the research. Advertising the research took place in February and March 2014.

The consent process

The first presentation of the research topic and research approach to potential participants plays a crucial role in the recruitment of participants, establishing a research relationship and providing information for consent purposes (Franklin, Rowland, Fox, & Nicolson, 2012). This presentation should provide potential participants with enough information to be able to consider fully whether they want to participate, and details of who the intended audience for the work will be (Kaiser, 2012). This opportunity was afforded through an allocated half hour timeframe with the new graduate nurses. A ten minute PowerPoint presentation about the project was given, and time for questions and an invitation to the nurses to be involved in the data collection activities were provided. The presentation outlined three data collection options: focus groups, non-participant observation and interviews. Further detail of the data collection methods are presented later in this chapter.

'Participant Information and Consent Forms' (Appendices 4 and 5) were provided to the potential participants and outlined the opportunity to choose their preferred level of involvement. An underlying assumption was that new graduate nurses may be hesitant to be involved in a study, due to the generally daunting nature of the first year of practice. Therefore, the choice of being involved in some or all of the data collection activities was given, to provide an option for engaging as many participants as possible. Participants who consented to being involved were asked to sign the consent form and provide phone and email details so that they could be contacted to organise dates suitable for data collection.

Another aspect of the consent process which was pivotal, was the principle of voluntariness of involvement (Ignacio & Taylor, 2013) in the study. This was of particular concern with regard to the potential vulnerability of the new graduate nurses, since their direct

supervisors were present at their recruitment for the data collection and there was the potential for being seen as a 'motivated' or 'unmotivated' new employee. Therefore, voluntary participation in the study was especially highlighted and restated by both the new graduate coordinators and the researcher. The potential for coercion was further mitigated by the exclusion of the new graduate coordinators and the researcher during the final signatory consent process.

Outcome of the recruitment process

While the recruitment process for each site was the same, access to the orientation programs differed and was determined by the structure of the particular health service's new graduate program. At the time of the participant recruitment, the first site offered one intake of up to 47 new graduate nurses for the 12-month new graduate program. The first site recruitment took place on the new graduates' second day of a two-week orientation program.

The second site offered two intakes of 30 nurses staggered over a two month interval. The second site's formal new graduate orientation program consists of two days, the first of which is a generic health service orientation, with the second focused on specific issues related to the new graduates. The new graduate coordinator initially allocated a time during the orientation, however this was subsequently withdrawn following a review of the tight scheduling on both days.

As an alternative, an option was offered to meet the new graduates during one of their weekly one hour voluntary in-service sessions. These are conducted over a six week period and are repeated on two different days to maximise attendance and take place during the

morning/afternoon shift staffing overlap. The new graduate coordinators advised that these sessions are generally not well attended.

One of these voluntary in-service sessions was set aside to focus on inviting participation in the study. Of the potential group of 60 new graduate nurses, fewer than 50% attended the in-service. Most who did attend agreed to participate. While the procedure for recruitment for site two was identical, access to the new graduates was impeded by limited exposure to the nurses. This highlights the power of gatekeepers in accessing potential informants (Franklin et al., 2012).

Table 2 presents the results of the recruitment of participants across the two sites.

Table 2. Recruitment of Participants

Site 1	Site 2	Total
Participants recruited (n) Interested participants (z)	Participants recruited (n) Interested participants (z)	Participants recruited (n)
n= 35 (z=37)	n= 9 (z=29)	n=44

Overall, 66 new graduate nurses expressed interest in the study by completing their consent forms. However, the number of recruited participants that were involved in the data collection (n=44) is reflective of the different new graduate nurse programs at each site, and the opportunities the nurses had to attend the focus groups.

Data Collection

There are multiple options for data collection for resourceful researchers using an interpretive descriptive approach, with decisions focused on a critical analysis of what will

yield the most credible results (Thorne, 2016). Using different strategies to elicit a representation of the phenomenon of interest if successful, will capture the associations and contrasts of that phenomenon (Denzin & Lincoln, 2017). To collect data for this phase of the study, multiple strategies were utilised. The purpose of using different data collection strategies was to gain some 'snapshots' of different contexts and conversations about moral habitability in the new graduates' world that would form the final product. This was not to portray objective reality, but offer a meaningful representation (Denzin & Lincoln, 2017).

Three strategies were used for data collection: focus groups, interviews which took place at two points of time, and non-participant observation. In considering which data collection strategies to use, a critical review of the strengths and limitations was undertaken to ensure each strategy was suited to provide a different lens on moral habitability in the practice experience of new graduate nurses. The focus groups were used to view social constructions through interactions with each other; the interviews, to examine language cues and the perceptions of the new graduate nurses' experiences; and, the observation periods considered actions within the context and interactions with other staff (Thorne, 2016). The next section outlines characteristics of the participants and their engagement in the data collection process.

Participant engagement in data collection and participant characteristics

The sample numbers of 30-40 participants targeted at the start of Phase Two were met, with 44 (66%) of the 66 participants who were initially interested in the study taking part in at least one element (focus groups) of the data collection. Table 3 provides the actual number of participants who contributed to each element of data collection:

Table 3. Participants Involved in Each Data Collection Strategy

Data collection strategy	**Site 1 (n)**	**Site 2 (n)**	**TOTAL (n)**
Focus groups	35	9	44
Interviews	11	3	14
Observation	9	3	12
Full data sets	**Site 1 (n)**	**Site 2 (n)**	**TOTAL (n)**
Focus group/Observation/Interview	9	3	12
Focus group/Observation/Interview/2nd interview	6	2	8

The data collection took place over the whole new graduate year, a 12-month period. The focus groups had a total of 44 participants and of these, 14 (32%) were engaged in the interviews. Twelve (27% of the 44) continued on to the observation periods. Eight (18% of the 44) participants overall were involved for the whole 12-month period and engaged in all of the data collection strategies which took place across four different timeframes.

After the focus groups took place, emails were sent to all the consenting participants at both sites to recruit for the observation and interviews. The emails were followed by text messages, on the assumption that the participants might use their mobile phones more consistently than email. This procedure was repeated twice at an interval of two months with a view to maximizing the number of consenting participants taking part in the next elements of data collection. While 29 (66%) of the 44 focus group participants initially responded to either the email or the text message, only 14 (32%) ultimately participated in further data collection.

The take-up rate for other elements of data collection by only 14 of 44 participants who took part in the focus groups may have been the result of number of factors. Participants

themselves identified challenges or competing priorities, including difficulties related to roster changes, night duty requirements, annual leave and sick leave. It is also possible that enthusiasm to participate may have been higher during the initial four weeks of the new graduate programs when recruitment for the study took place, than it was later as the realities of their new graduate programs set in. New graduates are faced with acquiring time management and clinical skills as well as acclimatising to shift work (Parker et al., 2014).

Engagement by 44 participants in focus group sessions and eight who continued over the whole 12-month period across four different timeframes, provided sufficient opportunity to gather an insight into the new graduate experience over time. Details of the specific characteristics of the new graduate nurses involved in the data collection follows.

Participant characteristics

The demographic characteristics of the participants collected were gender, age group, education level and previous experience working in a healthcare related role. These parameters were collected to enrich the understanding of the participants involved in the data collection. Characteristics of the participants involved in each data collection strategy are summarised in Table 4.

Table 4. Characteristics of the Participants

Characteristics of the participants	Participants FG/O/I/2nd I (n=8)	Participants FG/O/I (n=4)	Participants FG/I (n=2)	Participants FG only (n=30)	Total (n=44) %
Gender					
Female	7	3	1	28	39 (89%)
Male	1	1	1	2	5 (11%)
Age					
20-25 years	2	2		14	18 (41%)
26-30 years	2		1	3	6 (14%)
31-35 years	1	1		4	6 (14%)
36-40 years			1	4	5 (11%)
41-45 years	1			3	4 (9%)
46-50 years				2	2 (4%)
50 years +	2	1			3 (7%)
Education					
Bachelor degree	8	3	1	28	40 (91%)
Masters level		1	1	2	4 (9%)
Previous Experience in Healthcare					
Enrolled nurse	1	3		8	12 (27%)
Patient care assistant	1		2	4	7 (16%)
Other	1			1	2 (5%)
No experience	5	1		17	23 (52%)

Key: Focus Groups (FG), Non-participant Observation (O) and Interviews (I)

The new graduate nurses' ages ranged from 20 – 58 years with 59% of the participants being over 25 years of age and 11% being males. This is consistent with male representation in nursing in the Australian workforce who account for 9 – 11% of nurses (Australian Institute of Health & Welfare, 2015). Approximately half (48%) of the participants had prior working experience in healthcare related roles, which included enrolled nursing, patient care assistant and veterinary and dental nursing. In Australia an 'enrolled nurse' has completed an accredited program at a diploma level (Nursing and Midwifery Board of Australia, 2017). To become a registered nurse in Australia requires education to a minimum standard of a baccalaureate degree (Nursing and Midwifery Board of Australia, 2017). All participants had completed a nursing degree and were registered with the Nursing and Midwifery Board of Australia, with four having completed a graduate-entry pre-professional program at Masters level.

The following section outlines the specific details regarding the strengths and weaknesses of each data collection strategy. The first data were collected during the focus groups.

Focus groups

Focus groups were the first data collection method and they were conducted in the first four weeks after the initial recruitment process. The utilisation of focus groups as the initial data collection method provided an opportunity to view the social interactions of the new graduate nurses through a process of establishing some baseline understandings and agreements about the concepts identified in the first phase of the research. The timing of the focus groups, shortly after the conclusion of initial recruitment, was intended to maximise the likelihood that interest in participation in the study would be maintained as

the potentially conflicting activities and areas of focus increased as their new graduate year progressed.

Focus groups are commonly used in qualitative nursing research (Jayasekara, 2012; Shaha, Wenzel, & Hill, 2011). Focus groups can be used in different ways as a method of data collection by either being the primary, supplementary or collateral source of data. In using a combination of strategies, the researcher is trying to gain something distinctive and also a "mutual enhancement of the understanding of each method by the other" (Liamputtong, 2013, p. 78), as was the intent in this study. As a data collection method, focus groups provide an approach where a homogenous group with shared experience can develop meaning about a topic or a type of social knowledge through the process of interaction (Thorne, 2008). Multiple groups and sites are advocated to enhance quality (Kidd & Parshall, 2000). Four focus groups were conducted over the two sites. While bringing groups of new graduate nurses together to interact and construct some meaning around moral habitability was desirable, there were some challenges to overcome.

There is evidence that new graduate nurses do not feel their theoretical preparation from universities and clinical settings is adequate, particularly in relation to discussions about the moral component of their work (Laabs, 2011). This posed a potential challenge in relation to the groups being able to effectively discuss aspects of their moral practice. This was compounded by the language of moral discourse itself being ambiguous. It seemed likely that moral discourse would be difficult for group discussion if the participants had been under-exposed to ongoing ethics education. Denzin and Lincoln (2008) support the view that in qualitative research the researcher may adapt strategies to meet the contextual needs of the research. Therefore, to overcome the potential absence of exposure to ethics

education, the focus groups were designed to establish some baseline understanding of and agreements on the concepts identified in the first phase of the research.

The focus groups also provided an opportunity to engage participants in facilitated activities to discuss these concepts in relation to their practice and to gain insights into new graduate nurse moral habitability. An additional benefit was the chance to develop a relationship with the participants for the scheduling of further data collection strategies.

The role of facilitator can impact the quality of the data collected (Liamputtong, 2013). Focus groups and other group activities have limitations, including the potential for dominant views to obscure other participants' opinions (Happell, 2007) and to be a "coercive data-collection mechanism" (Thorne, 2008, p. 132) if poorly facilitated. This was an important consideration in both the development of the activities and the actual facilitation of the focus groups. To enhance quality in this form of data collection, Thorne (2016) advocates the creation of a safe environment of confidentiality and respect. Questions can be posed that are both wide-ranging and more targeted to elicit a group response.

The focus groups were facilitated in pairs by the student researcher and one of her research supervisors. Both the supervisors and student researcher have many years of experience and expertise in facilitation strategies that were utilised to augment the quality of the focus groups.

Each of the four focus groups lasted for two hours and began with an initial five minute presentation of the first phase of the research and a handout (see Appendix 6) to be used as

a reference sheet, if clarification of terms was needed. For example, the definition of moral agency was as follows:

> *Moral agency can be referred to as the overall ability to recognise, think about, then make moral decisions and act on those decisions (Peter & Liaschenko, 2004).*

The concept map and integrative literature review were utilised as a framework to develop activities based on the findings that directly related to the concepts of moral agency, moral sensitivity, moral climate and moral distress (see Appendices 7, 8 and 9). The three activities focused on what moral habitability in the new graduate workplace might look like, how it was experienced and the strategies new nurses used to maintain habitability. Each activity included discussion of a question, development of themes and visual representation of the groups' discussion through mind maps and drawings. The focus groups were digitally recorded and transcribed verbatim.

Self-reflection and complementary data from the focus groups

In addition to the data generated by the new graduate nurses in the focus groups, journal notes were kept by both facilitators. In qualitative research, the researcher is located and active in the construction of data, and this requires an ongoing reflection and justification of the intellectual processes to ensure accountability of findings (Thorne, 2016). This was achieved through the use of self-reflective journaling and the information from this was treated as complementary data. From a methodological standpoint, reflective journals not only provide transparency to the decision-making processes of the researcher but also have tangible effects on the actual design (Ortlipp, 2008). This was particularly important in shaping the interview questions.

Reflections on the processes of the focus groups confirmed that the timeframes allocated to complete each activity were justified. Other aspects that were noted were that in each group the new graduate nurses participated in all of the activities without any apparent hesitation. All of the groups were collegial, most of the participants were open in sharing and there was frequent nodding of heads and non-verbal agreement. In sharing some of their vulnerabilities, they listened intently to each other and at times participants would write words down for each other on the mind map, although there was generally tacit agreement about that. Participants may find publicly airing opinions in a homogenous group difficult (Morse, 2012). This was particularly relevant in the case of new graduate nurses who may not have wanted to contribute, but rather preferred to be a more passive member of a group consensus. After the focus groups were completed the interview process began.

Interviews

Interviewing an individual with experience of the area of research interest has, for decades, been the backbone of qualitative research (Thorne, 2008). It provides an opportunity to gain depth when using an interpretive approach. Interviews provide access to more than simply a conversational account of a person's life by giving some understanding of "motives, meanings, actions and reactions" of the person (Minichiello, Aroni, & Hays, 2008, p. 10). In this way, the researcher learns more than the answers to questions, but also how the individual sees their world (Brinkmann & Kvale, 2015).

In-depth interviews were conducted over two timeframes using different processes. This was done because, as Thorne (2008) states, as the interpretation evolves it is useful to repeat interviews to provide an opportunity for clarification and further questions.

The first interviews were conducted using a semi-structured approach with 14 participants and were held during the first three to six months of the participants' experience in the new graduate year. The semi-structured approach supports the researcher in focusing on a topic while retaining flexibility in the actual questions, and is useful where the researcher has an understanding of what they want to ask but are unsure of what the responses will be (Morse, 2012). Using this interview approach was intended to enable the participants to give a more authentic account of their experience (Minichiello et al., 2008).

An interview guide was developed (see Appendix 10) to better ensure the focus was on answering the research questions and was informed by the concepts identified in the Phase One of this study. The guide was not prescriptive and served primarily as a reminder of what to cover. The guide offered something of a systematic structure, but the conversation with the participants was not forced into only the areas of interest within the study.

In beginning an interview, building rapport with the participant is essential (Brinkmann & Kvale, 2015; Liamputtong, 2013). As all of the participants who were interviewed had been involved in the focus group, rapport was built by inquiring how they had been since our last encounter, prior to asking permission to record and commence the interviews. This 'small talk' allows the participant to become comfortable (Liamputtong, 2013). Next the introductory question was posed: *Tell me what it is like to be a new graduate nurse.*

This provided an opportunity for the participant to talk freely (Liamputtong, 2013) and to allow new insights to emerge that were not influenced by the question 'agenda' that followed. The interviews lasted from 55 to 60 minutes and were digitally recorded. A brief summary of the salient points from the interviews was given to the participants at the end

of each interview to confirm the intent of their narratives. The recordings were transcribed verbatim.

As an adjunct to the interview process, journal notes were kept that reflected experiences and thoughts on the process, context and the participant's non-verbal responses. The substantive notes provided a means of setting the circumstances of when the data were collected and were written in a detailed manner (Minichiello et al., 2008). The journal notes were also used in a critically reflective manner to develop interviewing techniques with each subsequent interview and to review the quality of the questions in regard to the research intent.

During each of the data collection strategies, and particularly during the interviews, the participants sought mentoring from the researcher. Often the conversations occurred after the interview recordings had been completed and the participants wanted the discussions to continue. They expressed gratitude for the opportunity to discuss their experiences. Thorne (2008) labels this "stepping out of the role" (p. 111) and suggests journaling these experiences can provide a place for the researcher to examine where the inquisitive learner (researcher) has been replaced by the clinician.

During the final six months of the participants' new graduate year, second interviews were conducted with eight of the participants to further capture their experiences and add depth to the data. For these interviews, a recursive approach was undertaken. The use of recursive interviewing using a framework outlined by Minichiello et al. (2008) was undertaken, as it is consistent with a heuristic interpretive description approach (Thorne, 2008). Recursive questioning is unstructured, more conversational and the interaction between the researcher and the engaged participant directs the process (Minichiello et al., 2008). This

allows the unique experiences of the individual to unfold and creates a dynamic interview technique which is ideal for an interpretive approach (Minichiello et al., 2008). As an iterative approach shaped this inquiry, the use of recursive questioning allowed further insights of the nurses later in their new graduate year to be revealed. The interviews began with a similar question to the first interviews: *Tell me how the new graduate year has been.* The conversation was directed by the responses.

One disadvantage of recursive interviewing is the risk the conversation will go off on a tangent and thus not answer the research questions. To avoid this, 'refocusing' questions were used to connect back to the study (Minichiello et al., 2008). In preparation for each interview, the transcripts and journal notes were reviewed multiple times. Recounting some of the narrative the participant had voiced in the first interview was used to refocus the current conversation. This had a twofold effect: re-visiting information gained from the first interview allowed it to be either contradicted by later experiences in a new context, or alternatively, further elaborated on. The participants were very engaged with this process in remembering what they had said. While a summary of each interview was presented at the end of the first interviews, this use of refocusing provided an opportunity to re-visit their stories. This was particularly relevant as the new graduate nurses had gained further experience in new settings and new insights often emerged.

Non-participant observation

There were 12 non-participant observation episodes of three to four hours in length. The location of the observation periods was dictated by the locations of the 12 participants who had consented to being observed. Observation took place at both of the sites targeted in the study and in a range of diverse care settings including medical, surgical and critical care

environments. The observation periods took place during both day and evening shifts, depending on the preferred timeframe that the participants had negotiated.

Prior to entering the field, the typically lengthy process of negotiation with stakeholders began (Mulhall, 2003). Establishing relationships with the clinical site was imperative to ensure ongoing access. Entry was gained through negotiations with the Nursing Unit Managers, who discussed the observation periods with their staff during staff meetings. Because the field component focused on the new graduate nurses within the context of their practice, everyone within that context needed to be adequately informed, including Nursing Unit Managers, Graduate Support Nurses, other staff, patients and relatives. To ensure any concerns that arose for patients, relatives and staff were addressed, posters and flyers explaining the purpose of the observation and details of an 'opt out' option were visible and available in all ward areas. The details of counselling services located within the healthcare services were also made available should participants have required their services in relation to participating in the study.

During the field observation, the focus was on the new graduate nurse's decision-making and social roles, and not on patient interactions. However, because the patient is central to the nurse's role, verbal consent was sought from patients and other people of specific relevance to the patients (e.g. health professionals and visitors) who may have formed part of the observational context. Consent was recorded in the field notes. The wishes of any person not wanting to be part of the observation were respected, and the researcher left the room for the duration of the interaction. Field notes were recorded during the observation period and then transcribed electronically.

The interviews provided data that were reconstructions of the individual participant's experience. Utilising non-participant observation as a third data collection method enabled viewing the new graduate nurse workplace and the social interactions that were taking place there. This was "explicitly capitalising on the distinct angles of vision supported by different data collection methods" (Thorne, 2008, p. 135). Using observation as a strategy is particularly relevant to the experience of moral habitability, since it enables the consideration of context and the dialogical processes taking place with the participants, patients and other staff.

In addition to being an observer in a non-participatory role, there are a number of alternative approaches to observation, including being a participant within the observed field, like for example working as a nurse in the new graduate nurse's ward (Schneider, Whitehead, Lobiondo-Wood, & Harber, 2016). Non-participant observation was chosen as it has a number of strengths relative to this study. This method allows the researcher to cast a non-judgemental gaze without being swayed by the "powerful effects of language and social influence" (Thorne, 2008, p. 134). The non-participant researcher may uncover important information which a person socialised into their reality would not see (Mulhall, 2003). Specifically, because the new graduate nurse is focused on becoming a part of the social group (Malouf & West, 2011), this may limit not only what they report in interviews and focus groups, but also what they can 'see' in their world.

However, as with all data collection methods, non-participant observation has limitations. The duality of the role of being a nurse/lecturer and a researcher, for example, can blur role boundaries (Bloomer, Doman, & Endacott, 2013). The neophyte nurse may look to the

researcher for assistance and clarification of practice, which would be inappropriate to the ethical agreement established with the institution through the ethics process.

Completion of data collection

In making decisions on when to cease data collection, 'data saturation', a term usually related to grounded theory (Liamputtong, 2013), can be applied. Data saturation is said to occur when no new insights are being yielded from the data (Bryman, 2015). In using an interpretive descriptive methodology, Thorne (2016) emphasises that, while working towards data saturation is the traditional approach, finding no new variations among participants in healthcare studies is unlikely. Specifically, Thorne and colleagues suggest there may be differing levels of complexity and richness in data (Thorne et al., 2016). Data collection was planned to be ceased when the quality of the data (Padgett, 2012) was deemed sufficient to meet the needs of the research questions in conjunction with a consideration of flexibility and complexity (Liamputtong, 2013).

For the present study, the concept of data saturation was employed to aid in determining when sufficient data had been gathered to provide an understanding of each of the concepts related to moral habitability in nursing identified in Phase One, rather than seeking full saturation. This meant that there were different levels of richness and complexity associated with each concept. To ensure this complexity and richness were captured, the self-reflective journal notes outlined in the methods section included methodological reflections. Once data collection was completed, the data were stored prior to analysis.

Data management

As outlined previously, audio data from the focus groups and interviews were de-identified and transcribed into documents. These documents were then entered into NVivo for coding

and analysis. The observational and methodological notes were maintained in notation format. The data will be retained for five to seven years from the completion of the study, in accordance with the requirements of each of the institutional ethics committees. A number of data management strategies, approved by the committees and consistent with legislative requirements, were employed to ensure security of the data and maximum privacy for the participants.

The non-participant observation and methodological notes were stored as field notes, which were stored in a locked filing cabinet in a locked office. Audio recordings of the focus groups, including the researcher's reflective recordings, and interviews were de-identified using an assigned code and stored in a password-protected computer. The de-identified audio files were then transcribed into password-protected electronic documents. Demographic information was also de-identified, aggregated and used to statistically describe the population. Telephone contact details were stored in a separate password-protected electronic file and used only for contacting the consented participants to arrange times for data collection. The data were then utilised for analysis.

Data Analysis

Qualitative analysis is complex. There is a tension created between a process that is non-linear and iterative and yet requires a systematic and organised approach (Holloway & Wheeler, 2010, p. 281). Historically, social sciences methodologies have been adopted and adapted as a means to analyse nursing data (Thorne et al., 2016). However, this adaption may not always create data that are relevant to the creation of nursing knowledge and may compromise the analytic logic of the nursing study (Thorne et al., 2016).

The present study was derived from the nursing knowledge around concepts relevant to moral habitability in nursing and this is why interpretive description, a non-categorical approach, was adopted. Thorne and colleagues support the notion of nursing knowledge being used as a framework by providing a "robust, coherent and authentic scaffolding" (Thorne et al., 2016, p. 6).

The findings of Phase One of this study created an analytical framework based on a critical review of current nursing ethics knowledge linked to the concept of moral habitability in nursing. In Phase Two, the field component of the study data from a specific context were sought to further explore this phenomenon. These data were thematically analysed using inductive processes.

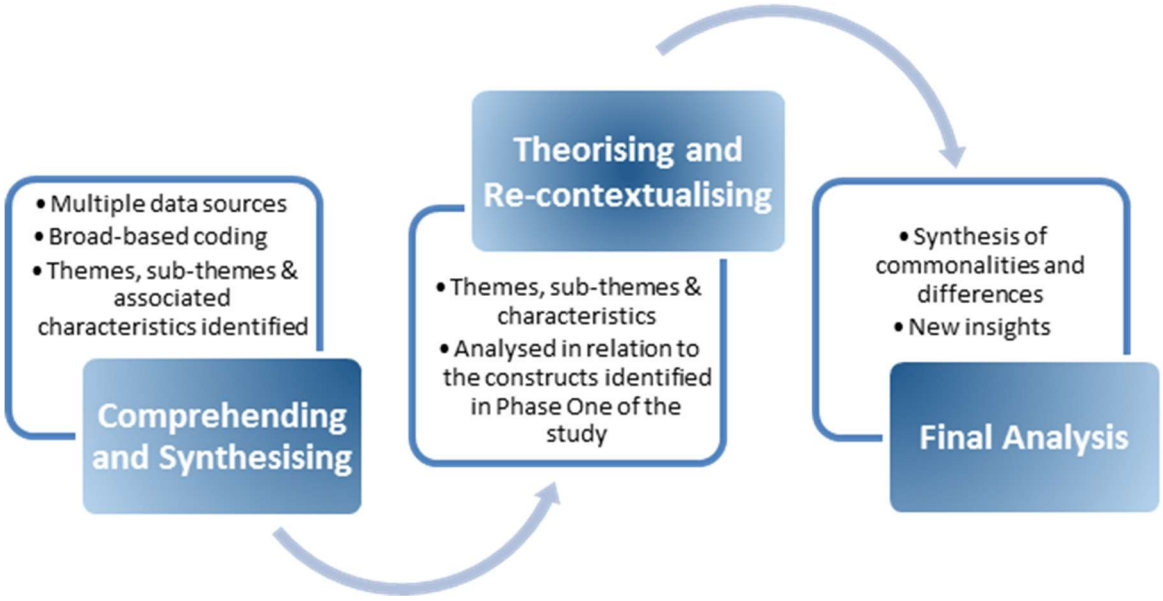
Analytic process

While quantitative researchers collect and then analyse their data, the qualitative researcher needs to be engaged throughout the full process of research in a concurrent, iterative approach to data generation and analysis (Thorne, 2008). Through a process of induction, ideas are generated to create an understanding of the phenomenon under investigation. To create an interpretive descriptive product that has applicability to the discipline, there is a need to explicitly account for the analytic processes of how the data were translated to themes and what this signifies (Thorne et al., 2004). Strategies such as reviewing transcripts, keeping reflective memos and initial visual mapping of what was found, were employed in this study to aid this process. Interview synopses were also developed and these informed the on-going non-participant observation and the content of the second interviews.

In using interpretive description as a methodology, the development of themes should occur after looking for patterns that provide a foundation for new perspectives of possibility rather than specific truths (Thorne, 2016). In analysing the data for Phase Two, there was a tension between the influence of the Phase One results and not seeing the patterns that were inherent in the Phase Two data. Initially the data were viewed as a whole in order to remain open to what was evident. This was undertaken by reading and re-reading the transcripts, mind mapping possible patterns and constantly challenging initial ideas. To be interpretable, the data still requires some form of disassembly (Sandelowski, 1993). After the initial stage of analysis, broad based coding was used (Vaismoradi, Turunen, & Bondas, 2013). This inductive process included coded data from multiple sources in the clinical context which were synthesised and analysed to develop sub-themes and themes. During this process, questions guiding Phase Two based on the concepts identified in the first phase were kept in mind but did not drive the data analysis. This provided a means of not deviating from the purpose of the fieldwork and remaining open to new insights.

Thorne (2008) highlights four cognitive processes of analysis to better understand the analytic process. These processes are comprehending, synthesising, theorising and re-contextualising (Morse, 1994). How the steps are utilised varies depending on the type of inquiry. However, they provide a means to understand how raw data move to a final research product (Thorne et al., 2016). This was a useful framework in developing an approach to link the two phases of an emergent conceptual study. During the analysis all sets of collected data were utilised and the processes undertaken for the analysis are explained in the following section. An overall approach to the analysis is presented in Figure 7.

Figure 7. Overall Analytic Process



Comprehending and synthesising

The first process outlined by Morse (1994) is *comprehending*. This entails absorbing the context and experiences of the participants in a non-judgemental manner (Thorne, 2008). The initial phase of analysis was undertaken through reading, re-reading and listening to all the transcripts, questioning the overall meaning of the whole and being alert to pieces of data that draw attention (Thorne, 2016). This was done in conjunction with keeping in mind the questions that guided this phase of the study and was further supplemented by reflective consideration of asking why each piece of data was pronounced. To aid this process during this immersive period, marginal memos were made on the printed transcripts and overall impressions of each transcript were journaled. Creating memos and journaling assisted the analytic process in three ways. The first was to gain an overall understanding of the data and then, second, as data collection and analysis were concurrent, insights that had been drawn could influence the ongoing data collection.

Finally, the memos and journaling assisted in the process of considering the individual while looking for commonalities and contrasting experiences.

The amount of data collected was extensive. To create an organised process, pieces of data with similar or contrasting properties, identified by Thorne as "from pieces to patterns" (2008, p. 142), were labelled with a broad-based code and the software program NVivo was used as the coding tool. It was imperative to avoid premature closure in order to be open to new insights (Thorne, 2008) and the year-long length of the data collection and analytic period allowed time for continued reflection.

The next cognitive process is *synthesing* (Morse, 1994). During the iterative process of interrogating the data, the extensive list of codes was reviewed, informed by further data collection, refined and collated into sub-themes and themes through what Thorne (2008) terms as moving forward "from patterns to relationships" (p. 149). The next step in the analytic process involved considering the insights identified in the thematic analysis and considering "why these relationships appear as they do" (Thorne, 2000, p. 69). This lead to the development of themes. The resultant themes, sub-themes and characteristics of the thematic analysis are outlined in Chapter Five.

Theorising and re-contextualising

During the design of this study, a methodological tension involved how to reconcile both sets of findings from the two phases of the study. The second method of data analysis reconciled both phases of the study by addressing the theorising and re-contextualising analytic stage (Morse, 1998). This was undertaken by using the concepts identified in the concept map and the integrative literature review as a theoretical base to reveal congruence or contrast with the thematic outcomes of the field data analysis. One focus

was to discover how useful the concepts identified in Phase One were in understanding particular patterns of behaviour associated with the concept of moral habitability in the clinical practice of new graduate nurses. The other focus was to identify if other elements that may advance the understanding of moral habitability were evident.

Contemporary nursing knowledge, which had been critically appraised and used to develop the Phase One conceptual framework, was analysed in the search for relationships, common links, contrasts and new insights with the outcomes of the thematic analysis of Phase Two. The process began with identifying linkages by referring to the findings of the thematic analysis and creating memos and reflections about it. For example, how does the sub-theme 'getting around the system' weave through the concepts of moral climate and moral community? This was an adaption of the cognitive process of both the *theorising* and *re-contextualising* phases of analysis identified by Morse (1994). Through this intellectual process, the themes were considered in relation to the concepts identified in Phase One of the study.

How the new data are "considered, examined, and reformulated to become a research product" (p.70) may vary due to the nature of the study (Thorne, 2000). Therefore, in the present study, *re-contextualising* was achieved through positioning the new knowledge discovered during the field component back into the context of what was evident in the nursing literature around the concepts related to moral habitability in nursing from Phase One.

Healthcare environments are dynamic and findings in nursing research tend to be actioned rather than theoretical (Thorne et al., 2016). To make the outcomes of this study useful, this integration of the findings of each phase was needed, to provide an evolving platform of

ideas, rather than precise explanation and understanding of moral habitability. The synthesis of the findings of Phase One and the context laden findings of Phase Two provided a means to meet the aim of the study. Chapter Nine provides an interpretive description of moral habitability in nursing.

Trustworthiness of the Study

The development of interpretive description was specifically focused on addressing research design issues that were weak methodologically and which addressed rigour from a quantitative perspective (Thorne, 2008). The shift from a rigid set of quality criteria focused on validity and reliability, to the development of criteria epistemologically and methodologically aligned with qualitative research, has been well accepted (Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013). The most commonly used framework to demonstrate trustworthiness, an alternative term to rigour, was developed by Lincoln and Guba (1985) with four criteria: credibility, dependability, confirmability and transferability. These criteria were developed to be congruent with a qualitative approach, where the notion of a single reality is rejected and the 'truth' identified from the data is bound by time and context (Schwandt, Lincoln, & Guba, 2007).

Consistent with the constructionist paradigm which influences the present study, the data generated cannot be objective as it is co-developed by the researcher and participant and, while it cannot be measured, it can be interpreted (Liamputtong, 2013). However, there is still argument over whether there is or should be a single standard (Denzin & Lincoln, 2008; Rolfe, 2006). Thorne (2016) states that, while there are a variety of frameworks to judge qualitative research, there are also common general principles. Informed by these general principles, Thorne (2016) provides guidance on evaluating the outcome of an interpretive

description using four criteria: epistemological integrity, representative credibility, analytic logic and interpretive authority.

Epistemological integrity

To demonstrate epistemological integrity, there needs to be a defendable logic trail for decisions made about the process of the research (Thorne, 2016). The first phase of the study was conceptually driven from current nursing knowledge, consistent with an interpretive descriptive approach, and informed the development of credible research questions for this phase. Furthermore, the overall aim of the research was pervasive and was returned to consistently through the analytic process. The process of construction and analysis of data does not have to be linear and can be modified. However, all decisions must be coherent (Morse, 2002, 2012). Each phase was detailed from inception and any changes to the process were explicated. An understanding of the constructionist paradigm guided the expectation of multiple realities and the research design for this phase supports this expectation.

Representative credibility

The constructionist assumption is that there are multiple realities socially constructed by the participants in their contexts (Lincoln & Guba, 1985). Therefore, it is important that representation is plausible. Prolonged engagement in the field is an accepted strategy to enhance credibility (Liamputtong, 2013). The participants for this study were new graduate nurses from two health services and were a demographically suitable representation of the new graduate nurse population in the acute care setting. Clear descriptions of the context and the characteristics of participants and notes on the research experience were made to enhance credibility (Cope, 2014). Data collection was over a 12-month period, with

opportunities to develop rapport and engage with the participants in different timeframes using different strategies. Another strategy to enhance credibility is the use of multiple strategies for data collection (Sandelowski, 2000; Thorne, 2008), so that a range of perspectives can be revealed (Casey & Murphy, 2009). Data were collected using three different strategies, each had strengths that enhanced depth of understanding. Capturing the new graduate nurses' experiences during their initial employment (focus groups), mid-year employment (observation and first interviews) and in their final months of their new graduate year experience (second interviews) provided a means to enhance the richness of the data.

Analytic logic

There is a need for evidence, not just assurance, throughout the report on the study that inductive reasoning has occurred (Thorne, 2008). The audit trail for this study includes decisions made about data selection and analysis. The analytical process has been demonstrated diagrammatically to enhance clarity. Dialogues with supervisors and analytical notes were maintained throughout to demonstrate the reasoning pathway. Thick descriptions of the contexts and the use of verbatim vignettes from the transcripts augment the usability of the research. The tension in maintaining confidentiality while providing a thick description was reflected in conversations with supervisors and self-reflective journaling.

Interpretive authority

As interpretations are co-created with the participants and researchers, the knowledge claims made need to account for an awareness of social context and critical reflection on the researcher's own values and experiences. One strategy that was implemented to

address this issue was the use of a reflective journal for both the data collection and analytical phases of the research. The field journal was utilised for critical reflection on how personal values, theories and experiences came into play (Houghton et al., 2013). Another strategy employed in an attempt to enhance interpretive authority was member checking (Long & Johnson, 2000). Summaries of the first interviews were presented to the participants in the second interviews as a means of seeking agreement or clarification of the participants' reports and as an avenue for further exploration of their experiences.

Other considerations of trustworthiness

Thorne (2008), influenced by Leininger (1994), challenges the inquirer to not just have a set of rules for the evaluation of rigour in qualitative research, but to also undertake a subtle critique by consideration of disciplinary, social and historical contexts. Considerations of whether the study is morally defensible, relevant to the discipline of nursing and has pragmatic use, are imperative in an interpretive description (Thorne, 2008). New graduate nurses were chosen specifically because moral habitability is an important concept for this cohort. The findings are of disciplinary relevance for both pragmatic uses in assisting new graduates and in further developing the concept of moral habitability in nursing.

Ethical Considerations

The nature of qualitative research means that it is difficult to predict all issues that may arise and questions and design "may alter in response to emerging findings" (Pollock, 2012, p. 2). While this flexibility and emergent direction is consistent with an interpretive descriptive study, there are common ethical areas of concern when conducting qualitative research on human subjects. Consent is essential in operationalising ethical considerations. Information on, consent to and options for withdrawal of consent by peripheral participants

were outlined earlier in this chapter. In this discussion, issues such as confidentiality and those that focus on nature of the participant-researcher relationship (Ignacio & Taylor, 2013) are of primary concern. The principles of integrity, beneficence, non-maleficence and justice guide the researcher in considering these areas of concern (Polit & Beck, 2012).

New graduate nurses are at risk as a study population, as the first year of practice is very demanding. Job stress, unreasonable workloads and issues in transitioning to a new independent role have been consistently reported (Higgins et al., 2010). In the present study, autonomy was promoted by the voluntary nature of participation and by participants having the choice of being involved in as many data collection strategies as they desired. Being involved in a research study that has a focus on the moral component of their work and included an interactive focus group may have been useful to the participating new graduate nurses. The potential benefits include enhanced theoretical ethical knowledge and, through the process of professional reflection regarding personal and organisational moral components of practice, an enhanced moral sensitivity to patients care needs. This was evident in the feedback from the participants, which is addressed in the findings chapters.

Avoiding harm, and in particular psychological discomfort, was paramount. There was some potential for psychological discomfort for the new graduate nurse participants in the reflective process of discussing moral practice. Institutional processes provided by the new graduate program support services such as preceptors, debriefing mechanisms and counselling services, were made available to the nurses involved. This was achieved through lists of contact details on the information sheet, and reiteration of this information by the researcher at times of interaction. During the data collection process, there were no

expressions of discomfort. In addition, no patients, family or friends, or nursing staff expressed discomfort with the presence of a researcher during the observation periods. The principle of justice was addressed by giving all of the new graduate nurses in their year cohort an opportunity to participate. Other ethical considerations that were addressed follow.

Confidentiality/privacy

The right to confidentiality and privacy is fundamentally accepted in Western culture. Data rich in detail which includes research participants' social experiences is comparatively easy to identify. For research participants involved in a study that examines the moral life, it is possible that identification of individuals may have adverse results for their continued employment. Legislation regarding privacy provides guidance in managing personal information to ensure anonymity and secure storage of the data (*Privacy Act 1988* (Cth)). The data management strategies outlined earlier in the chapter were utilised to ensure that participant data remained unidentifiable. The field observation notes were written on paper and once transcribed to a computer file, the pages were destroyed. The interviews and focus groups were taped and the audio files were transcribed to Word documents. Participants were allocated a pseudonym and no reference to their name or organisation was retrievable from the transcripts. Demographic information was de-identified, aggregated and used to statistically describe the population. Telephone contact details were stored in a separate file and used only for contacting the consenting participants. All data forms were kept in a secure, password-protected format on the hard drive of a computer used by the researcher in her office and in backup form on a portable password-protected hard drive which was stored in a filing cabinet in an office with a locked door. Consistent

with the specific institutional and university guidelines, on completion of this study the data will be retained in a secure area under the responsibility of the primary supervisor for a period of seven years.

Participant – researcher relationships

The interpersonal dialogic process of participating in peer group exchange during the focus groups, engaging in conversations through interviews, and being observed at a time when the participants are developing their identities as graduates rather than students, raised important ethical considerations. One way to address this is by stressing a partnership rather than a hierarchical approach while conducting data collection (Eide & Kahn, 2008). However as discussed in Chapter Two, given the researcher's role as a nursing lecturer teaching ethics and transition to practice subjects, there was potential for new graduate nurses to bring problems to the researcher to be solved. The tension lay in not becoming an advisor or counsellor and yet providing feedback when appropriate and within the researcher's scope of experience and knowledge (Eide & Kahn, 2008). For example, during the interviews and observation periods, appropriate encouraging words were provided as a supportive measure when it appeared that the new graduate nurse was asking for feedback. Another example was providing information about resources to assist their problem solving if directly asked by a new graduate nurse. Reflection on this process took place both during the encounter, in discussions with supervisors and in the field notes.

Finally, there was potential for the researcher to witness significant unethical behaviour. As part of the researcher's professional responsibility, had unethical behaviour been witnessed, it may have been necessary to report the behaviour within the organisation using the appropriate institutional processes, and to advise the Nursing and Midwifery

Board of Australia in accordance with mandated legislative requirements (*Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic)). During the data collection no instances of significant unethical behaviour were witnessed, but an ethical issue was raised by the participants during the focus groups and interviews and is detailed below.

Ethical issue encountered

While the risk to participants was deemed minimal by both the researcher and the Human Research Ethics Committees, an ethical issue was encountered. In the reflective process of discussing moral practice, some of the participants identified procedures and care choices made in one particular ward that were not consistent with either their personal or professional values. The researcher did not witness these events during the observational data collection and was only made aware of these practices through the focus groups and interviews. The new graduate programs involved had support systems in the form of mentoring, debriefing mechanisms and counselling services. The participants who expressed discomfort with the care choices made within this ward were guided to use the institutional processes available to them.

Summary

In the previous chapters, the key arguments for using an innovative two-phase approach and the choice of interpretive description as a methodology to underpin the study, were presented. The focus of this chapter was to demonstrate the influence of these factors in conducting the second phase of the inquiry. In an interpretive descriptive approach, the focus on the contextual nature of data generation and acknowledgement of the existing field of disciplinary evidence were congruent with the methods of data collection and the analytic approach for Phase Two. For example, interpretive description recognises that data

can be sourced from multiple methods over different timeframes. The three methods of data collection, focus groups, non-participant observation and interviews, were discussed in detail. The Phase One conceptual framework guided the examination of the new graduate nurses' experiences of moral habitability in their workplaces. This provided deeper understanding, and the subsequent rich description of the thematic analysis of the data generated by Phase Two is presented in Chapters Five to Eight.

CHAPTER 5 PHASE TWO FINDINGS: PARTICIPANT ENGAGEMENT, PARTICIPANT DEFINITIONS AND OVERVIEW OF THE THEMATIC ANALYSIS

Since moral habitability in nursing is an under-researched concept, the second phase of this study, the field component, was specifically designed to capture the experiences of the new graduate nurses through multiple data sources and over the whole first year of practice. The resultant extensive data, the length of time and the level of engagement by the participants proved to be important factors in the analytical process.

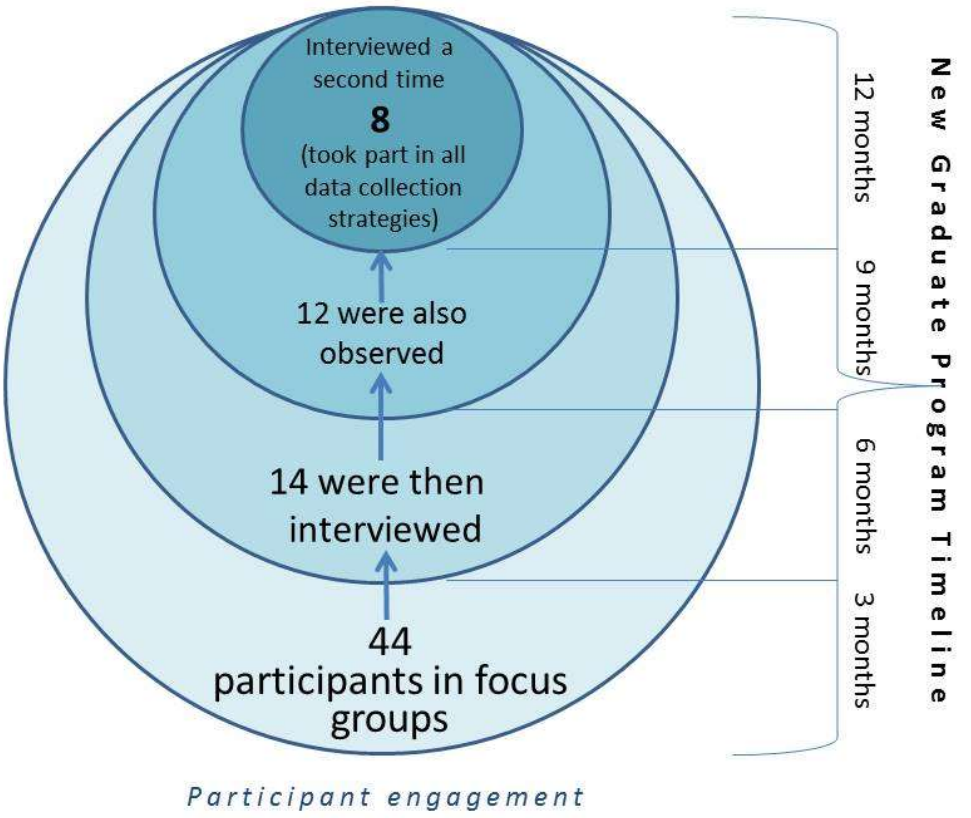
There are three areas of focus in this chapter. The first is to provide the reader with an understanding of the impact of this engagement on the analytical process and insights into the characteristics of the participants. These features are offered in advance of the detailed outcomes of the thematic analysis presented in subsequent chapters. The second area of focus is a presentation of the outcomes of the initial interactions of the new graduate nurses during the focus groups. These data, while integrated into the iterative process of the thematic analysis, offer insights into the new graduate nurses' initial understandings of the term 'moral habitability'. The chapter concludes with the third area of focus, an overview of the outcomes of the thematic analysis.

Overview of Participant Engagement and Characteristics

The level of engagement of the participants was important, due to the complexity of the phenomenon under scrutiny. The data were collected at two sites, from two different new graduate programs, and engaged participants over multiple timeframes and numerous clinical contexts, using a range of strategies. This process provided a means of explicating

data that could be indicative of the experience of moral habitability in nursing. Figure 8 diagrammatically depicts this engagement over time.

Figure 8. Engagement of Participants over the 12-Month Period of Data Collection



Engagement of participants

All 44 of the participants who took part in the data collection contributed to one of the four focus groups. Of this cohort, 14 were engaged in the interview process and 12 in the non-participant observation periods. Over the whole 12-month period of the new graduate nurses' program, eight participants were engaged in data collection over four timeframes and in three different clinical environments. These eight participants were involved in the focus groups in the first three months of their new graduate program, a non-participant

observation period and individual interview in the following seven months and then a second interview in the last two months of their particular program.

The significance of engaging with these participants over time and in multiple contexts is that it informed a multifaceted and nuanced description of their experiences. Since data analysis took place concurrently with the data collection, this level of engagement also influenced the development of the themes. Through an iterative process of seeking individual and common experiences, developing themes and then reviewing and modifying themes, meeting with the participants over the 12 months provided a means to refine the research process. In addition, extended engagement with the participants provided a way to check and re-check the co-creation of the meaning of their experiences.

Characteristics of the participants by pseudonym

While demographic characteristics of the participants involved in the data collection were presented in detail in Chapter Four, this section groups the specific characteristics of the participants involved in the interview and observation periods by pseudonym (refer to Table 5). This is provided to enable the reader to gain an insight into the participants involved in Phase Two who contributed to the specific vignettes that are presented in the findings of the thematic analysis in the subsequent chapters.

The blue shaded section of the table identifies the eight participants by pseudonym who were involved in data collection across the whole 12 months of the study. As detailed above, their accounts were significant, as they provided a means to elucidate the key nuances of their entire new graduate program experience. The other participants identified by pseudonym were those involved in the observation periods and interviews during the first seven to eight months of their new graduate programs. These data on, the sex and age

group of the participants are axiomatic. An explanation of the level of education and prior experience was detailed in the previous chapter. For example, their level of education necessary to meet the requirements of registering as a nurse is either at bachelor degree or graduate entry masters level. Prior healthcare-related roles ranged from a diploma level enrolled nurse to working in veterinary or dental practices.

Table 5. Characteristics of Participants by Pseudonym

Pseudonym	Data	Gender	Age group	Education	Previous experience in healthcare roles
Ruby	All	F	20-25yrs	Bachelor degree	Nil
Billie	All	F	50+yrs	Bachelor degree	Nil
Kate	All	F	26-30yrs	Bachelor degree	Nil
Liz	All	F	41-45yrs	Bachelor degree	Other
Ben	All	M	31-40yrs	Bachelor degree	Patient care assistant
Ashley	All	F	20-25yrs	Bachelor degree	Patient care assistant
Courtney	All	F	46-50yrs	Bachelor degree	Enrolled nurse
Lily	All	F	26-30yrs	Bachelor degree	Nil
Didi	FG/O/I	F	31-35yrs	Masters degree	Nil
Simone	FG/O/I	F	20-25yrs	Bachelor degree	Enrolled nurse
Dot	FG/O/I	F	50+yrs	Bachelor degree	Enrolled nurse
Pip	FG/O/I	F	20-25yrs	Bachelor degree	Nil
Tim	FG/I	M	26-30yrs	Masters degree	Patient care assistant
Mel	FG/I	F	36-40yrs	Bachelor degree	Patient care assistant

Key: Focus groups (FG), Non-participant observation (O) First interview (I) All data (All)

To ensure that confidentiality was maintained, each participant involved in the individual interviews and non-participant observation periods was invited to choose a pseudonym. While some chose their own pseudonym, others asked to have one allocated.

Cultural background was not included as a question in the demographic survey. While the pseudonyms do not reflect cultural diversity, the cohort was culturally diverse, as evidenced by the information provided by some participants during the interviews and non-participant observation periods. Where anonymity may have been at risk because of the choice of a culturally-specific pseudonym, the pseudonym was altered. Pseudonyms were not allocated to participants who were involved only in the focus groups, since their contributions were not separately identifiable in the audio recordings.

To provide further insight into the perceptions of the participants, the outcomes of the initial engagement with the participants during the first month of their new graduate program are presented prior to introducing the outcomes of the overall thematic analysis.

Participants' Definitions from Focus Groups

As discussed in Chapter Four, the assumption underlying the development of the initial activity for the focus groups was that the participants may have had limited experience with conversations regarding the moral aspect of practice. Therefore, the initial activities of the focus groups were designed to establish some baseline understanding of and agreement on the concepts developed in the first phase of the research. Each activity (see Appendices 7-9) included the discussion of a question, the development of premises and a visual representation of the group's consensus through mind maps and drawings.

As an opening exercise for the focus groups, definitions of the terms 'moral', 'habitability' and 'moral habitability' were sought to gain insight into the new graduate nurses' views and provide data for the overall analysis. The following questions were asked:

- What does the term 'moral' mean to you?
- What does the term 'habitable' mean to you?
- What would a 'morally habitable workplace' look like?

Responses from these questions provided the initial data. After posing each of the questions, the participants worked in groups to create agreed definitions of the terms by listing the representative traits. The final term, 'moral habitability', was then agreed upon, defined and visually represented in a diagram by each group.

Participants' definition of the term 'moral'

When asked what the term 'moral' meant to them, the participants' responses indicated that the term had an element of both decision-making and directing behaviour. This was expressed by the participants as choosing right over wrong and how this choice resulted in good behaviour. The attributes that influenced being a 'moral person' were listed as personal honesty, integrity and adhering to the values learned as a child. The axiom of treating others as they would want to be treated was commonly expressed as acting morally. The following comments from various focus groups illustrate the new graduate nurses' perceptions of the term 'moral':

> *Making the right decision, doing the right thing (Participant, Focus group 1).*

> *Making good decisions each step of the way, like not cutting corners with safety, providing some elements of the relational side of nursing, I think particularly for patients who are particularly unwell. Yes, being a support for them, or - I know that when I first started I came out really hard, and having the time to talk to them and*

listen to patients when you've got a million things to do is difficult. But I guess moral to me would mean being able to make good decisions each step of the way (Participant, Focus group 1).

Your morals are your beliefs, aren't they? No matter what sort of job you're working in they kind of form the basis of how you behave (Participant, Focus group 4).

The definitions highlight an understanding of the term 'moral' in their expressions of right and wrong behaviour. During their discussions, the new graduate nurses were not hesitant in sharing their understandings of the term. This was also a feature of their descriptions of the term 'habitable'.

Participants' definition of the term 'habitable'

The term 'habitable' had diverse meanings for the participants ranging from being in an environment where basic living requirements are met, to environments where people actually flourish. The following sample of responses elicited from all four focus groups illustrates this diversity:

A place that is suitable for living in (Participant, Focus group 4).

How you live there (Participant, Focus group 1).

Shelter, warmth, ability to sustain (Participant, Focus group 2).

Thriving and stimulating, being a habitable place to live where you can flourish (Participant, Focus group 2).

In the following description, a more expansive view of the term habitable was provided by one of the focus group participants:

The term 'habitable' means being able to not only survive but sort of thrive in an environment, rather than just sort of going through the motions. 'Habitable' means all your needs - maybe not always your wants, but all your needs are fulfilled. Yes, so that

environment comes from basically people's attitudes, and your ability to work the way that you feel is best. It doesn't always work that way - because of time. But habitability, I guess, means thriving in your environment, rather than just surviving (Participant, Focus group 3).

The participants in the focus groups were then asked what the experience of 'moral habitability' in their workplaces would look and feel like, and were then instructed to create a pictorial representation.

Participants' definition of the term 'moral habitability'

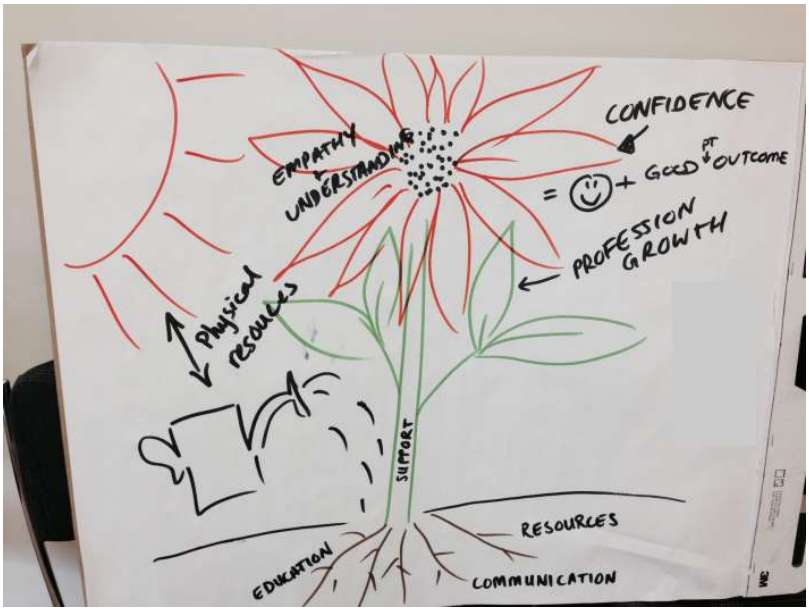
The discussion, words and pictures produced by the new graduate nurses were predominantly relational, that is in regard to relationships with others. The qualities and attitudes of nursing, medical and other staff during workplace interactions were specifically highlighted. The words associated with describing a morally habitable workplace were listed and categories were developed by each of the groups from the collection of words. An overview of the categories and associated words and statements identified during the focus groups as imperative to a morally habitable workplace, are presented in Table 6.

Table 6. Categories and Words to Describe a Morally Habitable Workplace

Safety	Qualities of Staff	Attitudes of Staff	Good Teams	Outcomes
Able to ask questions Staff are non-judgemental Lots of resources	Respectful Compassionate Patient Caring Dignified Understanding Empathetic Honest	Approachable Encouraging Helpful Supportive Inviting and friendly	Good communication Feelings of togetherness Smiling and happy Lots of education	Satisfaction with patient care Confidence Growth Flourishing Ongoing Education

The categories and words were then used to create diagrams to visually represent moral habitability in the participants' workplace. Figure 9 provides an example of a drawing by a group in the fourth focus group.

Figure 9. Moral Habitability Drawing by Focus Group 4 Participants



In describing the drawing of the flower to the other groups involved in the activity, the participants stated that the roots represented management, the stem represented staff support and the flower represented the notion of flourishing in the workplace. Examples drawn from all of the focus groups' reflections on what a morally habitable environment would entail, follow:

> *A place where it allows me to properly act as I see right, and be able to give the care that I need to give, and yes, be able to voice my opinion, as appropriate, and feel supported to do so. Just, yes, be able to be the nurse I need to be (Participant, Focus group 1).*

> *Where you can make good moral decisions and work well. I think it is somewhere where we treat others as we would want to be treated (Participant, Focus group 3).*

It would look like working in an environment where you can work according to your own moral principles, and the workplace, if not totally the same, would be fairly similar. It is where I can happily go to work every day (Participant, Focus group 4).

I think it's somewhere that, yes, that I feel safe and supported, and that I can work in an environment that has the same - that allows me to express my morals and work up to those standards that I feel are right (Participant, Focus group 2).

Moral habitability is when I can feel at ease at work and that I can feel supported and that I'm doing a good job. It all blends together (Participant, Focus group 1).

While the impetus for the initial activity of the focus groups was to provide a baseline and common understanding of moral concepts that would be explored during the data collection, details from the researcher's reflective notes provided an overall impression that the new graduate nurses were highly insightful. In sharing their perceptions, the key features of a morally habitable environment were that it offered a sense of safety, support and satisfaction with their work.

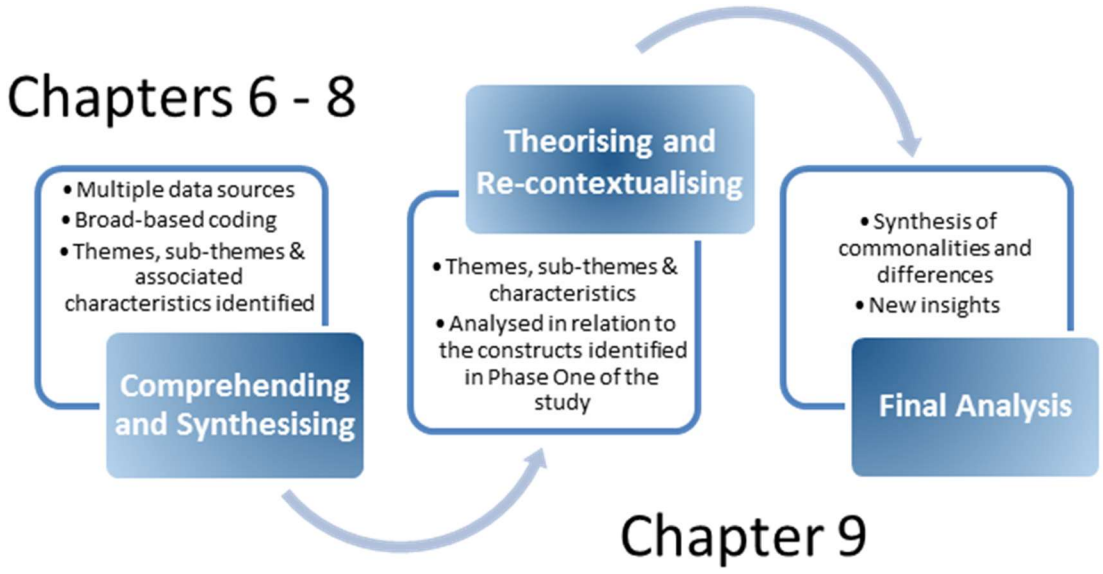
In the preceding section, the outcomes of the initial activity of the focus groups were presented to give further insight into the characteristics of the participants involved in the study. The interactions of the participants in this activity and the comments and diagrams were also integrated into the overall thematic analysis.

Overview of the Thematic Analysis

Prior to the chapters reporting on the themes identified in the analysis, an overview of the process and thematic outcomes is introduced to provide context for the reader. As previously detailed, data was sourced from new graduate nurses in the first year of their nursing practice through focus groups, interviews and non-participant observation. By utilising multiple data sources, different lenses of the new graduate nurses' experience of

moral habitability provided a rich data set (Thorne, 2016). The overall data of this study were analysed using two methods prior to final analysis being undertaken (Figure 10).

Figure 10. Two Stages of the Analytic Process



The focuses of Chapters Six, Seven and Eight, are the outcomes of the *comprehending and synthesising* stage (Morse, 1998). The theorising and re-contextualising stage of the analysis is presented as a synthesis of the two phases in Chapter Nine. While the specific details of the two stages of the analysis were described in the previous chapter, the following discussion highlights the methodological tension that existed in the analytic approach.

Two-stage analytical process

A methodological tension existed in ensuring that an inductive method related to the analysis of the Phase Two data was undertaken with no apriori or thematic overlay of the Phase One findings. This was achieved through an analytic attitude of openness and attentiveness (Thorne, 2016) to what was present in the data, by setting aside the Phase One concepts and not allowing them to drive the analysis. Using an interpretive descriptive

approach requires “learning to see beyond the obvious” (Thorne, 2016, p. 156). Therefore, rather than force the data into the conceptual findings of Phase One, it was possible to remain open to the discovery of new insights. The resultant themes, sub-themes and characteristics are presented in Chapters Six, Seven and Eight.

The second methodological tension involved how to reconcile both sets of findings from the two phases of the study. The second method of data analysis reconciled both phases of the study by addressing the *theorising and re-contextualising* analytic stage (Morse, 1998). Here the themes, sub-themes and characteristics of the thematic analysis were analysed in relation to the concepts identified in Phase One. This provided a means to link the findings of the first and second phases of the study. The subsequent synthesis of the findings of Phase One and Phase Two, an interpretive description of moral habitability in nursing, is presented in Chapter Nine.

Themes, sub-themes and characteristics

The major themes, sub-themes and characteristics identified through the thematic analysis are presented in Table 7 and reflect the words used by the participants to describe their experiences. Each major theme and its associated sub-themes are then detailed in the following chapters. Excerpts of data (vignettes) are provided in italics to illustrate and support the subsequent development of the themes. Citations of data excerpts include the participant’s pseudonym and whether it was an observation period or a first or second interview. Because the contributions to the focus groups were not individually identifiable in the voice recordings, the term ‘participant’ is used for the focus group vignettes.

Table 7. Themes, Sub-themes and Characteristics

THEMES	SUB-THEMES	CHARACTERISTICS
Being a Nurse	Not just a job	It's a vocation Feeling disillusioned
	Making decisions about care	Of benefit to patient What would the patient, my family, or I want? Being an advocate and dignified caring Respecting their choices Relieving their suffering
	Being with patients	Sensing their needs Feeling satisfied with care I could have done so much more
	Expectation mismatches	Talking to patients Getting the tasks done
Working Relationships	Being supported	I can help you Being approachable
	True leaders	How are you going? So patient with me
	Being part of the team	Shared responsibilities
	Working with doctors	Feeling frustrated with them Picking up the pieces
Insider/Outsider	Having a voice	Feeling safe to ask questions Having influence
	Talk to the hand	Being ignored and excluded 'Big' or 'Strong' personalities Being bullied
	Being new	An expectation we will cry Feeling incompetent Seeing things they don't see
Toughening Up	Avoiding conflict	Staying quiet Staying away from some people
	Trying to stay true to my values and principles	Getting around the system Feeling 'morally torn' Debriefing with the right people
	Thinking things through	Letting it go
Influence of the Working Context	Awesome places	Welcome and wanted Respect for everyone
	Horrendous periods	Culture of tasks and no breaks Never having enough resources Culture of blame
	Feeling the impact	Feel it in my chest Extreme changes

Summary

The initial perceptions shared by the new graduate nurses demonstrated awareness of and insight into their experiences of moral habitability in nursing. While the initial findings of the study offer these insights, the data were integrated into the analysis through an iterative process over the entire 12-month engagement with the participants. Variations in age and extent of prior healthcare experience revealed a participant group that was not homogenous. However, it was reflective of the new graduate nurses employed in the two sites of the fieldwork. Finally the themes were presented in order that the reader has the context for the detailed outcomes presented in the following chapters. The next chapter outlines the first theme from the thematic analysis, 'Being a Nurse'.

CHAPTER 6 PHASE TWO FINDINGS

THEME 1: BEING A NURSE

The purpose of this chapter is to present the first theme about moral habitability in nursing identified in the new graduate nurse findings of the thematic analysis. The theme 'Being a Nurse' was generated across all of the data sets and expresses the reason, decision making, purpose and personal expectations of what the new graduate nurses viewed as what it is to be a nurse. Being a nurse was an important finding in relation to moral habitability in nursing. Table 8 highlights the sub-themes and characteristics that support this theme.

Table 8. Theme 1: Being a Nurse

THEME	SUB-THEMES	CHARACTERISTICS
Being a Nurse	Not just a job	It's a vocation Feeling disillusioned
	Making decisions about care	Of benefit to patient What would the patient, my family, or I want? Being an advocate and dignified caring Respecting their choices Relieving their suffering
	Being with patients	Sensing their needs Feeling satisfied with care I could have done so much more
	Expectation mismatches	Talking to patients Getting the tasks done

Over the 12 months of data collection, the new graduate nurses consistently demonstrated a desire to meet their patients' holistic needs. This was reflected in how they identified as a nurse. The focus on being with their patients and identifying their patients' needs, also

determined whether their work experience was satisfying. They reported their practice environments often promoted an orientation to completing clinical tasks over 'being with patients', a term used by many of the participants. The new graduates claimed that this was at odds with their preferred focus on being with their patients to build relationships and understand their needs and then act on those needs.

In making decisions about the actions of being a nurse, a factor that was prominent in the interviews and focus groups was imagining themselves or their family members in the same situation as their patient and then considering what they would want to occur in that particular state. This was often expressed through a holistic approach to patient care, which included the psychosocial and, at times, the spiritual needs of the patients. This was a dominant thread to their discussions and was frequently observed. If the new graduate nurses' perception of meeting the needs of patients was undermined, dissatisfaction was expressed. This dissatisfaction was also evident in the focus groups and many of the first and second interview transcripts. Dissatisfaction was also evident when the service-oriented, vocational aspect of the new nurses' ideal was not met. This was expressed the following sub-theme.

Not Just a Job

While just under half (48%) of the participants had previously worked in healthcare-related roles, during the focus group discussions it was evident that nearly all of the participants had experienced some type of employment prior to their new graduate nurse position. The conversations during these discussions often highlighted that nursing meant more to them than their previous employment. The emphasis on the importance their new career direction had was also evident in many of the interviews. However, some of the participants

expressed disillusionment with their new job (i.e. nursing), when it did not meet their perceived ideal of *being more than just a job*. The characteristics of this sub-theme, 'it's a vocation' and 'feeling disillusioned', are discussed in the following sections.

It's a vocation

The term 'vocation' was used directly or implied by many of the participants in the focus groups and during some of the interviews in discussions regarding their work. An illustration of this experience came from Billie who discussed the vocational nature of nursing work, and the difference she perceived in working with people in her new role as a nurse. Billie entered nursing after a long career in other non-healthcare-related roles and after bringing up her children. During her second interview at the end of her new graduate year she stated:

> *Nursing is not a 'walk away from it' job. I have chosen to do nursing at a time in my life as a bit of a vocation. It's something I want to do. I don't just view it as a job and treat it differently than my other jobs. Even though I was involved in them [previous jobs], I didn't go home and think about some of the people I met that day (Billie, 2nd Interview).*

While the participants were not directly asked why they had become nurses, discussions in the focus groups and interviews often spontaneously led to the motivational influences of their choice to be a nurse. A variety of motivations were expressed with responses that included value statements such as *"being of service to others" (Participant, Focus group 4)* and personal fulfilment, and a very small group of participants cited religious obligations.

Service orientation and personal fulfilment were expressed by the majority of the new graduate nurses as their reason for being a nurse. This is reflected in a statement by Kate,

who expressed this vocational nature of nursing during her first interview after three months of working in a critical care environment.

> *I needed to be fulfilled in my job, to know that I was doing something that I felt was important to people - to help other people. I think that that's why I chose this path (Kate, 1st Interview).*

However, the vocational motivation of being a nurse was at times at odds with some of the new graduates' experiences. At times this led to disillusionment.

Feeling disillusioned

While the majority of the new graduate nurses expressed a vocational motivation for their choice of nursing, some of the participants in the focus groups and interviews expressed how they were deeply disillusioned by the realities of practice. This lead to questioning why nursing as a career had not met their expectations. For example, many of the participants spoke with intensity about the tension they experienced in what they perceived was the goal of a nurse, i.e. holistic care, and how their experience of working as a new nurse rendered this goal impossible. Liz, who had previously worked in a different healthcare role, spoke of her disillusionment as a new nurse in not being able to provide what she stated was *"real care" (Liz, 1st Interview).* This form of discouragement was frequently observed and evident in the focus group and interview discussions. For example, Liz shared her feelings of discouragement about not being able to provide adequate care while she was working in a busy medical ward:

> *I don't want to sound like this has been the worst experience of my life, but it has been – I'm a little bit disillusioned by nursing practice, to be perfectly frank (Liz, 1st Interview).*

The challenge of not meeting vocational expectations of what 'Being a Nurse' entailed was deeply disappointing to these new graduate nurses. This sub-theme highlighted that nursing was more than just a job for some of the new graduate nurses and for many, their experience of their work fell short of this ideal. While this sub-theme highlighted the reason for becoming a nurse, the next sub-theme features the decision-making that being a nurse requires.

Making Decisions about Care

In this sub-theme, the decision-making and purpose of being a nurse is highlighted. Decisions regarding patient care are not only structured around the clinical benefit to the patient but also place emphasis on the importance of supporting patient's choices. For example, the decision of when to wash a patient includes consideration and balancing of the clinical needs, such as the need for mobility and an expressed request by the patient to delay hygiene. Decisions of this nature are focused on what would be of benefit to their patients.

Of benefit to patients

Discussions by the new graduate nurses throughout all of the data sets demonstrated an attitude to care decisions that were 'of benefit to their patients'. This was illustrated by Kate, who had completed her nursing degree immediately after high school and was working in a critical care environment for her final placement in the new graduate year long program. Kate was involved in all of the data collection strategies and her perception of her purpose in being a nurse remained consistent across the 12-month period. This consistency of purpose was evident in all of the eight new graduate nurses who participated in this

study over their entire new graduate program. Kate provides an example of this consistency of the purpose of nursing care prioritisation:

> *Focusing on what is of benefit to the patient (Kate, 1st Interview).*

> *Purely, if it's to benefit the patient. If I feel that it's something that is – if it's going to benefit them then that is my priority (Kate, 2nd Interview).*

For the majority of the participants, benefit to the patient was not limited to physical care requirements. Care decisions were often expressed in a holistic manner and identified the corresponding psychosocial needs of the patients:

> *Just things like, you've got a patient who has been in bed for the last five days, feels like crap, and you've come into that room. You're like, okay, well, I could just give them a wash in bed because that's easier for me, or I could go and get the hoist, get them out, give them a shower, and put them in a big comfy chair, so that they don't end up getting pneumonia on top of everything else they've got. Which takes you an hour and a half. But at the end of the day, they feel happier and it's best for them (Pip, 1st Interview).*

Another factor that was influential in discussions about care decisions by some of the participants in the first interviews, was ensuring that care was not only holistic but maximised. Simone, who had previously worked in a healthcare role provided an example of this ideal of how care decisions need to be patient-focused to ensure all needs are met:

> *It's not about you, it's about them and their whole care, and making sure that it's maximising their potential (Simone, 1st Interview).*

In deciding how to maximise care from a holistic perspective, the participants frequently expressed an empathetic element to their decision making. This is captured in the following characteristic of this sub-theme.

What would the patient, my family or I want?

In making patient care decisions the majority of the new graduate nurses expressed an underlying desire to do what the patient, would want to happen. When the patient's wishes could not be ascertained, they considered what they themselves or a member of their family might want if they were in their patient's place. This was a dominant feature of discussions in both the focus groups and interviews, and further substantiated in the observation periods. During the second focus group a participant provided an example of this commonly-held value that influenced how the new graduate nurses made decisions about nursing care:

> *I tend to think if I was that patient, or if that patient was my mum or uncle or sister or whatever, what would I want to happen? (Participant, Focus group 2).*

Another participant who was involved in all of the data collection procedures was Ruby. During the second interview with Ruby, in the last three months of her new graduate year, she provided further insight into the application of these values to care decisions. Here Ruby discusses an elderly patient who had sustained a head wound and had blood covering her face:

> *I think I always put myself in - like in that circumstance, in the family's shoes. I always think about, if I was the family member, what would I want, or if I was the patient, would I want my grandsons to see me being washed? (Ruby, 2nd Interview).*

This envisioning of what the experience might be like was demonstrated in many of the interviews. In an example afforded by Tim, he reflected on the challenges for immobile patients in the neurology ward where he was working:

> *I mean, I always view that if I were immobile, I probably wouldn't be too keen to ask for help. I'd like someone to pay attention to me, to see that I might need moving or*

> *helping, that way the less mobile patients would get a 'fair go' in the busy mornings instead of being left out (Tim, 1st Interview).*

The primary goal expressed by the new graduate nurses when referring to care decisions for patients was that care should be in the patients 'best interests'. This was particularly evident at times when it was not possible to ascertain the patient's view of what their 'best interests' entailed. During observation this was substantiated by both comments and actions. The new graduate nurses were often seen asking patients or their families about their needs. This was exhibited during an episode of observation with Ben in a busy surgical ward during his fourth month of the new graduate program when he commented:

> *I guess my first instinct would be what does the patient actually think? I mean, if they're not able to choose for themselves for whatever reason (Ben, Observation).*

Ben was then observed discussing care decisions with the patient for whom he was caring.

Another aspect of making care decisions and identifying the purpose of being a nurse was expressed in the prevailing dialogue which included the importance of advocacy and dignified care.

Being an advocate and dignified caring

Discussions in all of the focus groups, particularly in regard to Activity Two (see Appendix 8), included commentary on the importance of patient advocacy and upholding patient dignity. These values were key to how the new graduate nurses viewed what was integral to the role of the nurse. Being an advocate for their patients was seen both as a primary responsibility and as a means to make care decisions to meet patient needs. An example of this was provided by a participant in the first focus group who stated:

> *Being your patient's advocate - fulfilling our main role as an advocate is a good way of how you meet the needs of your patients (Participant, Focus group 1).*

During many of the observation periods, the new graduate nurses appeared to have a heightened sensitivity to the need to advocate for patients' needs that may have been missed by other staff. This was exemplified in an observation episode with Pip, where the vulnerability and frustration of a patient unable to eat due to a ward policy was quickly recognised and acted upon.

In contrast, this promotion of patient advocacy was limited when the ability to act was inhibited. For example, in the same observation period with Pip, advocacy did not extend to a patient with a drug addiction who was in intractable pain. Unable to find resolution after advice from more senior staff that it would not be possible to alleviate the patient's pain, her response was to cease advocacy and remove herself from the patient so as not to witness the effects of the patient's pain. This suggested that her advocacy might be limited to when she perceived she could do something to address the patient's needs. Limits to advocacy were also a feature in other observation periods and in focus group discussions. For example, Liz was observed repeatedly attempting to find assistance to move a patient at their request. However, unable to find assistance, she moved to another task.

The new graduates' understanding of advocating for patients also involved ensuring patients were not disrespected in ways that breached their dignity. This was particularly evident in many discussions in the focus groups and interviews regarding caring for the dying, the vulnerable and patients they perceived as suffering. Upholding dignity through advocacy was also witnessed on a number of occasions during the observation periods. Ben

provided an example while caring for an elderly patient with dementia when he commented:

> *Sometimes even when you are busy you just have to stay with them, make sure they are covered up, and keep their clothes on, until their family comes (Ben, Observation).*

The imperative of providing dignified care was not isolated to the early experiences of the new graduate nurse year but continued across the 12 months of data collection. This was evident in all of the eight participants who were involved across the whole of their new graduate program. An example of the importance of dignity in all care episodes was demonstrated during the second interview with Courtney when she discussed the importance of providing dignified care to her patients in a holistic manner:

> *You treat people with respect and uphold their dignity. It happens in every job that you do for them, from showering to changing their dressing or to getting them their medication. Just everything that you do for that person, when you come into contact with them, you would want to do to the best that you can do (Courtney, 2nd Interview).*

The importance of caring for patients in a dignified manner in all aspects of care was explicitly stated or implied by many of the new graduate nurses, and at times in ability to meet this ideal caused difficulty.

During the first and second interviews, over half of the participants expressed highly critical views about nursing staff who they perceived were not treating patients with respect and dignity and were not working as advocates for their patients. For example, Billie shared an experience where she was critical of the nurse unit manager's critique of her care prioritisation:

> *Then my confused lady was incontinent and took all her clothes off. I go to her in the shower and then I could not get her out. It's a single room, so I was in there for maybe half an hour with this poor lady. Eventually the nurse manager came in and said, "What are you doing in here?" I said, "Well, I can't leave her – she's naked and confused, and a super-high falls risk." She then said to me I needed to re-prioritise and I needed to work out who my sickest patients were. This lady was incontinent, naked and unsafe. This was not only a safety issue but also a dignity issue! (Billie, 1st Interview).*

Examples of the new graduate nurses' disapproval of nursing colleagues' attitudes was witnessed in eight of the 12 observation periods. This was important, because the periods of observation provided the opportunity to gain contextual understanding and reflect on behaviour and context. An example of this disapproval arose during an episode of observation with Liz while she was working in an acute medical ward. During the observation period Liz appeared angry when she emerged from the room of a patient she had not been assigned to. On enquiring what was of concern, she recounted her experience of finding a morbidly obese patient who was not under her care, shivering and undressed with a bowl of cold water on his bedside table. The patient had not been given assistance to wash himself and had been left undressed with the bowl of water for over an hour. When Liz asked the nurse to whom the patient had been assigned if she could now assist the patient to wash, the response from the nurse was that the patient was lazy and should do it himself. Liz believed he could not manage it and assisted him and commented to the researcher:

> *What do you do with attitudes like that? This is outrageous, he obviously can't do it by himself (Liz, Observation).*

In making this statement, compounded by her angry facial expression, Liz conveyed her anger at the disrespectful attitude displayed by the other nurse. This experience was similar

to many of the other new graduate nurses' experiences and highlighted the importance afforded to this aspect of practice.

When successful in providing advocacy and dignified care decision-making, the new graduate nurses frequently articulated a sense of fulfilment and satisfaction in 'Being a Nurse'. Another characteristic that produced a sense of satisfaction was the ability to respect their patients' care choices.

Respecting their choices

The majority of the new graduate nurses, during the focus groups and interviews, expressed the imperative of upholding the autonomy of their patients. This was particularly emphasised by the respectful attitude to the choices their patients made. This is exemplified by the following narrative of a focus group participant and illustrates the satisfaction of supporting a patient's choices in the end stages of life. Her patient had a long history of cancer and he had been admitted with pneumonia. After three successive attempts with antibiotic therapies, he chose to cease treatment. The new graduate nurse worked with the family and the patient to ensure their needs were met. She described the experience vividly:

> *So everything was stopped. He died that night. I sat with him as he died, bawling my eyes out. But it was the most beautiful thing I've ever done. I felt so privileged. His family had been there all the time and of course they'd left - but knowing that's what he wanted. Amazing! The most powerful thing you can do for someone's end of life is respect their wishes (Participant, Focus group 3).*

However, choosing to respect the choices of patients was not always straightforward. Conflicts between the new graduate nurses' own beliefs and patient choices were often present in their discussions. One participant during the first focus group outlined an

example of the difficulties associated with trying to respect patient choice when in direct conflict with her own underlying beliefs as to what would be beneficial for the patient:

> *I think it's hard, because sometimes I do watch people, and I can see myself going, "This is definitely what's best for you", and it's not but I need to go with what they want (Participant, Focus group 1).*

While respecting patient choices produced conflict at times, in all four of the focus groups a consistent dialogue regarding factors that influenced care priorities was whether the patient was in pain or suffering.

Relieving their suffering

Relieving pain and suffering was viewed as the primary responsibility of a nurse. The need to identify sources of potential discomfort was exhibited by many of the participants during the observation periods, interviews and focus groups. There was a shared expectation that relieving suffering should be *the* priority in decision-making. During all of the focus groups when participants were sharing examples of how they attempt to relieve patients' suffering, there were often nods of agreement around the table. This primacy was further demonstrated by a participant in the third focus group during a conversation regarding making care decisions:

> *Some care, if it has the - it has the potential to be delayed, but you know it's going to be given, that's okay. But there are other things, such as pain and suffering that must be dealt with straightaway (Participant, Focus group 3).*

Throughout the focus groups, interviews and observation periods, all of the new graduate nurses demonstrated a restorative caring response. This was exhibited by not only relieving pain and identifying sources of potential discomfort but by attempting to find a solution to

the discomfort their patients may have experienced. An example of this focus was presented during the fourth focus group when one participant stated:

> *If I have patients around me, and I've seen that their nurse was not necessarily as nice as they need to be, I might just stick my head in and have a bit of a chat and offer them a drink, or give them another blanket or something; try and make up for the negative experience they've just had (Participant, Focus group 4).*

For the participants, the focus on being able to identify and then rectify discomfort, suffering and provide holistic patient care involved being with their patients. This is discussed in the following sub-theme.

Being With Patients

The sub-theme 'being with patients' highlights the expectations of the participants in how they identified what it is to be a nurse and was dominant in all of the data sets. Developing a strong relationship with their patients by 'being with' them was expressed as imperative in decision-making and the provision of comprehensive care. It was closely linked to their experience of satisfaction in what it was to be a nurse. The following characteristic, 'sensing their needs', was influential in how the new graduate nurses made decisions about care by 'being with patients'.

Sensing their needs

'Sensing their needs' was expressed and observed as a reciprocity of mutual sharing between the patient and new graduate nurse. It was evident in some of the interviews, that the new graduate nurses needed time to develop rapport with their patients to ensure they had an understanding of their needs. This reciprocity of sharing was expressed by Pip when she was working in a busy medical unit in her first three months of her employment:

> *I build a really good rapport with them, so then they'll tell me things that, like, a lot of people might not have even picked up. But they feel that they can open up to me, because I open up to them and that way I can sense their needs (Pip, 1st Interview).*

The linking of rapport and identification of patient needs was also observed in three of the observation periods. An example occurred during observation with Ben who had previously worked in a healthcare-related role while studying to be a registered nurse. During a particularly hectic shift in a critical care environment, Ben was observed comparing tattoos with his patient. In a discussion regarding this interaction he commented that relationship-building provided a means to know his patient and know what he needed. While not a dominant characteristic of this sub-theme, it was influential in the experiences of the new graduate nurses who believed it was easier to identify the holistic needs of their patients through the rapport and communication developed during the time spent with them. It was also evident that 'being with patients' was linked to whether the participants were satisfied with the care they provided.

Feeling satisfied with care

In the new graduate nurses' conversations related to the sub-theme 'being with patients', the participants identified three common elements which they perceived to be imperative to feeling satisfied with the care of their patients. These included spending time with their patients and the sense of being able to meet the holistic needs of the patient, particularly if the patient was highly vulnerable. Being thanked by patients for the care the new graduate nurses had provided was also a contributor to their sense of satisfaction. During her first interview, Ruby's response is an example of this satisfaction with care, based on patient approval and the perception of meeting all the needs of the patient through time spent with them.

> *I'm satisfied when the patients are happy and clean, and all the medications are given, all the paperwork is done - yes, and spending time with the patient (Ruby, 1st Interview).*

It was notable in the data was that most participants demonstrated the satisfaction they experienced in their new profession when they spent time with their patients. In the responses gathered from the interviews and focus groups, satisfaction with the care they provided was central to their satisfaction with their work. They specifically highlighted the satisfaction they felt in caring and being with their patients at vulnerable moments in their lives. A typical example was shared by Kate, who began nursing after working for many years in what she described as unfulfilling non-healthcare-related roles. In her first interview during the fifth month of her new graduate program while she was working in a critical care environment, she spoke animatedly about the job satisfaction she felt being with her patients and their families:

> *I can be that person, that in somebody's most critical time, whether it's for the patient supporting and being with them or the family as well, the job satisfaction from that I feel is huge (Kate, 1st Interview).*

Satisfaction with 'being with' and spending time to meet patients' needs was further demonstrated during a discussion in the first focus group. In the next example, one of the participants recounts a situation she encountered the night before in a medical ward with an elderly woman who had received a diuretic and who urgently needed a bedpan to urinate:

> *I was working - an old lady, who was there for ages, needed to use the bedpan and didn't want to bother me because she thought I was busy. I said, "No, no, no, no!" I put the call bell next to her and then after I got her off the pan, she started crying. I said, "What's the matter?" and she said, "I just feel like I'm being a nuisance." I'm like, "This is my job. You're not a nuisance……She was like, "Okay." From then on, even though she had to use the pan every hour because she was busting, she still managed to call me and said, "Can I have it?" and I said, "Yep, I'll get it right now."*

> *Its two minutes; popping it under and giving her some privacy, doing the next thing, coming back and saying, "How are you feeling now?" (Participant, Focus group 1).*

In providing this account, the participant then discussed with the other participants in the focus group the satisfaction she felt when she could meet the needs of a patient she perceived as being vulnerable.

Some of the new graduate nurses expressed that they viewed spending time and communicating with patients as a moral imperative. An example that showcased this was provided by Tim, who had eight years' prior healthcare-related work experience:

> *I feel like I'm taking that little bit of extra time during the day, and endeavouring to communicate with patients. I can conduct myself in a moral way. In a way that I'm happy with and in a way that lets me come home and enjoy my time at home, and fall asleep (Tim, 1st Interview).*

In her account, Mel highlighted that the satisfaction of patients was also integral to her personal work satisfaction:

> *For me, it's when you go at the end of your shift to say goodbye to your patients, and they thank you for what you've done. I think people aren't going to say thank you if they're not happy for what you've done. Sometimes they'll say, "Are you back tomorrow, will I see you tomorrow?" (Mel, 1st Interview).*

Being thanked by the patient assisted the new graduate nurses to assess their level of care, viewed as 'being with' patients. An example of the satisfaction this produced was viewed during an observation period with Ruby when a patient provided positive feedback on how she appreciated the time Ruby had spent with her that day. Ruby commented that this had made her *"feel so good and just gives me so much satisfaction"* (*Ruby, Observation*).

In contrast to the satisfaction with care exhibited by 'being with' patients was the deep dissatisfaction the participants expressed when this was thwarted and is represented by the following characteristic.

I could have done so much more

One dominant thread in the discussions, particularly during the focus groups, was the strain the new graduate nurses experienced if they felt that not all of the patients' needs had been met. There was a strong sense that if they had not been able to 'be with' their patients and attend to their psychosocial needs, their care was inadequate. Profound dissatisfaction was expressed when the participants spoke extensively in the focus groups and interviews, reflecting on gaps they perceived in the care they had provided during the previous shift. Interestingly, even though they spoke about how the patients thanked them for their care, they sometimes expressed conflicting emotions. This represented the dichotomy of positive feedback from their patients against a self-evaluation of inadequacy. This was supported by a reflection shared by a focus group participant:

> *To the patient I'd say, "Thank you," outwardly, but internally I say, "I could have done so much more" and feel terrible (Participant, Focus group 4).*

This statement appeared to resonate with the group of eight other participants who murmured *"yes, yes" (Various participants, Focus group 4)*. In a similar account, a participant in the second focus group stated:

> *But according to my plan for the day, I didn't get everything done that I wanted to get done, and they were thanking me, and saying I was wonderful and thanking me, and saying, "I hope my next nurse is as lovely as you," and I was just thinking to myself, "I could have done so much more for you today. You have no idea." But I just didn't have the time to be with you or the help to do it (Participant, Focus group 2).*

The self-evaluation of inadequacy was also witnessed in an observation period, where Lily expressed her frustration in not being able to spend time with a distressed bariatric patient when she commented:

> *I always feel like I am not doing enough for patients (Lily, Observation).*

Although Lily had been observed tending to the patient's clinical needs, such as changing a soiled incontinence pad and dressing a wound over a two-hour timeframe with this patient, she critiqued her performance as being inadequate. The frustration in not meeting all of their patients' needs was exacerbated by a mismatch in the personal expectations of the new graduate nurses and those of their more experienced nursing colleagues about what 'Being a Nurse' entailed.

Expectation Mismatches

The final sub-theme, 'expectation mismatches', identifies the challenges to the participants' understanding of their responsibilities and what being a nurse involves. This sub-theme featured two incongruent characteristics: the expectations of the new graduate nurses who prioritised 'talking to patients' as against that of the experienced nursing staff who prioritised 'getting their tasks done'.

Talking to patients

During all of the focus groups and many of the interviews the frustration of mismatched expectations was expressed repeatedly by the participants, particularly in regard to feedback they had from nursing staff in prioritising nursing tasks over talking with patients. Many of the participants were articulate about the tension of being pressed to meet tasks over what they perceived to be of *equal* importance, communicating with patients. This

championing of the importance of talking to patients remained consistent over the entire 12 months. During her second interview in the last month of her new graduate program, Liz shared her reflections on the incongruence between her perception of nursing care and the importance of talking to patients, and what she perceived as being those of other staff who were focused on getting tasks done:

> *Sometimes it's priorities that are tasks being pushed onto you rather than actually what you think patient care is, like talking to your patients (Liz, 2nd Interview).*

This conflict of priorities was a dominant feature of the interviews and focus groups.

Many of the new graduates expressed discontent with working in environments where the nursing staff promoted meeting only the clinical needs, for example dressings or medications, of the patients rather than what the graduate nurses saw as taking a more holistic approach. In the new graduate nurses' opinion, time spent talking with patients was of competing importance to a task such as the physical needs of wound dressing or medication administration. An example of this disparity in expectations was witnessed during an observation period with Courtney midway through her new graduate nurse program. Working in a busy medical setting a senior nurse was observed expressing frustration with Courtney because she was spending time talking to patients rather than writing her report. This kind of contradiction in expectations of nursing responsibilities was significant to the new graduate nurses' understanding of 'Being a Nurse' and is highlighted in the following characteristic.

Getting tasks done

Over a third of the participants interviewed stated that they were unsure of their responsibilities due to an internal conflict between wanting to spend time communicating

with their patients and the demands of other nursing colleagues to fulfil their 'nursing' tasks. This sentiment was also commonly expressed in the focus groups and contributed to a sense of failing to meet the needs of patients. The primary focus of being with patients while being pressed by senior nursing staff to forgo this *"luxury" (Participant, Focus group 1)* generated an internal challenge for the new graduate nurses. This focus on nursing tasks where patient interaction was limited was often expressed by the new graduate nurses with distain, using terms such as *"tick box" (Participant, Focus group 2) or "task oriented" (Ashley, 1st Interview; Billie, 2nd Interview)*. An example of this internal conflict was outlined during one of the focus groups:

> *It's kind of like a battle with doing the tasks they want you to do or doing what's right like trying to spend time with them. It is task-orientated, as opposed to actually trying to do what they need you to do (Participant, Focus group 3).*

The mismatched expectations of nursing care responsibilities for the new graduate nurses caused significant tension in the juxtaposition of what was perceived as 'right' and what was 'expected' by their nursing colleagues.

Summary

Being a nurse was an important theme generated by the participants regarding their experiences of moral habitability. Being a nurse was identified as more than a 'normal' job by the new graduate nurses. When they were able to meet their own perceptions of nursing, of meeting the holistic needs of their patients rather than simply completing a list of tasks, they described their work as fulfilling. Interacting and communicating with patients was highly regarded and was important for understanding what the needs of their patients were. In making care decisions, having time to be with their patients was considered a mandatory factor for the development of an empathetic understanding of care imperatives.

In that way the new graduate nurses could ensure their care maintained dignity and they could advocate for what the patient would want to happen. Dissatisfaction occurred when the new graduate nurses perceived their care was inadequate, because they were forced to focus on a set of tasks to complete, over spending time with patients. This theme reflected the core perceptions of the new graduate nurses of what it means to be a nurse. The impact of how external workplace relationships influenced their perceptions of themselves and their practice is discussed in the next chapter.

CHAPTER 7 PHASE TWO FINDINGS

THEME 2: WORKING RELATIONSHIPS AND THEME 3: INSIDER/OUTSIDER

For the new graduate nurses, working relationships and the experience of being Insider/Outsiders were important aspects of moral habitability; these second and third themes are presented in this chapter. New graduate nurses enter the workplace and have to negotiate relationships with colleagues across the diverse disciplinary boundaries of the healthcare context (Pfaff, Baxter, Jack, & Ploeg, 2014). Themes Two and Three emphasise the interdependence of the working relationships encountered by the new graduate nurses and the effect on their professional self-perception. The chapter begins with the findings related to Theme Two.

Theme 2: Working Relationships

This theme highlights the relational nature of the new graduate nurses' experiences, and in particular, the interconnected nature and interdependence of this experience. This was predominantly manifested through communication between the new graduate nurses and their colleagues and the effects of this communication. Ashley, in the last week of her new graduate program, eloquently captured this interconnected relational experience when she simply stated:

> *In all we do as nurses, people influence people (Ashley, 2nd Interview).*

This theme was generated from data from the focus groups, interviews and observations. The sub-themes and characteristics of this theme are presented in Table 9.

Table 9. Theme 2: Working Relationships

THEME	SUB-THEMES	CHARACTERISTICS
Working Relationships	Being supported	I can help you Being approachable
	True leaders	How are you going? So patient with me
	Being part of the team	Shared responsibilities
	Working with doctors	Feeling frustrated with them Picking up the pieces

The importance of an open style of communication in developing and sustaining relationships in workplaces considered supportive, dominated the data related to this theme. Communication with colleagues, whether perceived as helpful or at times dismissive, was highly influential in the new graduate nurses' overall satisfaction and in how they understood their care responsibilities. Being supported was integral to meeting these responsibilities.

Being supported

As previously stated, during the new graduate year the participants worked in three different clinical contexts. Over 80% of the new graduate nurses who were involved in the interviews expressed that they had experienced very demanding and unsupportive workplaces in one or more of their clinical placements. However, the majority of the new graduates had also experienced working in highly supportive environments. The comparison of experiences of high support and significant lack of support during their first year of

nursing practice was particularly evidenced by the eight participants who were involved in data collection over the entire 12 months.

This sub-theme illustrates the experiences of the new graduate nurses of feeling supported in their workplace. Of particular interest was a contradiction between their statements in the interviews and focus groups about what they perceived as supportive communication and actions of other nurses, and the fact that this form of support was rarely observed by the researcher. What were described as supportive relationships during interviews and focus groups were nursing staff offering assistance with a demeanour of approachability. This is captured in the following characteristics that relate to this sub-theme.

I can help you

Throughout the discussions of the new graduate nurses in the focus groups and interviews, feeling supported was strongly associated with a proactive response by nursing colleagues in providing practical assistance. An example of this perception was provided by Simone during her first interview while she was working in a very busy orthopaedic unit:

> *Fantastic group of nurses who are very helpful, and are always like, "if you need anything, let me know. I can help you give that patient a wash; I can help you turn them" (Simone, 1st Interview).*

This willingness to assist the new nurses offered by other members of the nursing team was highly valued. The value of this interdependence on each other influenced the participants' sense of being supported.

In contrast to the new graduate nurses' accounts, proactive assistance was not often noted during the observation periods. In two-thirds of the observation periods, although the new graduate nurses stated that the staff were supportive, there was a lack of evidence that this

support was available. On a number of occasions during observation, many of the nursing staff were dismissive and did not inquire whether they could assist the new graduate nurse, even though they were exhibiting signs of needing help. An example of the dismissive rather than proactive stance of the other nursing staff was witnessed in an observation period with Lily while she was working in a medical ward. Lily was observed walking rapidly around the ward trying to find assistance with cleaning a hemiplegic patient who had spilt a drink over himself. Although she continually asked for assistance from the other nurses who walked by, she was unable to obtain support. Her frustration was evident when she stated:

> *They are nice but not helpful, not there when needed (Lily, Observation).*

This contrary view of working with nurses who were considered 'nice' and yet not providing proactive or even needed support, was common to many of the new graduate nurses observed and interviewed.

While support was rarely evident during the 12 observation periods, it was witnessed in some of the clinical environments. For example, during an observation period with Ben in a very busy medical ward, staff were frequently observed stopping what they were doing to check if he needed assistance or any questions answered. That this proactive assistance was valued was evidenced in Ben's comment:

> *It takes so much time to get help, it is much better if they just ask you (Ben, Observation).*

Relationships with other nursing staff that were viewed as contributing to a sense of being supported were characterised by not only pre-emptive assistance, but also approachability.

Being approachable

During the focus groups, sentiments related to how approachable nursing staff were, were often shared by the participants:

> *Being able to approach people is one of the things that are really supportive in the environment (Participant, Focus group 1).*

This contributed to an overall feeling of being supported and feeling satisfied. In a similar account during the third focus group, a participant described her positive experience of her relationship with the nurses in her current workplace:

> *Everyone's approachable, so if I've gone to them and said, "I think this needs doing," they'll say, "Okay. What do you need? What do you want me to do?" (Participant, Focus group 3).*

In describing what approachability of nursing staff meant to the new graduate nurses, 'feeling respected' dominated and it was imperative to them that they were not viewed as a nuisance. This was expressed by a participant in the fourth focus group:

> *They give you respect, I suppose. They don't see you as a pain (Participant, Focus group 4).*

Approachability was also highlighted by a sense of being comfortable in asking questions without an associated feeling of being judged. The notion of being viewed as a nuisance was linked to whether the questions that they asked were 'stupid'. This was a common experience amongst the new graduate nurses and is articulated in the experience of Didi:

> *The attitude of,' it's okay'; there's no such thing as a stupid question, and what can I do for you, do you need help? (Didi, 1st Interview).*

The importance of rapport with regard to the approachability of other staff was reiterated by many of the new graduate nurses. Nurses who were viewed as approachable were willing

to share elements of their outside life. This contributed to a rapport between the new graduate nurse and the approachable staff member. In describing an 'approachable nurse' Courtney had worked with, she stated:

> *Approachable as well. Sharing their knowledge, if they're more senior. Sharing in the little things that you wouldn't necessarily think about that. Just like sharing what you've done on the weekend? So building that relationship, the rapport (Courtney, 1st Interview).*

Another aspect of the interconnectivity and influence of working relationships during the new graduate nurses' experiences in their different placements was the significance of the leadership styles of more senior nurses. The following sub-theme reflects the importance of leadership.

True leaders

In describing the individual characteristics of working with supportive nurses, the participants did not restrict their use of the descriptor 'leader' to a nurse with management responsibilities, but instead, used it to describe nurses with more experience who demonstrated what they perceived as leadership. This was manifested in two specific characteristics. The two common features attributed to a 'true leader' that were most highly valued by the majority of the participants were being proactively asked how they were managing and patience.

How are you going?

Descriptions of a 'true leader' often included attributes such as being friendly and happy. However, particularly in the interviews and the focus groups, the new graduate nurses spoke most animatedly about working with someone who inquired about how they were managing their current placement. During her first interview, when she was working in a

very difficult acute gerontology ward, Courtney provided some insight into this experience of working with a 'true leader':

> *Friendly, smiley, happy face; someone who is open, and their expression - like, they acknowledge you by eye contact and they say hello and they ask you how you are managing (Courtney, 1st Interview).*

The value of a friendly, inquiring demeanour was echoed by Ashley at the end of her new graduate year:

> *There's a lot of laughter. Our Nurse Unit Manager has a very dry sense of humour, which I think makes hand-over and the ward much friendlier. She really looks after the grads as well, and looks out for people (Ashley, 2nd Interview).*

While not overt in the interviews and focus group data, a feature that dominated all of the observation periods was that the 'true' nurse leader did more than simply ask how the new graduate nurse was going but also exhibited the same caring attitude to patients. They demonstrated a respectful attitude to patients and staff by spending time inquiring about their wellbeing. This was highly valued by the new graduate nurses who were observed. An example of this attribute was witnessed during an observation period with Ben:

> *Ben was observed approaching a senior nursing staff member who was currently in conversation with a patient enquiring how the patient was doing, when Ben asked for assistance. He was greeted with an open and respectful manner [displayed through a warm smile and open body posture and, explanation to the patient that she needed to address Ben's concerns] and assistance was then rendered (Ben, Observation).*

Another attribute of a 'true leader' that was highly regarded by the new graduate nurses was patience.

So patient with me

The importance of a leader who demonstrated patience in their communication with the new graduate nurses was a major characteristic of this sub-theme, and was expressed repeatedly in both the focus groups and interviews. Nurses who exhibited an attitude of patience were viewed as 'true leaders'. Rather than being a role model, the 'true leader' who showed patience was someone who assisted the new graduate nurse in developing their skills, providing support when confronted with relational issues and this heightened their confidence and self-esteem. During her first interview, Didi highlighted the importance of an attitude of patience in leadership in developing new graduate nurses' skills:

> *I think patience is a big thing. As a grad it can be - when you first start, you can - maybe you need to hear things said three of four times before you get it, or you forget to bring something when you're doing your check and the person has to wait for you to go and get it and come back. You just need people to be patient with you while you're learning to do everything and get by. That's - if people can be patient, that's really helpful (Didi, 1st Interview).*

Two aspects dominated this characteristic of 'so patient with me' for the new graduate nurse: giving time and listening to them. The importance of staff providing the time for the new graduate nurse to work through acquiring a new skill or procedure or working through an issue of care provision, was particularly emphasised in the early part of their first year of practice. However, it remained constant for most of the participants and was still highly valued in the later part of their new graduate program. For example, Ashley shared who she viewed were 'true leaders' when she was about to finish her new graduate program:

> *The staff that actually do take the time, like when you're not sure about something. They don't just, like, rush through and go, "It's just done like this." They actually take the time to discuss with you about a procedure or about something beforehand, or if they're not sure themselves, they'll look into it with you. I think that's really positive (Ashley, 2nd Interview).*

Interaction with a nurse leader who exhibited patience included building confidence and self-esteem in many of the new graduate nurses. Lily, who had previously worked in healthcare for many years prior to becoming a registered nurse, substantiated this in her first interview in describing the encouraging effect of a supportive nurse who demonstrated patience when Lily was struggling to provide care to a very ill patient:

> *But you have those moments where you feel really silly, you think 'Gosh, I should know this'. But it makes you feel better about yourself when they sit with you and them being so patient and working through it with you - it's a positive thing and makes you feel good about yourself (Lily, 1st Interview).*

In many of the new graduate nurses' accounts, the positive effect of spending time listening was not only related to patient care issues but also challenges with other nursing staff. This was evidenced in Tim's account of the patience of a nursing unit manager when he went to a nurse leader for advice:

> *She talked me through it. She was incredibly patient. There was no moment when she interrupted. She helped me get some sense of perspective; that I shouldn't be going home and stewing and not sleeping (Tim, 1st Interview).*

The previous sub-themes highlighted attributes that were valued in working in relationship with other nurses. The following sub-theme outlines the importance of how a shared responsibility for patient care was imperative to a productive working relationship between the new nurses and the other nursing staff.

Being part of a team

In this sub-theme the interdependence of sharing responsibility for the patients, rather than working in isolation, was highly valued by many of the participants, and was frequently discussed in both the interviews and focus groups. While many of the new graduate nurses had not always had positive experiences of being part of a team, their discussions focused

on the ideal of sharing responsibilities for patients. This was only occasionally apparent in the observation periods, except for critical care contexts where an enhanced experience and perception of shared patient care was evident. In either discussing an idealised view of shared responsibility of patient care or witnessed in the observation periods, what was apparent was that this feature was influential in the decision-making capacity of the new graduate nurses.

Shared responsibilities

The new graduate nurses expressed a sense of heightened confidence and a clearer understanding of their role in providing patient care when their role was viewed as being part of a collective, which is not working in isolation but as part of a group. This was evidenced by a response from a participant in the first focus group in a discussion about teamwork:

> *Talking together, sharing together it's everybody's responsibility, not just whoever's looking after that person at that time or the nurse in charge, whoever. Everybody works together as a team (Participant, Focus group 1).*

As previously stated, this ideal of sharing responsibilities was not as evident in some of the observation periods, where the new graduate nurses were often observed in an agitated state, in contrast to other nursing staff who appeared relaxed. An example of this was witnessed during a four-hour observation period in a surgical ward. Courtney had been allocated five post-operative patients and appeared flustered [evidenced by moving quickly between patient's beds with an anxious facial expression and speaking in short sentences]. During this observation period other nursing staff were often observed sitting at the reception desk of the ward engaged in congenial conversations while Courtney rushed between care episodes. The following comment by Courtney during this observation

exemplifies the experiences of the other new graduate nurses observed who expressed the lack of sharing responsibilities for patient care:

> *I wish they would work as a team. I would like to sit down sometimes too but I can't get my work done (Courtney, Observation).*

Conversely, the sharing of responsibility and congeniality of working as a team was particularly evident in the observation periods in intensive care units, emergency departments, coronary care units and short-stay perioperative areas. The importance of sharing responsibility for patient care was also evident in the second interviews with participants who had worked in these contexts. An example was provided by Kate when she commented about the impact of team relationships on her decision-making in the critical care unit where she was working:

> *I think that relationships with other staff can have an impact, like if they are getting on well and working together as a team caring for patients that makes it a lot easier. It makes the whole situation better, more enjoyable. I think that if you get stressed or anxious or frustrated you can make bad decisions (Kate, 2nd Interview).*

Working relationships with other nurses dominated the discussions of the new graduate nurses. However, relationships with doctors were also a key feature and were associated with heightened frustration.

Working with Doctors

There was a sense of frustration around accessing and communicating with medical staff expressed by the new graduates because they felt ignored and their opinions undervalued. This was evident in all the data sets and contexts. The new graduate nurses spoke of having to rectify patient care issues that they perceived were caused by doctors' lack of

communication with patients and with nursing staff. Discussion of the two characteristics of this sub-theme that reflect their experiences follows.

Feeling frustrated with them

The sense of frustration at being ignored by medical staff was demonstrated by Liz when she was discussing the interdependence of working with doctors:

> *So often waiting for other people to do their job so I can finish my job is a bit of a challenge. It does my head in. It's almost like you feel like you're being ignored, and that's probably the most difficult part (Liz, 1st Interview).*

Being ignored by the medical staff had implications for the quality of care provided by the new graduate nurses. This was exemplified in the following comment by a participant who spoke forcefully about the difficulties she had experienced:

> *I didn't think that it would be so difficult to get in touch with a doctor so that you could facilitate a better care experience for your patient (Participant, Focus group 2).*

In contrast to these experiences, one of the new graduate nurses expressed how one medical staff member had been both accessible and communicative:

> *We had a doctor come on last night and she said, "Hi. I'm whoever," and I was so shocked. She said "I just hate it when people sit down and you have no idea who they are". I thought, wow that's so nice. I'd never seen a doctor do that before (Participant, Focus group 1).*

In relating this experience it was evident that this was outside the normal interactions with doctors.

Another aspect of the interdependent nature of the working relationship with medical staff expressed in the focus groups, many of the interviews and in the observation periods, was

having to resolve issues that had been caused by medical staff. This is captured in the following characteristic.

Picking up the pieces

Many of the new graduate nurses expressed a deep sense of frustration at often needing to rectify difficult patient experiences they perceived were caused by poor communication from medical staff. In an example during the focus groups, a new graduate nurse relayed the frustration of having to tell a patient their test was not going to occur because of poor medical staff communication:

> *10 minutes later, gastro called and said, "I don't know anything about it, just let him eat." Like, literally nearly, what, 15 hours later, after he'd been starving - so, he wasn't happy about that, and I, of course, had to be the messenger of the news (Participant, Focus group 4).*

Another example of this commonly reported communication breakdown between doctors and patients was evidenced during the observation period with Pip. The following excerpt from the field notes highlights the frustration of having to 'pick up the pieces':

> *Pip was observed caring for a patient waiting for discharge (the doctor had stated to the patient he could go home) however, the doctor had not communicated this in written or verbal form to the nursing staff. The wife had come into pick him up and became furious that he was not ready to go. Pip stated that she was left to "pick up the pieces". She disclosed that she often felt really sorry for patients and their families in these kinds of situations (Pip, Observation).*

In contrast, the experience of communication difficulties with medical staff was not a feature of the critical care unit observation periods, where interaction between nursing staff, medical staff and patients or their families was observed to be frequent and helpful. An example of this multifaceted interaction was provided by Kate during an observation period in a critical care unit when she commented:

The doctors and nurses work together to make sure the patient's family knows what is going on (Kate, Observation).

This was further supported by comments in the later interviews. Of the eight participants engaged in the study over 12 months, 50% worked in a critical care unit during that time. The narratives of their experiences of working with supportive, communicative medical staff in critical care units were in direct contrast to their previous experiences working in other clinical environments.

In summary, this theme highlighted how the interconnected and interdependent working relationships of the new graduate nurses, more experienced nurses, and medical staff influenced moral habitability. Primarily the focus was on the interactions with nursing staff. Being proactively supported by nursing staff who exhibited a high level of patience promoted confidence and eased work pressures for the new graduate nurses. Responsibility for patient care that was perceived as a shared experience heightened confidence in being able to deliver care. Conversely, not being supported and shortfalls in medical staff communication increased the new graduate nurses' frustration and workloads by having to 'pick up the pieces', and promoted feelings of isolation and dissatisfaction. This sense of isolation was considerable in the experience of being the new person in the workplace. This is portrayed in the following theme.

Theme 3: Insider/Outsider

As the participants experienced different clinical environments during their first year of nursing practice, they were the new person each time they entered a different context. The implications of changing workplace contexts are reflected in this theme. Their experiences of trying to fit in with their new work colleagues, how they were treated, and their

perceptions of power imbalances dominate the new graduate nurses' narratives in all the data sets. Table 10 outlines the sub-themes and characteristics of the theme 'Insider/Outsider'.

Table 10. Theme 3: Insider/Outsider

THEME	SUB-THEMES	CHARACTERISTICS
Insider/Outsider	Having a voice	Feeling safe to ask questions Having influence
	Talk to the hand	Being ignored and excluded 'Big' or 'strong' personalities Being bullied
	Being new	An expectation we will cry Feeling incompetent Seeing things they don't see

There are three sub-themes related to the 'Insider/Outsider' theme and the first addresses the new graduate nurses' ability to be heard and influence patient care in their new workplace environments.

Having a voice

The sub-theme 'having a voice' was associated with whether the new graduate nurses perceived they had any influence in their workplace. This was evident in the focus groups during discussions about their ideal workplace. Often these conversations centred on 'safe' places where they could ask questions and voice opinions.

Feeling safe to ask questions

The ability to ask questions freely and safely was viewed as imperative for facilitating good nursing care. It enabled the new graduate nurses to influence care by being able to express concerns and find answers to nursing practice issues. To not be 'safe' was associated with fear of chastisement or indifference of other nursing staff. A focus group participant reflected this sentiment when discussing her ideal workplace:

> *I suppose there's ability to share concerns without fear of being ridiculed (Participant, Focus group 1).*

This was echoed in a similar account in the third focus group where a participant described her rewarding experience of working in a surgical ward:

> *Having a nursing team that encourages asking questions and having a workplace where you're not scared to ask questions (Participant, Focus group 3).*

Conversely, in workplaces perceived as having poor cultures, the new graduate nurses' contributions were silenced. Some of the participants spoke vehemently of feeling insecure and unsafe in placements where they had witnessed poor nursing care practices, but were constrained from speaking out. An example of this sense of constraint was provided during the focus groups when a participant expressed the difficulties in not being able to influence care by vocalising issues:

> *It's harder to speak up when you've got a culture and nurses where you think the habits are bad and the patient care is poor (Participant, Focus group 2).*

In many of the discussions of the new graduate nurses, being able to ask questions and voice opinions had a direct effect on whether they felt they had an influence on care decisions within their current context of work.

Having influence

In many of the interviews, having a voice that could influence patient care was directly related to the reactions of other nursing staff. For example, in her first interview Lily exemplified this influence, highlighting her motivation to provide optimal care by stopping a patient from being discharged too early but lacking confidence to follow through with her decision. In this example she spoke of the reaction of another more experienced nursing staff colleague:

> *I talked to her about it, and I was just saying - kind of raising my concerns. She said, "Never let someone force you into sending a patient home if you don't think they're ready." …… Now I feel really empowered to use my assessment skills and refer to the physio or things like - kind of go through all the double-checking and make sure everything is the best for the patient, so that we're not kind of kicking people out before they're ready, like if they don't have the support that they need (Lily, 1st Interview).*

In this scenario, and consistent with many of the participants' narratives, the sense of empowerment of being given the opportunity to have a voice and therefore to influence an important care decision for a patient, had an ongoing effect on future care decision-making.

In environments where the new graduate nurses felt constrained in contributing to the dialogue regarding patient care decisions, the effect was intense frustration. This was substantiated during many of the observation periods where the new graduate nurses attempted to voice the needs of patients under their care. At times the tension of speaking up and influencing care was overwhelming, as is detailed in the field notes from an episode of observation:

> *It was just before the lunch period and Courtney was trying to finalise her clinical pathways [paper work]. She stated to me that "being a new graduate is very stressful". I asked why and she stated that she had come into nursing to "maximise the potential for a patient to go home and be healthy, but it isn't like that". She gave*

> *an example of a delirious patient taking so much time that she neglected others and this made her emotional, cranky and frustrated. She said the nurse unit manager is too 'business oriented' and that "I have no voice" (Courtney, Observation).*

Workplaces where the new graduate nurses felt free to voice opinions were empowering through the enhanced perception of influence over care delivery. Conversely, influencing care delivery was thwarted by the inability to voice opinions. In workplaces of this nature, the challenges related to trying to fit in and negotiating different personalities were considerable. Features of a workplace which contributed to a sense of being an 'outsider' are addressed in the following sub-theme.

Talk to the hand

In over half of the observation periods nurses were witnessed holding their hand up to the new graduate nurses' faces while looking away and not responding to their inquiry, in colloquial terms 'talk to the hand'. During some of these overt physical displays, the new graduate nurse had not even had a chance to speak a word prior to the intrusive gesture of the other nurse. An example of this behaviour was witnessed in an episode of observation with Billie where the nurse placed her hand in front of Billie's face and then greeted another colleague warmly, effectively stopping any possible interaction. This overt sign was a physical representation of what the new graduate nurses perceived as being deemed an 'outsider'. The following characteristics of this sub-theme illustrate experiences that contributed to this sense of exclusion.

Being ignored and excluded

As the new graduate nurses entered their new work placements, many of them discussed feeling ignored and not being included in the interactions with the staff permanently employed in that particular context. This occurred in three ways: being ignored when asking

for assistance, being excluded by nursing staff during social or work-related interactions, and being ignored during the handover of their patients. At the midpoint of her new graduate program, Liz provided an example of being ignored, as indicated in the following field notes from the observation period:

> *Working in a four-bed room a senior nurse walked into the room and stated Liz had not done enough of the necessary patient tasks but "don't worry about it". With the mixed messages of the nurse, Liz attempted to seek further information of what hadn't been done. The other nurse ignored her multiple questions completely, turned her back and left the room (Liz, Observation).*

This was not an isolated incident for Liz and many of the new graduate nurses. In an interview Liz stated:

> *On a number of occasions I was ignored when I was asking for help, and that just throws you off (Liz, 1st Interview).*

The ramifications of being ignored included an inability to complete the care needs of their patients, as the new graduate nurse was unable to gain the assistance needed. Experiences like this were context-specific. Ashley provided an example of the influence of context during an observation period in a critical care unit:

> *There was lots of happy discussions between the nurses working with patients on either side of Ashley's patient. Ashley was included in the conversations which were both social and offers of assistance. Ashley commented "my previous placement sucked, they kept ignoring you - I couldn't get anyone to help me" (Ashley, Observation).*

Reflecting on experiences of being ignored in some contexts in stark contrast to working in other contexts, was a common feature of the new graduate nurses' discussions. In workplaces where the new nurses perceived they were being ignored and excluded, the

behaviour was often very overt. An example of this exclusion was provided by a participant in the first focus group when she discussed her arrival at work:

> *…even coming on to the ward and you say, "Hi!" to everyone – no one even looks up (Participant, Focus group 1).*

This experience was common among the new graduate nurses and was amplified during handing over patients to the oncoming shift of nurses. While working in a medical unit midway through his new graduate year, Tim describes trying to give a handover to a staff member who undervalued and ignored his input:

> *He refused the handover and proceeded to enter the four-bed room and show me nothing but his back, while he inspected the patients. I tried to catch him on the way out and I was promptly met with a sarcastic, "Yes, yes, you've been very diligent. Go home" (Tim, 1st Interview).*

Physical and verbal displays of exclusion during the handover of patients, such as Tim's experience, were frequently witnessed during the observation periods. This contributed to a sense of being an 'outsider', someone who is not an included member of the workplace. Another feature of workplaces which further highlighted this sense of exclusion was the personalities of particular nursing staff. The following characteristic captures the attributes of what the participants termed as 'big' or 'strong' personalities.

'Big' and 'strong' personalities

The feeling of being perceived as an 'outsider' was exacerbated by certain nurses who exhibited inaccessibility, exclusion and judgement, and who seemed to exhibit an informal (i.e. not managerial) sense of power. These nurses were described by the new graduate nurses in colloquial terms, such as having a 'strong personality' or 'big personality', and these carried a highly negative connotation. In all four focus groups, these terms were used

to describe a nurse who made the participants' working experience extremely difficult and made them feel excluded. The perception of exclusion was exacerbated through the acceptance of this personality type by the more experienced nurses working in that particular context:

> *Everybody knows what her personality type is like. She has a big personality. She's a very dominant woman (Participant, Focus group 2).*

Many of the participants spoke with frustration about how nurses who exhibited this personal style were accepted as knowledgeable staff members and yet not challenged for their poor behaviour toward more junior nurses. The participants expressed the perception that having many years of experience provided immunity from having to behave in a manner that was supportive to junior nurses:

> *I guess, even though they might not necessarily have a position of authority, because of their years of experience, people are unwilling to put them in their place or challenge them - I think they really have a negative influence on your experiences (Lily, 1st Interview).*

Consistent with other comments by the new graduate nurses, in this situation Lily disclosed how isolating it was to be treated in a manner that she perceived as unsupportive, when this attitude was not shared by other nurses. This isolation contributed to a sense of disempowerment of the new graduate nurse when working with a nurse with a 'big personality'. This is highlighted by the following excerpt from the field notes during an observation period with Liz:

> *The nurse working with Liz was explaining how she should go about a patient care procedure. However, from her body language it appeared to be a reprimand as she was very forceful in the interaction. Liz appeared anxious. Liz commented "It's like an hour later and I'm still running behind and I've had to stand there and listen to that woman. She makes you feel like you don't know enough, and you're a little bit nervous, those sorts of people really impact on your day" (Liz, Observation).*

The disempowerment experienced by the new graduate nurses in working with nurses who were perceived as having 'big' or 'strong' personalities was exacerbated by a lack of respect. In some circumstances, disrespectful attitudes extended to the level of bullying. This is reflected in the next characteristic of this sub-theme.

Being bullied

The data from the focus groups and interviews suggest that almost all of the participants experienced feeling a sense of being coerced or intimidated by a nurse or nurses who worked in one or more of their placement contexts over the year-long new graduate program. However, there was a distinct difference from nurses who had a 'big' or 'strong' personality, who they were generally tolerated and even liked by other nurses working in that context. By contrast, nurses who were viewed as bullies not only affected the new graduate nurses, but also appeared to affect the whole culture of the ward. During her first interview, Didi highlighted both the personal and wider effects of the interactions with a nurse who she viewed as a 'bully':

> *One particular staff member, who I suppose I can only describe as a bit of a bully - I feel like I'm generally a very confident person and a relaxed person, but this nurse made me feel like - she'd second-guess everything I did and actually - she'd ask you certain questions when you were doing certain things, so her attitude - it seemed to penetrate the whole team on the shift. It's amazing how one person - one negative person - can influence a culture, which is otherwise pretty good (Didi, 1st Interview).*

This was echoed by Lily during her second interview, late in her new graduate year, when she described what she stated was a common experience for all the nurses working with the bully in their ward, that of being treated in an intimidating and demeaning manner:

> *I stuck my head into one of the rooms nearby – the curtain was drawn and I could hear other nurses in there, so I'd assumed that nurse I was looking for was in there. I stuck my head in, and said, "There's someone on the phone for Bed 26." The nurse*

> *ripped my head off and she said, "Well, why don't you just tell them that the other nurses are busy?" I went, "Okay," and I stood outside the curtain for a second shaking (Lily, 2nd Interview).*

This visceral reaction was consistent with other new graduate nurses' accounts during the interviews and focus groups. However, in their descriptions there was sometimes a distinct contrast between how the bully treated staff in comparison to how they treated patients. This was witnessed in the observation period with Simone who was working in a renal and general medical ward. The nursing staff member was observed speaking to Simone in a harsh manner and degrading her patient care:

> *Simone was trying to complete a renal assessment when the nurse working with her became angry and commented she "knew nothing". Simone appeared shaken. She commented "she is really close with some of the patients. She is friendly with them and brutal to us" (Simone, Observation).*

Some of the new graduate nurses who shared their experiences of being ignored, excluded or bullied, seemed perplexed by why this behaviour was tolerated by other nursing staff. Some of these new graduate nurses shared the perception that this was a component of 'being new'. The following sub-theme encapsulates the experience of feeling like an outsider through 'being new'.

Being new

The temporary nature of being in a new context every three to four months in the first year of employment meant that the new graduate nurses experienced 'being new' repeatedly. This was coupled with the challenges of being in transition between finishing their nursing education and working as a registered nurse. This lead to a perception of being the 'outsider'. Three dominant characteristics related to this sub-theme were discussed in the focus groups, and interviews and were observed.

An expectation we will cry

The first characteristic was a perception by the new graduate nurses that other nurses expected them to cry repeatedly throughout their first year of practice. Normalising this state of distress was shocking to some of the new graduate nurses. This was exemplified by Billie who reflected fervently:

> *It is not right, in an employment situation or a role of being a nurse, that the expectation and the understanding is that new graduates will spend a lot of time in tears. It just doesn't seem to be to be a reasonable expectation (Billy, 2nd Interview).*

This statement came at the end of her 12-month placement and reflected a view held by many of the new graduate nurses of this persistent assumption. In contrast to opposing the probability of tears, was resignation or acceptance that the first year of nursing practice entailed crying. During a discussion in the last of the four focus groups, one participant highlighted this acceptance:

> *You'll never get through your grad year without crying once (Participant, Focus group 4).*

Crying was not just an expectation, it was a reality. In a third of the observation periods the new graduate nurses were seen crying. In many of the narratives, the participants shared their experience of crying and also those of their peers. This included crying before, during and/or after their working day had concluded:

> *I have had one complete meltdown where everyone was very kind to me afterwards, but one of the things that struck me as a bit odd was when someone said "Don't worry, everyone cries when they are new." Many new grads have said to me they've spent months coming to work every morning and would sit in the car park crying before they went to work. I've gone, "That is a really weird approach to take to work" (Participant, Focus group 2).*

The narratives or observations did not reflect that the new graduate nurses cried about their patients or their ability to deliver patient care. The dominant trigger was the very nature of 'being new' to the workplace and other nursing staff.

Feedback can make you feel incompetent

The second characteristic of the sub-theme 'being new' related to the impact that interactions with nursing staff in their new workplace environments had on their confidence related to their level of competence. Self-perceptions of incompetence in their new role were not overtly evident in the data. Instead, when the new graduate nurses spoke of feeling incompetent, it was in direct relation to feedback they had received from another nurse, especially if it was not expected. This impact was particularly evident during the focus groups and interviews over the entire 12 months of data collection. This was demonstrated by Billie during the second interview when she described how feedback by a nursing staff member had suddenly reduced her belief in her nursing care ability:

> *I'd had a good shift, worked really hard, patients were happy, felt like I was on top of everything and then, my manager pointed out that I had been ten minutes late with an antibiotic! It's remarkable how one statement can be so powerful and then I left that day feeling really negative and inadequate (Billie, 2nd Interview).*

This tenuous quality of their self-evaluation of competence was at odds with what was seen during the observation periods. The new graduate nurses often exhibited a strong sense of belief in their ability to meet the care needs of their patients. The final characteristic of this sub-theme, 'seeing things they don't see', illustrated an aspect of 'being new' that heightened confidence in the new graduate nurses' ability to meet patient care goals.

Seeing things they don't see

While not overt in the focus groups or interviews, it was clear during the observation periods that some of the new graduate nurses felt that 'being new' had some advantages. This was exhibited by the perception that, because they were new to the particular workplace, they saw some aspects of care needs, such as pain relief, which were missed by other more experienced staff. This provided a sense of heightened confidence in their ability. An example of this characteristic was provided during an observation period with Lily when she was observed enquiring about the pain status of a patient who had not been allocated to her. When asked about this experience she commented:

> *Sometimes [we] just see things they don't see. His face shows he is in pain but [they] just don't see it because they have been here too long (Lily, Observation).*

Lily was describing how new graduate nurses [we] were more attuned to identifying missed care than the other staff [they]. Another example was provided by Ben when he was observed placing food closer to a number of patients who had not been allocated to him, to enable the patients to reach the food before it became cold. During these encounters Ben exhibited a sense of confidence in his comments and demeanour. Being an 'outsider' or new to the workplace, he was able to meet what he perceived were patient needs that were not being addressed.

This theme highlighted the social challenges presented to new nurses in trying to become a part of the ward or unit where they were working. The power of some personality types and feedback styles was influential in eroding confidence and feelings of competence in the new graduate nurses, which then exacerbated feelings of being an 'outsider'. To become an

'insider', the new graduate nurses, while striving to have an influence within the context of the workplace, needed to feel safe to speak.

Summary

This chapter has highlighted the interconnected nature of the working relationships the new graduate nurses encountered in their first year of practice and how this influenced their experiences of moral habitability. Of particular importance was the mutual relationships and subsequent support or lack of support of nursing staff. Their influence was a powerful indicator in how the new graduate nurses perceived their status as an 'insider' or 'outsider' in their work environments. Themes Four and Five are presented in the next chapter. This final chapter of the findings of Phase Two describes the adaptive or coping mechanisms used to manage the difficulties experienced by the new graduate nurses in their new role and the compelling impact of the diverse workplaces they encountered.

CHAPTER 8 PHASE TWO FINDINGS THEME 4: TOUGHENING UP AND THEME 5: INFLUENCE OF THE WORKPLACE CONTEXT

This chapter presents the final two themes of the thematic analysis which highlight the coping and adaptive mechanisms employed by the new graduate nurses in managing their first year of practice. This is particularly relevant in the 'Influence of the Workplace Context' theme, where the impact of the different cultural and organisational workplaces encountered by the new graduate nurses was most evident and influential in their moral habitability.

Theme 4: Toughening Up

In the focus groups and interviews the term 'toughen up' was repeatedly used to express the new graduate nurses' perceptions of what was needed to cope with their workplace experiences. While trying to be accepted in their new workplaces, it was evident there was tension between maintaining their personal values and compromising them. The three sub-themes (see Table 11) illustrate these value challenges and the strategies used by the new graduate nurses to adapt, or at times merely endure, in their workplace.

Table 11. Theme 4: Toughening Up

THEME	SUB-THEMES	CHARACTERISTICS
Toughening Up	Avoiding conflict	Staying quiet Staying away from some people
	Trying to stay true to my values and principles	Getting around the system Feeling "morally torn"
	Thinking things through	Debriefing with the right people Letting it go

Avoiding conflict

The sub-theme 'avoiding conflict' details two dominant strategies employed by the participants to ensure they could navigate their practice successfully: 'staying quiet' and 'staying away from certain people'. These strategies had widespread utilisation among the participants and were apparent across each of the data collection methods.

Staying quiet

Remaining silent was a prevailing strategy used by many of the new graduate nurses, and was particularly evident in the data from the focus groups and the initial interviews. Lily provided an example of the sense of the importance of avoiding conflict with other staff members in the early stages of her new career as a registered nurse:

> *I keep my mouth shut. I used to always be someone to speak up and say something, and I've learned - I mean, it's difficult, especially for me, in the position I'm in. I'm starting a career. I'm starting something, and I really want to stay with the organisation that I'm with at the moment, and work my way through. I've - before nursing, I have been in positions of leadership (Lily, 1st Interview).*

Lily was expressing a belief shared by other participants that to stay, be accepted and have career progression in the workplace may require not speaking out. In a similar account during an open and candid discussion in the second focus group, a participant acknowledged that perception of others was important to career progression and that at times choosing not to speak was the best option:

> *As difficult as it is, how people perceive you and what people think of you really impacts where you can go, not just your abilities. I guess I'm very cautious not to speak and upset the wrong people (Participant, Focus group 2).*

While this strategy was utilised frequently, in many of the later interviews and some of the observation periods it became apparent that staying quiet was at odds with the promotion

of quality patient care. An example was provided by Lily, late in her first year of practice, when she reiterated the difficulty she experienced in not speaking up when it impacted care decisions:

> *I have a sinking feeling inside myself, when I have to - yes, just bite my lip, or not be as direct about something when I make a comment (Lily, 2nd Interview).*

While earlier in her first year of practice the focus was on career progression, later, Lily and other participants expressed concern regarding the impact on their patients of not verbalising issues. The descriptions of the effect of not speaking out, echoed by Lily's comment, often included a physical or visceral sensation when it involved patient care.

However, for some of the new graduate nurses, staying quiet was not an option. Despite the risk of conflict related to not being compliant, some participants felt it was imperative to speak out about issues if they involved the promotion of appropriate patient care. An excerpt from the field notes during an observation period with Ben provided an example of promoting patient care over the personal risk of conflict:

> *Ben was observed confronting another nurse who had been speaking very loudly to a patient who did not speak English. The patient was being asked to have his blood glucose test but appeared not to understand. The other nurse continued to speak very loudly. Ben spoke to the nurse (I was unable to hear what he said) and she walked off angrily. Ben then continued to speak to the patient and obtain the blood (Ben, Observation).*

The tension between self-preservation and patient care choices was also evident in the next characteristic of the sub-theme, 'avoiding conflict'.

Staying away from some people

Avoiding difficult staff was a common strategy used by many of the new graduate nurses, although they often expressed concern for the heightened workloads of the nurses they

repeatedly approached. In discussing a nurse in the emergency department during the final month of her new graduate year, Didi said:

> *The way I did work around her was to just avoid her. I may have asked her for help when I really had to, like when no one else was available, which is bad in a way because then the other nurses suffer in terms of the workload. I'm not asking everyone equally for assistance, I'm just going to others because I want to avoid her (Didi, 1st Interview).*

The dominant characteristic of the nurses whom the new graduates avoided, the perception of being too busy and not interested in assisting them, was outlined by Mel during her only interview:

> *They have a vibe about them - like, a vibe that says, "Please don't ask me a question or please don't ask for my help, because I am too busy doing my own thing, and I can't be bothered with trying to help you" (Mel, 1st Interview).*

While avoiding conflict provided a means to stay within the workplace by 'Toughening Up', it was not without tension for the new graduate nurses. The primary challenge was expressed by trying to maintain their personal values while developing their skills as a new nurse within a new social environment.

Trying to stay true to my values and principles

The influence of personal values on the new graduate nurses' integration into their new profession and workplaces was a dominant sub-theme apparent in all the data sets. The new graduate nurses often used the terms 'values' and 'principles' during discussions about their practice decisions. For many of the participants, the term 'values' was viewed as personal beliefs, rather than a shared professional standard, and they guided their actions. An example of the personal nature of values was provided by Courtney during the first three months of her new graduate program:

> *Well, internally - what I set for myself. Like, there are certain standards you have, like your own guidelines.....so, my own beliefs and my own standards, kind of thing (Courtney, 1st Interview).*

While personal values were generally viewed as inflexible, that is, they were internal or part of that particular nurse, a contrasting view was held by some of the new graduate nurses who viewed personal values as dynamic. For example, one participant in the focus groups commented:

> *I think values are something that can change with knowledge (Participant, Focus group 3).*

Whether values were viewed as intransigent or dynamic, the challenge of maintaining personal values for the new graduate nurses was significant.

Getting around the system

Central to many of the new graduate nurses' discussions was maintaining their personal values and principles with minimal compromise. This was evident in an example of a conversation in the first focus group:

> *There's certainly times when it would be easier to short-cut and stuff and I think you have to make that decision of, "Am I going to take a short-cut here, or will I actually stick to the principles?" They say if you make exceptions to your principles, they're not really principles (Participant, Focus group 1).*

The values and principles which were consistently espoused by the new graduate nurses were focused on providing quality patient care. Finding ways to uphold what the new graduate nurses perceived as the most appropriate care for their patients, required strategies which at times circumnavigated the normal processes within the particular workplace. This was witnessed by the researcher in many of the observation periods and

was often implied in the interviews and focus group discussions. Pip provided an example of an attempt to maintain personal values with minimal compromise in the following scenario:

> *One patient had been complaining of dizziness for a couple of days and nothing had been done to assess or alleviate this. The Consultant and team were in the unit at the time and Pip asked the Consultant if the medication could be causing the dizziness? The response from the Consultant was terse "she is in bed anyway so it doesn't matter". Pip was observed getting around the Consultant by going to the Intern to see if the dose could be reduced. This was subsequently done and she reported to the patient the result (Pip, Observation).*

In this scenario, promoting patient comfort was of paramount value and this could not be compromised. Finding creative ways to 'get around the system' was common to many of the new graduate nurses' descriptions, particularly in environments where care was perceived as inadequate.

The new graduate nurses exhibited a heightened sense of anxiety in situations where they felt compelled to find alternative avenues to provide patient care consistent with their value sets. This was especially evident in their comments during the interviews and in the behaviours witnessed during the observation periods. An example of this during an observation period with Billie occurred in a workplace where she acknowledged to the researcher her personal values regarding patient care could not be maintained due to her perception of staff behavioural constraints. The field notes from this period included the following observation:

> *Billie was observed constantly looking around to see who was watching her work. At times she appeared almost startled when a member of the nursing staff asked her a question. Billie was working in a 4 bed room and was sitting holding the hand of a patient who had received bad news when the nurse unit manager came in she jumped up and picked up the patient's chart and stared at it. Later she commented to me that "I have to be seen doing what they want me to do" (Billie, Observation).*

In this example, and in many of the participants' accounts, trying to 'get around the system' to provide time for and care of patients consistent with their value sets was confounded by the quandary of whether to go with or against the dominant workplace values. That is, to choose to meet the holistic needs of patients or to self-protect. This created a hyper-vigilant state, and in many of the interviews the participants spoke of the anxiety and exhaustion they experienced in environments where their values were perceived as contrary to those espoused by their workplace.

It was not always possible to get around the system and compromising personal values became necessary for self-preservation within the workplace. This was particularly apparent when the values of the new graduate nurse were incongruent with those of more senior nursing staff. An example of this pervasive experience was presented when one participant detailed an experience where she felt she had to discard deeply held values regarding multiple patient care episodes to ensure senior staff satisfaction:

> *I sort of had a bit of a reality check and realised - a couple of things happened on the Friday shift. I had to just - I had to really fit in with what they want. It's so pathetic – that you've got to keep the senior staff happy when you know it is wrong (Participant, Focus group 4).*

Compromising personal values of patient care when it was not possible to manipulate contextual influence, was highly demanding. Another challenge in maintaining values was being confronted by what the new graduate nurses identified as 'moral' situations where they felt 'torn'.

Feeling morally torn

During the focus groups and interviews, over three quarters of the participants shared an experience of being confronted by what they identified as 'moral' challenges. This often

manifested in issues related to a perception of futile treatment they believed caused harm. This was exemplified in a candid practice narrative from Lily where she recounted caring for a frail, elderly palliative care patient and being given a pathology request for a further blood test:

> *She's 89 years old, and this lady is covered in bruises from head to toe, from being poked and prodded for more bloods. I felt really morally torn, because I wanted to support the daughter because she needs the support, she cares for her mum, and she doesn't want to lose her mum. But in the same token, someone had to stand up for this old lady, and that's my job. I felt very morally torn, in - I didn't want the daughter to think that I didn't care for her mother's wellbeing, and that I wanted her mother to die, as such. But I just couldn't see any good benefit from any further intervention from us, other than comfort interventions for this lady (Lily, 2nd Interview).*

This narrative, the sense of which was reflected in many others, identified a conflict between the desire to support a patient and family and yet avoid further harm. Moral challenges resonated with many of the new graduate nurses and another aspect that caused great concern were issues related to consent.

The topic of consent was discussed in both the interviews and the focus groups. Conflicts around consent issues were also witnessed in half of the observation periods with the new graduate nurses. For example, during a period of observation with Billie, she expressed her concern over the lack of consent, when an elderly patient who required intravenous fluids was refusing to be cannulated and yet the nurse was continuing to prepare for the procedure:

> *She (Billie) stated that she was "morally torn" between the clinical need of the patient, whom she perceived was competent to decide, and upholding her right to refuse treatment (Billie, Observation).*

Being challenged by moral issues and reflecting on their experiences manifested both 'in practice', as described above, and after the practice event. When the new graduate nurses

spoke of reflecting on issues after the practice event they also shared techniques they had used to aid their learning.

Thinking things through

Spending time seeking to understand their role, their place within the social context and their values related to patient care, was of pivotal significance for the participants' ability to cope with and adapt to their new roles and environments. Self-reflection was evident in many of the comments during the interviews and focus groups. The participants highlighted a number of strategies they used to consider their experiences. Two characteristics influenced this sub-theme, 'debriefing with the right people' and 'letting it go'.

Debriefing with the right people

Debriefing with trusted people was an important strategy that resonated with many of the focus group participants and was viewed as essential to understanding their practice experiences. This occurred with colleagues and also trusted people outside the healthcare arena. The participants spoke of being prompted by psychological or physical sensations, such as *"feeling it in my gut" (Participant, Focus group 2).* These intuitive triggers during practice prompted a sense of needing to reflect on that practice and discuss the event with colleagues or trusted others. An example consistent with the experience of many of the other participants was provided by Kate in her first interview when she shared the following:

> *I often get this tightness in my chest, just going, I'm not sure about that - so, just kind of listening to myself. So later at the end of the shift, going back and often asking a nurse if that is normal practice or if that is something that normally is allowed. I use my colleagues a lot, talking to them about it (Kate, 1st Interview).*

Self-reflection about practice and how the new graduate nurses could improve the patient experience by debriefing with colleagues was a common characteristic of this sub-theme. During her second interview after 10 months experience as a newly registered nurse, Ruby stated:

> *Leaving work with knowing that you've done the best that you can and speaking to your colleagues if you feel like you haven't - in reflecting back on what you've done and then waking up and going, "Okay, today I'm going to do this better and I'm going to act this way. I'm going to do this and then try and do it." (Ruby, 2nd Interview).*

Thinking through behaviour and then working towards improvement, while often focused on patient care, also included personal development in their new social roles. This was demonstrated by a participant in the second focus group when she discussed how her workplace and colleagues had differing values:

> *So it's just, for me, not how I expect my workplace to be. I expect it to be with things in order, but what I've learnt from that on a personal level is that the world is not always going to bend to fit to my will, so I've got to learn to go with the flow more. I've got that from being on the placement, so I know I've got to be a bit more flexible (Participant, Focus group, 2).*

This kind of insight was common among the new graduate nurses when they spoke of their personal growth and ways to adapt to their new workplaces.

The importance of being able to debrief and reflect on their experiences was central to coping with their new graduate year. During the concluding moments of the interviews many participants expressed gratitude for being able to talk about their experiences. A typical example was a comment by Tim at the conclusion of his interview:

> *Until I discussed this with you today I didn't realise how much I needed to debrief my experiences with someone (Tim, 1st Interview).*

This was echoed by Kate who had organised childcare so she would be free for her second interview:

> *Thanks for letting me discuss this with you I really want to talk to you about my experiences (Kate, 2nd Interview).*

In a similar account, Liz substantiates the need to debrief with the following response:

> *This has actually been quite cathartic. I feel like I've had a bit of a session with a psychologist about me. All these things have been sitting in my brain and I've been thinking, can I say these things? Can I articulate this? Because this is how I feel, and is it going to make me a worse nurse? Is it going to make me a better nurse? (Liz, 2nd Interview).*

While being able to debrief and reflect on experiences assisted their development as new nurses, at times this was also used as a coping mechanism. The next characteristic of this sub-theme reflects this process.

Letting it go

In an attempt to cope with their new roles and workplaces, many of the participants discussed how they needed to discard thoughts to be able to move forward. The term 'letting it go' was used to describe being able to put things in the past. Strategies to support their reflection often included writing about their experiences. Keeping a journal was a common tool utilised by many of the participants in the focus groups and interviews:

> *It's like, then that's it. Once you've written it down, you remember how to be a better nurse (Participant, Focus group 4).*

The act of writing thoughts down provided a means to cope with the new day's challenges. In another statement from a participant in the second focus group, this notion of reflecting and then progressing was evident:

> *…keeping it on that one shift, instead of bringing it through to the next day. If you have one bad night, maybe just cut your losses, it was a bad night that night and try to start fresh and positive the next day. New shift, new day, instead of bringing the negativity (Participant, Focus group 2).*

Not all of participants found journals useful, particularly if social interaction issues were involved. It was evident that for some, while reflecting on an event was important, recording it was less so, particularly if it had been a difficult experience with nursing staff. This was highlighted in a discussion with Billie during her first interview when she spoke about trying to adapt to social pressures in her workplace:

> *I have done some of that as well, but I also find – I spend a bit of time reflecting in my head, and I know you should reflect in writing – it's actually more effective. But there are some things I actually want to go through, and then I want to forget about them. I don't want to pick it up in a year's time and then go, "Look how much I've grown," I just want that to be in the past (Billie, 1st Interview).*

Another example of 'letting it go' was provided by a participant in the third focus group, who shared this response to her challenges of working with other staff in an oncology ward:

> *I spend a bit of time reflecting in my head on challenges I have had. There are some things I actually want to think through, learn from and then I want to forget about them. I just want that to be in the past (Participant, Focus group 3).*

In the process of 'Toughening Up' it was necessary to process the challenges of practice and social interaction and move forward.

In summary, in this theme the new graduate nurses outlined how there was a need to 'toughen up' in coping and adapting to their new roles, workplaces and nursing practice. While being new to nursing practice necessitated challenges involved in skill development, the primary challenges were actually around social integration with other staff. Coping strategies to manage difficult social interactions included avoidance of the issue or person

involved. Reflection was also used as a strategy in this adaptive process. This process was often positive and provided a means for the new graduate nurses to move forward. Finally, the tensions they felt in trying to adapt to their new environments and yet not compromise their personal values was very evident in their experiences.

Theme 5: Influence of the Working Context

In all of the data sets it was evident that there were two distinct workplace environments which had a considerable impact on the experiences of the new graduate nurses. This theme highlights the organisational and cultural influences that shaped the new graduate nurses' experiences. As previously discussed, the new graduate nurses were placed in up to three different clinical environments over the year. Of the eight participants involved in data collection during their entire new graduate program, 75% reported at least one of their environments was a 'horrendous period' of their experience. The significant contrasts among the environmental influences experienced by the new graduate nurses in their workplace contexts are represented in this final theme of the Phase Two analysis (see Table 12).

Table 12. Theme 5: Environmental Influences

THEME	SUB-THEMES	CHARACTERISTICS
Influence of the Working Context	Awesome places	Welcome and wanted Respect for everyone
	Horrendous periods	Culture of tasks and no breaks Never having enough resources Culture of blame
	Feeling the impact	Feel it in my chest Extreme changes

Awesome places

While workplaces varied, most of the participants expressed a high level of satisfaction in providing care for their patients. However, this did not always translate to the workplace being viewed with positive connotations. The features of this sub-theme were relational in that it was the social elements of the workplace culture which made it 'awesome'. The wards or units which the new graduate nurses described as 'awesome' were characterised by two dominant elements, appreciation and respect.

Welcome and wanted

Appreciation for their role in the workplace was a central feature of what was perceived as a positive or 'awesome' culture by the participants. This was often expressed in conversations that highlighted which they had been welcomed to the ward on arrival, and thanked for their participation at the end of the day, and this produced a sense of satisfaction. This is reflected in the following example:

> *You walk out with a bit of a spring in your step when your team leader thanks you on the way out. You say, "Thanks for your help today" and they say "No worries, you did a great job today" (Simone, 1st Interview).*

Another example that highlighted an appreciative episode occurred during observation with Kate who, while in a critical care context, had removed an endotracheal tube from a patient being weaned from ventilator support:

> *Lively banter across the cubicles was noted between three nurses and the new graduate nurse. One nurse stated to Kate "how good were you in getting the patient extubated and ready to move to the ward". Kate was observed smiling broadly (Kate, Observation).*

In an observation period with Ruby during her second placement in a neurosurgical unit she stated:

I feel so welcome and wanted, it is an awesome place (Ruby, Observation).

This was also reflected in the field notes of this experience:

> *The unit has posters on the walls that state 'staff are important' [title of the poster altered for the purpose of anonymity] and reports on staff satisfaction surveys. At the end of the shift two nurses thanked Ruby for her assistance during the day and Ruby responded with a wide smile (Ruby, Observation).*

In this environment, appreciation of staff was featured in wall displays and authentically displayed through the behaviour of the staff. In contrast, during observations in other workplaces where posters displayed similar messages, the behaviour of the staff towards the new graduate nurses was not appreciative. The following excerpt from the field notes of an observation period with Lily highlights this disconnection between espoused organisational values and experience of the participants:

> *"She's just a new grad" - comment made by two nurses in the ward said in a disparaging manner. The comment appeared to be associated with her work for the day. Later when Lily finished her shift she thanked the nurses for their assistance. She was met with no physical or verbal response (Lily, Observation).*

In three of the observation periods and in some of the interviews it was evident that both permanent and casual staff benefited from wards where the culture welcomed and appreciated nursing staff. Didi, who had experienced two workplace environments at this stage of her new graduate program, remarked on her experience in an 'awesome' ward:

> *I think the culture on the ward I work on now is really excellent. I feel really blessed to be where I am now, in that people generally help and thank each other a lot. One of the things that I've noticed - I don't know if this is relevant at all, but one of the things that I've noticed is the way that they treat casual staff. Every time that a casual staff member comes on, our manager thanks them for their help and makes sure that someone's buddied up with them so that they can ask questions or find things (Didi, 1st Interview).*

The influence of a workplace culture which was welcoming and appreciative was viewed as 'positive' by the participants and was particularly highlighted during the focus groups. Positive cultures shaped the new graduate nurses' attitudes. In an account from a participant during the focus groups, the power of a positive culture was highlighted:

> *If you've got a positive culture on the ward, then it's easier to become a positive person and even look at the bad situations positively (Participant, Focus group 3).*

This power was also evident in a contrasting example from a focus group participant who stated:

> *If the team are negative it's a lot harder to get through your shifts and your days (Participant, Focus group 1).*

Another influential aspect of an 'awesome' environment is detailed in the second characteristic of this sub-theme, 'respect' which encompassed everyone in that environment.

Respect for everyone

Working in an environment where the staff demonstrated respect for patients, families and other staff was imperative to what was viewed as an 'awesome place'. This was reflected in the majority of the new graduates' discussions regarding the importance of respect in working in a positive workplace. Ben revealed this importance in an overview of his busy surgical unit's culture:

> *My workplace culture is respect for you, for every staff member and every patient – it is amazing (Ben, 1st Interview).*

Observational data reinforced the importance of respect for both staff and patients in workplaces that were extremely valued. Demonstrating a respectful attitude was

manifested in workplace cultures through a high degree of civility in both the non-verbal and verbal responses among staff and patients. This is illustrated in the following field notes taken while observing Ruby:

> *The unit has a peaceful atmosphere even though the patient population is highly acute and it is very busy. The nursing staff speak politely to each other, this was evident in the interactions with the medical staff as well. In the tearoom Ruby is immediately included in the conversations the other nurses were having. Another nurse is witnessed walking hurriedly down the corridor but immediately stops when she sees the girlfriend of a seriously ill patient, and speaks in a gentle manner to her (Ruby, Observation).*

In defining 'respect', many of the participants highlighted the impact of social engagement, that is, respect was evident in verbal interactions. In a description of an 'awesome' work environment, Lily enthusiastically and with emphasis stated:

> *Being respectful is speaking to people appropriately, speaking to people as you'd wish to be spoken to and being polite (Lily, 1st Interview).*

In contrast, the importance of respect for patients was illustrated in a comment by a participant in the focus groups:

> *I really detest hearing people speak poorly of a person's character when they're sick. Fair enough, talk - say, "Gosh, their faeces really smelt," or this or that, or, "It was really gross when I had to do their wound." That's just your experience. But putting your own personal opinion about their character is just so disrespectful - that, to me, is really immoral (Participant, Focus group 2).*

Cultures where staff demonstrated disrespectful attitudes to their patients were highly criticised by participants. The time spent in placements where the culture enhanced the new graduate nurses' experience was in start contract to the 'horrendous' periods they endured. This is detailed in the next sub-theme.

Horrendous periods

Although not always evident in the observation periods, experiencing a negative workplace was widely reported by the new graduate nurses in the interviews and focus groups. The characteristics of this sub-theme were consistently described by participants as contributing to a workplace environment that became a 'horrendous period' of their new graduate program. While a lack of physical resources contributed to a difficult workplace, it was the influence of specific cultural expectations which had the more significant impact. The three characteristics of this sub-theme are presented in the following section.

Culture of tasks and no breaks

Only two of the 14 participants who took part in the interviews had not experienced what they described as a very difficult workplace culture in their new graduate year. An aspect which resonated with many of the participants, was a 'tough' culture where task completion took primacy over staff needs. This was evidenced by Billie when she described her experience of a very difficult workplace:

> *I've been told so many times, "Hurry up and complete tasks, and bunch your tasks", they don't care how I am going (Billie, 1st Interview).*

Nursing staff members who did not take breaks, particularly it meant more tasks were completed, were viewed in these workplaces as dedicated nurses. An example was provided during the focus groups where a participant sighed and stated:

> *We're busy, and if you're 'committed' you won't actually go and have a break (Participant, Focus group 1).*

Workplace environments which were 'tough' or 'horrendous' were often described as places where the cultural expectation was that taking breaks was viewed as demonstrating

low dedication to nursing practice. Many of the participants commented on the outcomes of not having breaks. Simone provided an example indicative of this experience when she responded in an exasperated manner during her second interview:

> *Stress, not having had your lunch break so you're starving and then your brain is not working properly makes you flustered (Simone, 2nd Interview).*

In this account, and in many others, the physical and mental impacts of not having adequate time to rest and eat during a busy shift were significant. This was compounded in those workplaces which had inadequate human and physical resources.

Never having enough resources

Many of the participants spoke vehemently when discussing environments where there were not enough human or physical resources, and the impact this had on patient care. This was evident in all data-sets and when speaking about their experiences, the participants sounded and appeared exhausted. In four of the interviews, this impact was considerable and they spoke of substantial constraints to their practice due to under-resourcing. In these interviews they also highlighted what they perceived as patients being put at risk due to chronic under-resourcing. In the following vignette Courtney provides an example of these encounters when she discusses her experience of a horrendous period:

> *There are never enough staff, nothing works, the staff that work there don't care – maybe they do but they are too tired, I don't know? I've seen patients fall that shouldn't have (Courtney, 1st Interview).*

While the participants stated how 'horrendous' their experience was, they would often attempt to normalise their situation with contradictory statements:

> *There is never enough staff, you're flat out trying just to meet the basics for your patients, and it's just exhausting. Oh I don't know some days are good, I guess it isn't that bad (Billie, 1st Interview).*

Working in under-resourced environments also featured during the observation periods. Kate provided insight into the experience of working in three different ward/unit environments over the 12-month period. This was detailed in an extract from the observation field notes where the contrast between a resourced and under-resourced environment was clear:

> *During observation with Kate in a critical care unit she became quite angry when she was describing her last placement in comparison to her current workplace. She described a workplace with very high patient to staff ratios, low skill mix, broken equipment and what she perceived as adverse patient outcomes. She marvelled over how this ward and her current workplace, which was very well resourced, could be part of the same institution (Kate, Observation).*

This was a consistent experience for the new graduate nurses as they worked in workplaces which contrasted both culturally and in the lack or abundance of resources. The final characteristic of a 'horrendous period' was when working in a ward that had a 'culture of blame'.

Culture of blame

During the observation periods in workplaces described as being 'horrendous', the culture was perceived by the participants as one where the focus was on blame rather than appreciation or improvement. This was also evident in the interviews and focus group discussions. A 'culture of blame' was described as one in which there was a focus on small errors, and no acknowledgement of achievements, such as working hard or skill mastery. An example of this culture was observed with Dot in a busy medical unit when she stated:

> *You get home and you just wait for someone to ring you and tell you have done something wrong (Dot, Observation).*

All of the new graduate nurses who had experienced a 'horrendous period' spoke of the apprehension of constantly monitoring their behaviour and how this resulted in extreme fatigue. The field notes during an observation period with Didi highlight a situation in the early part of a morning shift that illustrated this kind of apprehension:

> *After handover, Didi was writing up her plan for the day and kept apologising to me for taking so long. After washing one of her patients, who was now sitting in a chair for the morning, Didi was observed being chastised by the senior nurse for failing to make his bed. She looked and sounded tired when speaking softly to me she said "I was going to do this later as I need to give insulin to Mr x, you just can't catch a break here" (Didi, Observation).*

This was contrasted during an observation period with Ashley working in a surgical unit which was similarly busy. In this situation, the senior nurse acknowledged how busy Ashley was, how well she was doing and offered assistance in time management. The 'horrendous periods' of working in tough environments had a powerful impact on the new graduate nurses and manifested in both physical and psychological signs of distress.

Feeling the impact

In this final sub-theme, the damaging impact of some of the new graduate nurses' work contexts is presented. In these contexts, the constraints that hampered the provision of appropriate nursing care manifested in distress. The following characteristics of this sub-theme highlight both the common and the more extreme experiences of distress for the new graduate nurses.

Feel it in my chest

The most common consequences for the new graduate nurses of not being able to provide appropriate patient care due to workplace constraints were anger, expressions of anxiety and fatigue. An example of these physical and emotional manifestations was provided by a participant in the second focus group. She described how the needs of her chronically understaffed workplace over-rode what she believed was important, when she discussed being told to come and assist a staff member check a drug:

> *The other nurse said "Stop washing your patient. Just cover them up and come". At times like this I get really anxious. I feel it in my chest, I feel it in my throat, and I just get really angry (Participant, Focus group 2).*

When their care was perceived as poor due to contextual constraints, other indications of distress were exhibited. Sleeplessness was commonly reported in both the focus groups and interviews. An account by Tim who worked in a busy surgical ward demonstrates the impact of feeling constrained in providing adequate care:

> *I'm often unhappy with some of the actions I'd taken with patients because I feel there isn't enough time, not enough help, and it kept me up all night (Tim, 2nd Interview).*

Experiences of this nature were common among the new graduate nurses as they discussed workplaces that had been very difficult. However, they also occurred in workplaces where they felt valued. During the focus groups, a participant discussed the psychological ramifications of providing poor care as she spoke of a patient with unrelieved pain due to the workplace having unhelpful nursing staff on that particular day:

> *Sometimes it's just – what should I do? Thinking of possible pathways to solve this problem, but it takes a lot of time, and I can't really take action, the next step, and in the meantime the patient is suffering for such a long time, then the bad feeling*

increases in me. When the patient is suffering physically, I believe I'm suffering mentally as well (Participant, Focus group 2).

The expressions of distress were not always linked to workplace contexts that were perceived as poor. At times, even if the workplace was viewed as being positive overall, the constraints on a particular day through under-staffing or unhelpful nursing staff resulted in distress. In the following characteristic of this sub-theme, the 'extreme changes' experienced by some of the new graduate nurses were expressly connected to the worst workplaces they had encountered.

Extreme changes

Less common for all of the study participants, however highly compelling, were reports by three of the eight participants (40%) who participated in data collection over the entire 12 months. This group of participants was followed in three different workplaces during their new graduate program. Faced with what they perceived as environments which consistently provided inadequate and at times extremely poor care of patients, the participants described experiencing extreme physical and psychological reactions. The effects included reduced libido, depression, changes to their personality (reported to them by their close family or friends), and a perception that they had an increased susceptibility to infections.

Each of the three participants reported that the only thing that provided relief was the knowledge that the placement was limited to three months. However, the impact of their encounters was evident in detailing their workplace experience months after completing the particular placement. In her second interview, Kate recounted the impact of working in a ward that was the antithesis of her previous placement. In her description of the

environment, multiple patients suffered without having their pain addressed. The impact of this was evident when Kate commented angrily:

> *It gives me a sense of doom, depression, all I can do is get through it intact (Kate, 2nd Interview).*

'It' referred to the three-month timeframe of her placement. In another example, Courtney spoke of the impact of working in a 'horrendous' place. During her observation period in a ward where she described the staff as being 'passionate' about the care of patients, she reflected on her prior experience:

> *When I was working in xx I would go home and just sit, not talk to anyone. My husband says my personality changed. It was one of the worst times in my life (Courtney, Observation).*

While at the extreme end of the new graduate nurses' experience, the reported changes to mental health, physical health and their personality were very compelling.

To conclude this theme, while the participants worked in two or three different areas of the same institutions during their new graduate program, their experiences were often vastly different due to contextual cultural practices of the diverse workplaces. This theme considered the two extremes of their workplaces. The nature of an 'awesome workplace' was described in terms of appreciation and inclusiveness. The negative and at times extremely damaging impact of the 'horrendous periods' were also detailed.

Summary of the Phase Two Thematic Analysis

In Chapters Six to Eight, the findings of the thematic analysis provided an understanding of the concept of moral habitability through the experiences of new graduate nurses in their first year of practice. The new nurses encountered many challenges, including the need to

develop clinical expertise, the cultivation of relationships with other staff, and negotiating the varying cultural norms of their work environments. While the new graduate nurses' discussions around these challenges were at times centred on the development of clinical expertise, much of their focus, both implicitly and explicitly, was on their moral experience.

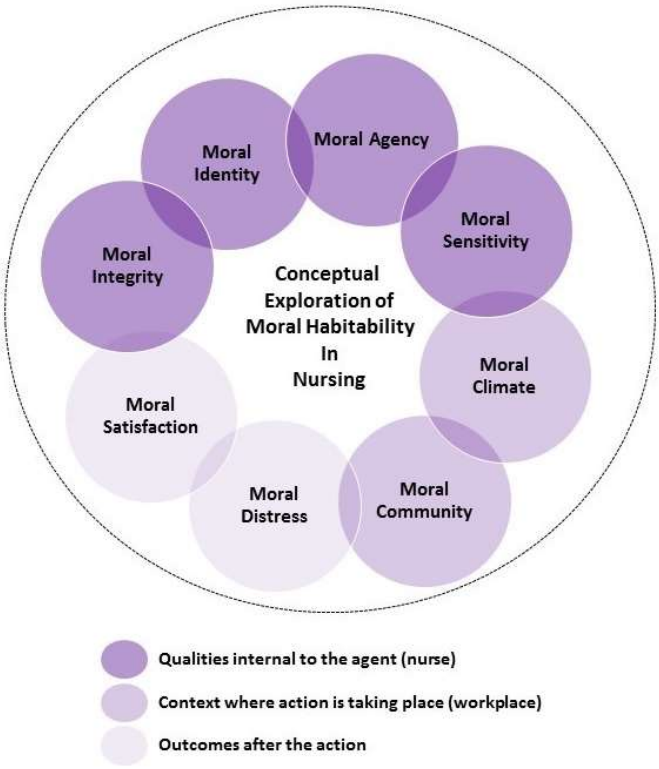
The new graduate nurses exhibited a strong sense of their identity, prioritised care in a manner that took into account the holistic needs of their patients, and they strived to achieve care that was in their patient's best interests. Maintaining their values and providing quality care were imperative and satisfying. Many of the new graduate nurses experienced challenges in their workplaces which were relational in nature and inhibited their practice. When this occurred, varying levels of distress were exhibited, and at times this distress was extreme. The thematic analysis identified experiences of the new graduate nurses in practice. In the next chapter, a synthesis of the conceptual findings of Phase One and the practice experience of Phase Two of the study is presented as an interpretive description of moral habitability in nursing.

CHAPTER 9 INTERPRETIVE DESCRIPTION OF MORAL HABITABILITY IN NURSING

The focus of this chapter is to provide an interpretive description of moral habitability in nursing, both conceptually and in practice. The reciprocity between the outcomes of the two phases of the study is explored and an analytic synthesis of the findings is presented. The synthesis highlights the dynamic quality of moral habitability in nursing, which became evident as a result of using the two-phase approach.

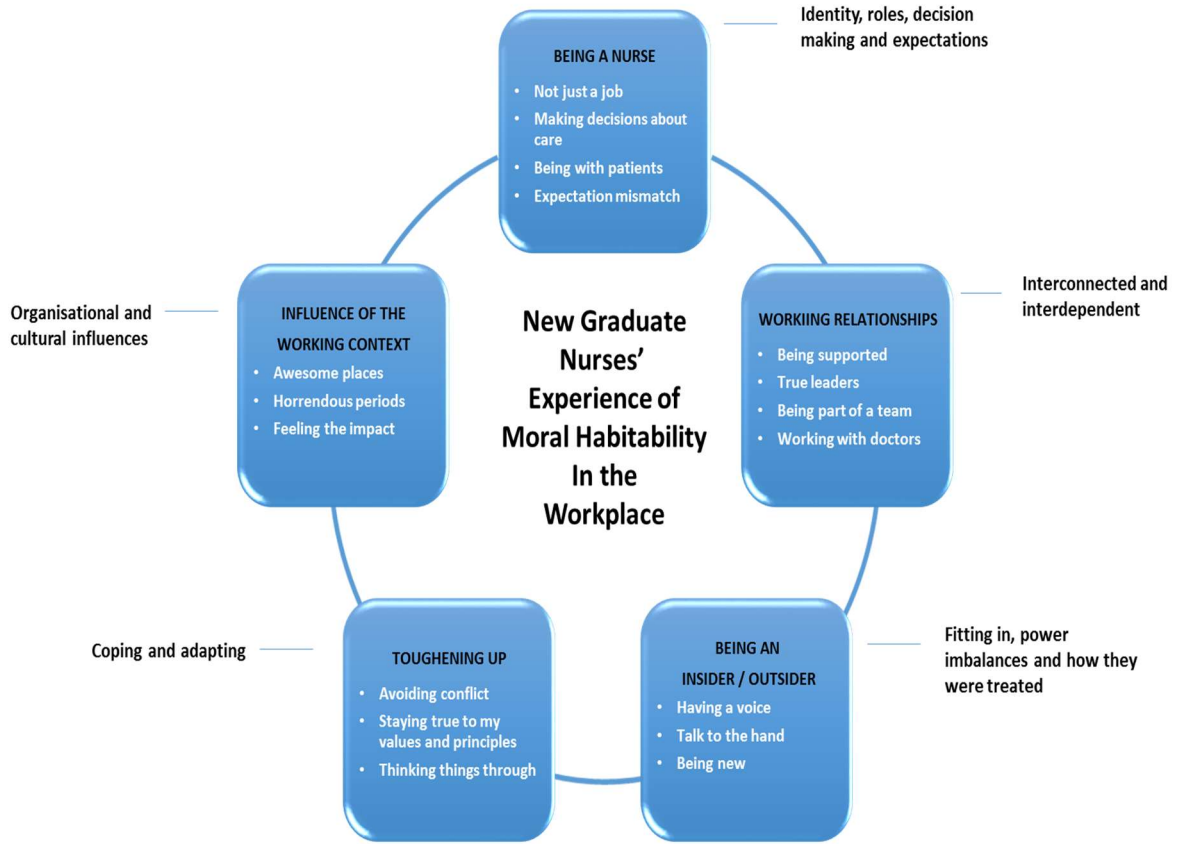
In Phase One an exploration of the nursing literature related to the moral aspects of nursing practice environments and nurses' moral interactions generated a framework of the concepts related to moral habitability in nursing (refer to Figure 11).

Figure 11. Phase One Findings: Conceptual Framework of Concepts Related to Moral Habitability in Nursing



As a result of this process, it became evident that moral habitability involves a complex interplay between the individual qualities of the nurse and the environment where practice takes place. It also became evident that the outcomes of this interaction could produce contrasting experiences. The complexity of this interchange was further revealed in the findings of Phase Two. By entering the social world of one subset of nurses, i.e. new graduate nurses in their workplace, thematic analysis of the nurses' experiences identified five themes illustrating the complex and dynamic nature of the concept of moral habitability in nursing (Figure 12).

Figure 12. Phase Two Findings: Themes and Sub-themes



Before detailed discussion of the synthesis of findings, the following section briefly explains the utility of using interpretive description as a methodology to enable the reconciliation of the two phases of the study.

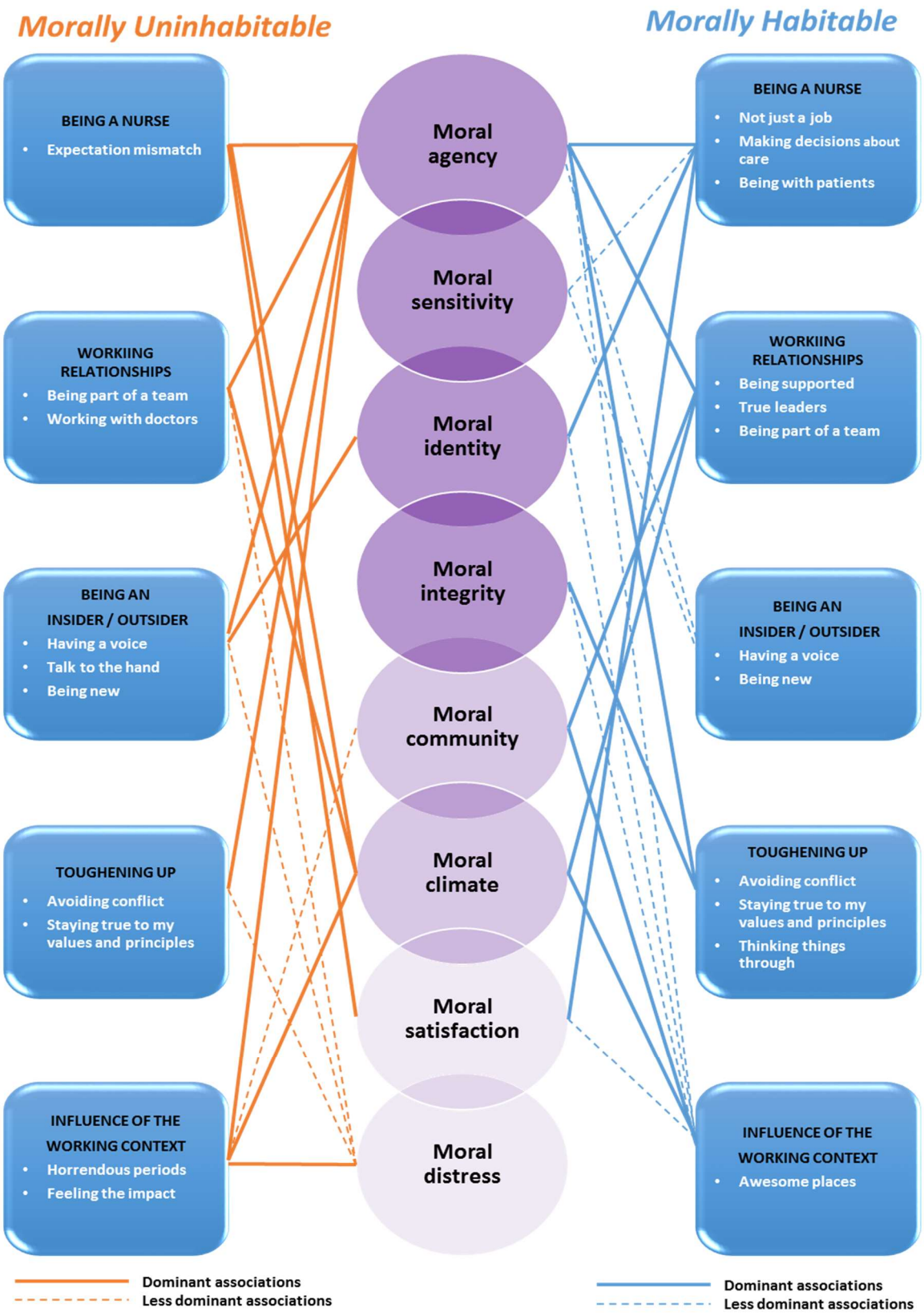
Synthesis of Findings of Phase One and Phase Two

When using interpretive description as a methodological approach, the outcome is focused on linking common elements that "also generates a mental heuristic" (Thorne, 2016, p. 188) so that it becomes easy to understand and relevant to application in practice. The synthesis of the findings of the two phases focused on identifying how useful the concepts identified in Phase One were in understanding moral habitability through the experiences of the new graduate nurses in their clinical environments. The other focus was to identify if other elements that could further the understanding of moral habitability were evident. This pragmatic process provided a means of integrating the findings of the first and second phases of the study and meeting the overall aim of the study. Themes and sub-themes from the Phase Two thematic analysis were synthesised in relation to the findings from Phase One. The broad features of the synthesis are diagrammatically represented in Figure 13.

Using the qualitative methodology of interpretive description means that "the ultimate purpose is not theorizing but rather illuminating relevant insight" (Thorne, 2016, p. 188). Therefore, the synthesis of the two phases is not attempting to be measurable, since this is not consistent with a qualitative approach. Rather, the term 'associations' is used to reflect where the concepts from Phase One have cross-connections or linkages with the experiences of the new graduate nurses that were identified in Phase Two.

Figure 13. Synthesis of Findings from Phase One and Two:

Dominant and Less Dominant Associations



The use of the term ‘dominant’ is reflective of how frequently or compellingly associations were evident in the Phase Two findings. For example, if the pattern of connection was very frequent or compelling, then it is referred to as dominant, and if the pattern of connection was infrequent and not as powerfully represented, it is referred to as less dominant. Each of these thematic and conceptual associations is detailed in this chapter.

Linkages between concepts and themes are related to whether the environment is morally habitable or morally uninhabitable. Each theme, apart from the concept of moral sensitivity, has elements of both. This reflects the complexity and dynamic nature of the new graduate nurses’ experiences. The findings suggest that moral habitability is not a static state and is deeply related to the contextual features and interactions of the new graduate nurses. For example, a single interaction between the new graduate nurse and a more senior colleague could change whether moral habitability was enhanced or inhibited. Adding to the complexity was that the data suggested some of the sub-themes are also represented as engendering both. For example, data related to the themes ‘Working Relationships’, ‘Being an ‘Insider/Outsider’ and ‘Toughening Up’ had characteristics which were both common and contrasting.

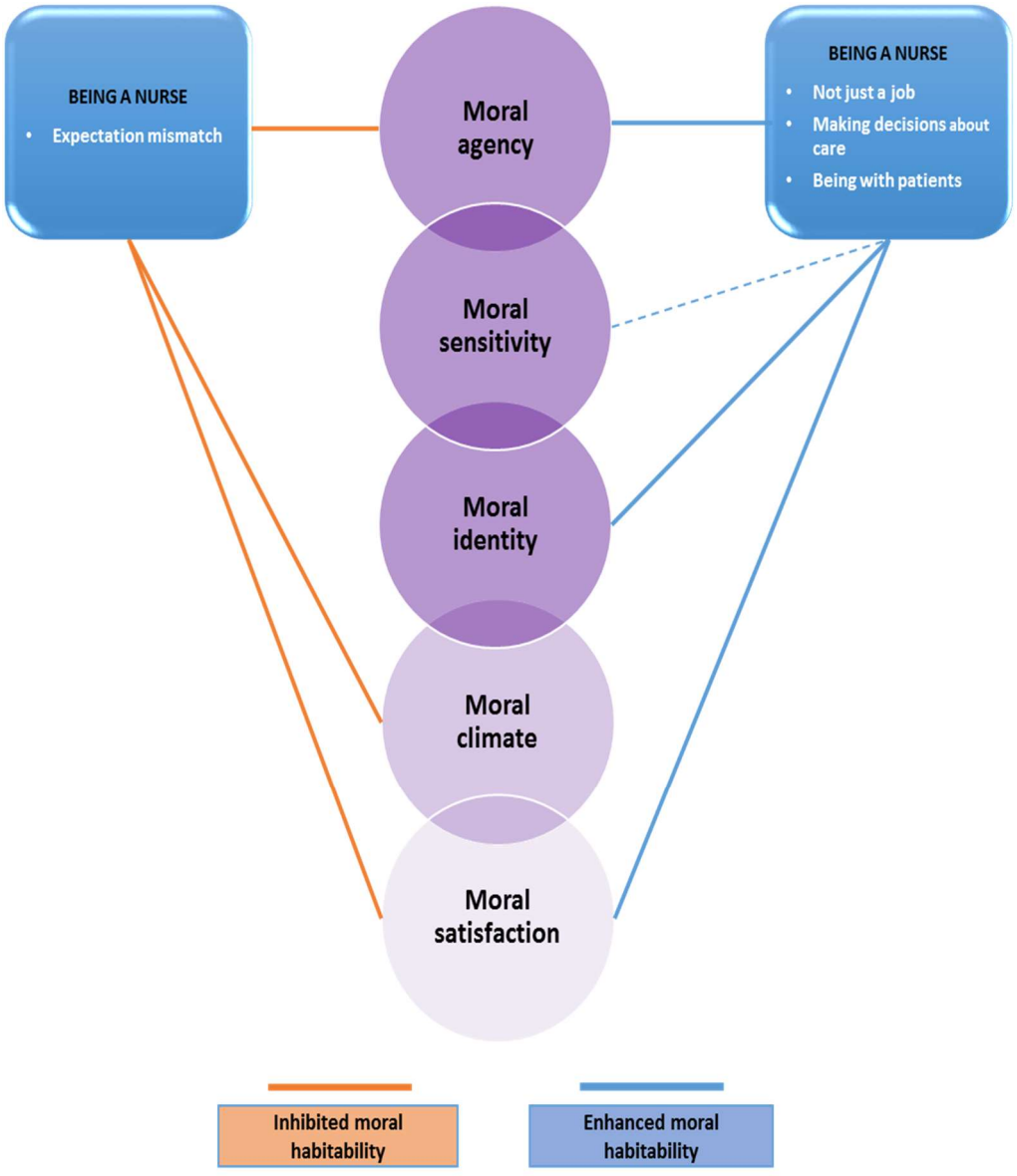
The following section presents the synthesis of the Phase One concept associations with the Phase Two theme ‘Being a Nurse’.

Moral Habitability and Being a Nurse

The theme ‘Being a Nurse’ emphasises the qualities, attributes and characteristics of the new graduate nurses in relation to the moral habitability of their working environment. This theme expressed what the new graduate nurses’ perceived as their role as a nurse and features of how they made decisions in their practice. Their personal identity and

expectations about what it means to be a nurse were also highlighted. Concepts identified in Phase One of the study that were dominantly associated with this theme were moral identity, moral agency, moral climate and moral satisfaction. There was a less dominant association with the concept of moral sensitivity. These associations are not disparate but are complexly interlinked. This is diagrammatically represented in Figure 14 and the following discussion provides the specific details of these associations.

Figure 14. Being a Nurse: Associations with Phase One Concepts



Moral identity

The concept of moral identity was evident in the qualities of the new graduate nurses and their experiences of enhanced moral habitability through strong associations with the sub-themes 'not just a job', 'making decisions about care' and 'being with patients'. The sub-theme 'expectation mismatch' was associated with the new graduate nurses' experiences of moral identity, particularly through the inhibiting influence of the moral climate of their workplace. This is consistent with the Phase One findings which identified that the concept of moral identity was situated, relational and contextual (Doane, 2002; Liaschenko & Peter, 2016; Peter & Liaschenko, 2013). This resonated with the experiences expressed and enacted by the new graduate nurses as being a dynamic interaction with themselves and others in context, and most specifically with their patients. The relational dynamic with their patients was fundamental to the new graduate nurses' sense of moral identity. The sub-theme 'being with patients', highlighted this strong desire, expressed by the new graduate nurses, to communicate and spend time with their patients above all other external contextual influences, often expressed by the attitudes of other nurses. This proximity was pivotal to their understanding of their identity and what 'Being a Nurse' was.

Peter et al. (2004), in their secondary analysis of moral habitability in the workplace, found that proximity to patients was important to understanding moral responsibilities and their findings were that, for many nurses, this understanding was confused. This was contrasted by the experiences of the new graduate nurses who expressed a clear understanding of their responsibilities, specifically that being with their patients was essential to ensure they understood the patients' care needs and could act on them. This was underpinned by a

strong vocational stance that their work was more than 'just a job' and their expressions of the need to be of service to their patients.

The new graduate nurses often spoke of relieving pain and suffering as being imperative to benefiting or being of service to their patients and to their understanding of what it meant to be a nurse. Related to the conceptual findings in Phase One, a study by Peter, Simmonds, and Liaschenko (2016) found that seeing improvement in patients, such as relieving pain, was viewed as a component of moral identity maintenance. Another aspect of nurses' moral identity maintenance was the expressions of gratitude by patients (Peter et al., 2016). This was very evident in the experiences of the new graduate nurses who identified patient gratitude as confirming they had provided good care. However, it was also evident in the Phase Two data, that maintaining moral identity through patient gratitude was complicated.

In Phase One of this study, the concept of moral identity was found to be a mix of both socially-mediated external factors and the internal dialogue of the nurses themselves (Doane, 2002; Liaschenko & Peter, 2016; Varcoe et al., 2004). This tension between external and internal dialogue was evident in the experiences of the new graduate nurses, who gained satisfaction from encouraging feedback from their patients but countered this by self-evaluation of inadequacy. While their understanding of their role as a nurse did not waiver, the data suggested that this self-evaluation of inadequacy was intensified by whether they felt they had enough time to be with their patients. What constituted having enough time changed from hour to hour and day to day, depending on the interactions in their workplace and was a particularly influential in inhibiting their sense of moral identity if the moral climate of their workplace reflected a task-oriented culture.

Maintaining and affirming moral identity were difficult in environments which had a task-oriented expectation. These environments created an internal conflict with the new graduate nurses' focus on 'being with patients' and the influence this had on decision-making and actions, i.e. their moral agency. The findings of Phase One highlighted the direct relationship between moral identity and moral agency (Doane, 2002; B. Kelly, 1998; Liaschenko & Peter, 2016). This link was particularly evidenced in the conflict that the new graduate nurses experienced. The findings of Phase Two suggested they had a clear sense of the purpose of being a nurse, expectations of the nursing role and the priority of patient care. However, what was also evident from their experiences were the difficulties in enacting moral agency in moral climates that promoted values that were contrary to their own. How this interplay of the Phase One concept of moral agency was exhibited in the new graduate nurses' experiences of Phase Two is discussed in the following section. The concept of moral sensitivity as a precursor to moral agency is also addressed, since even though this concept had weak associations with this theme, it was reflected in the meaning attributed to moral agency in the explanations of the new graduate nurses.

Moral agency and moral sensitivity

As described in the integrative literature review, the concept of moral agency concerns making moral judgements and decisions and acting on these decisions. The sub-theme 'making decisions about care' was dominantly associated with the Phase One concept of moral agency. One finding of the integrative literature review of Phase Two relevant to this association was the need for further understanding of the decision-making aspects contributing to moral agency of nursing practice (Goethals, Gastmans, & de Casterle, 2010).

The new graduate nurses' clearly and consistently articulated the influences related to their moral judgements and decisions about patient care. This was expressed by a fundamental need for dialogical interaction with patients to determine their needs. This was coupled with a strong internal focus on upholding patient autonomy, maintaining dignity, and providing advocacy for their patients. While the new graduate nurses recognised the importance of clinical tasks, their conversations suggested a focus on psychosocial requirements which they viewed as primary care needs. This was combined with a principled approach to care delivery demonstrated by adherence to moral principles, which was evident in the new graduate nurses' explicit and implicit expressions and actions. This focus on a holistic principled approach to decision-making adds another dimension to understanding the enactment of moral agency in enhancing moral habitability in nursing practice.

Another quality of the new graduate nurses' moral agency was an inherent empathetic understanding of the vulnerability of their patients, for example, prioritising care by seeking what the patient or their family would want. This was underpinned by the nurses' innate sense of the importance of upholding their values in their everyday care. The concept of moral sensitivity, identified in Phase One, is useful in considering these qualities of the new graduate nurses.

In Phase One, the concept of moral sensitivity was identified as capturing this recognition of vulnerability of the patient's situation and being able to identify the moral needs and implications of care (Weaver, Morse, & Mitcham, 2008). This view of the concept resonated with the empathetic approach exemplified by the new graduate nurses, where it was very evident in their dialogue and actions that they sensed vulnerability and were compelled to act.

Conceptual ambiguity is also a feature of moral sensitivity in the findings of the Phase One integrative literature review. Weaver, Morse and Mitcham (2008) addressed this issue using a concept analysis that consolidated understanding of moral sensitivity as demonstrating an ability to recognise vulnerability and take into account all aspects of the patients' needs, including cultural, spiritual, psychosocial and physical, in order to make the right decision. The concept of moral sensitivity draws on internal characteristics such as the attitudes of the nurse, the degree of compassion, intellectual awareness, clinical expertise, learning and the notion of courage to act when faced with constraints (Weaver & Mitcham, 2008). While the findings of Phase Two in the theme 'Being a Nurse' identified aspects of these internal characteristics in the new graduate nurses, including taking an holistic, empathetic, compassionate approach to nursing care, other aspects of moral sensitivity were not evident. For example, the data did not display aspects of their intellectual awareness and moral courage. Therefore, the associations with the Phase Two findings in this theme and the concept of moral sensitivity were less dominant. This was coupled with the definitional restrictions of the concept in everyday practice, a finding of the integrative literature review and subsequent literature (Milliken & Grace, 2015).

While the integrative literature review found that there continues to be ambiguity around the concept of moral sensitivity, there were increasing links between moral sensitivity and moral agency, moral identity and moral climate (Lutzen, Blom, Ewalds-Kvist, & Winch, 2010). The findings of Phase Two highlighted the links between these concepts. Of particular relevance to the theme 'Being a Nurse' was the Phase One finding of the need to further explore constraints to the moral agency of nurses (Rodney & Varcoe, 2012). The integrative literature review emphasised the link between the context of the workplace and the action

by the moral agents in the environment. The Phase Two Theme, 'Being a Nurse', captured examples of how the new graduate nurses understood the need for care that encompassed important moral imperatives, such as maintaining the dignity of their patients. However, it also highlighted that working in some contexts where task completion was valued over spending time with patients meant their moral agency was thwarted. The sub-theme 'expectation mismatch' draws attention to context being crucial for the new graduate nurses to enact their moral agency. Here the Phase Two findings of what the new graduate nurses encountered in their practice provided new illustrations of and rich contextual data on how context and agency are linked in everyday practice.

Moral climate and the impact on moral identity and moral agency

The concept of moral climate was particularly useful in understanding the contextual features of moral habitability. In the sub-theme 'expectation mismatch', the concept of moral climate was predominantly associated with inhibiting moral habitability for the new graduate nurses. The integrative literature review found the concept of moral climate is a representative subset of the organisational culture of the context of where nurses practice; in particular, the values espoused that influence care delivery at a micro (individual, ward), meso (organisation) and macro (societal) level (Rodney et al., 2013). These values can be overt in, for example, practices and procedures, or implied by the behaviour of management or colleagues. While the concept of moral climate as a finding of Phase One emphasised the impact of all levels (micro, meso and macro) in integrating the two phases of the study, it was evident that the new graduate nurses' experiences of moral climate occurred at the micro level - specifically, the ward or unit. This micro level was observed to

be specifically impacted by mismatches between the expectations of ward staff and those of the new graduate nurses.

Wards where the moral climate was one in which managers and nursing staff prized the completion of tasks represented a direct contrast to what the new graduate nurses viewed as central to being a nurse. This type of moral climate inhibited their moral agency and moral identity. The findings of this study suggest that the expectations of staff, whether at a general cultural or individual staff level within the ward, have the greatest influence on moral climate, and when these expectations were mismatched, on inhibiting moral habitability.

This impact only at the micro level rather than organisational level was particularly evident, since the new graduate nurses worked within the same organisations over a 12-month period and yet had vastly different experiences, depending on the ward or unit in which they were practising. Apart from some extreme examples, where the moral climate of the ward or unit was consistently poor, the experiences of the new graduate nurses were not static or related to whether their experiences occurred early or later in their new graduate year. This was supported by the findings of Phase Two, which demonstrated that most of the new graduate nurses had experienced one or more task-oriented climates which consistently constrained their moral agency through mismatched expectations. Moral agency was further challenged by the influence of variances in power of the other nursing staff, which was evident in the sub-text of the data.

The integrative literature review highlighted the lack of evidence of a link between the moral climate and moral behaviour within the workplace. However, it was evident in the sub-theme ‘mismatched expectations’ that new graduate nurses’ behaviour was adversely

affected by the contextual features of their workplace environment, since they could not behave in a manner consistent with their understandings of being a nurse. This also had an impact on their satisfaction.

Moral satisfaction

The Phase One concept of moral satisfaction was predominantly associated with the theme 'Being a Nurse'. The data related to this theme had associations with the Phase One concept in both enhancing and inhibiting moral satisfaction. While the term 'moral' was not always overt in the Phase Two data, the dialogue surrounding work satisfaction was often about the moral aspects of practice. The concept of moral satisfaction was undetermined during the conceptual mapping of Phase One, but the experience of satisfaction with moral choices and actions of care was important to explore in Phase Two.

The findings of Phase Two were that moral satisfaction was a dominant concept and in particular was enhanced by fulfilment of the new graduate nurses' role expectations. This was demonstrated in their discussions about how maintenance of their moral identity and moral agency and were the key to satisfaction. The context of practice influenced whether this satisfaction was attainable. Moral satisfaction fluctuated, depending on whether the contextual constraints were common or intermittent. Dissatisfaction was an outcome of moral climates that consistently inhibited moral agency and the maintenance of moral identity.

In summary, the key features of the synthesis of the Phase One concepts with the theme 'Being a Nurse' identified both the qualities of the new graduate nurses and the influence of context on their experience of moral habitability in practice. This particularly highlighted the

links between moral agency, moral identity, moral sensitivity and the inhibiting influence of moral climate.

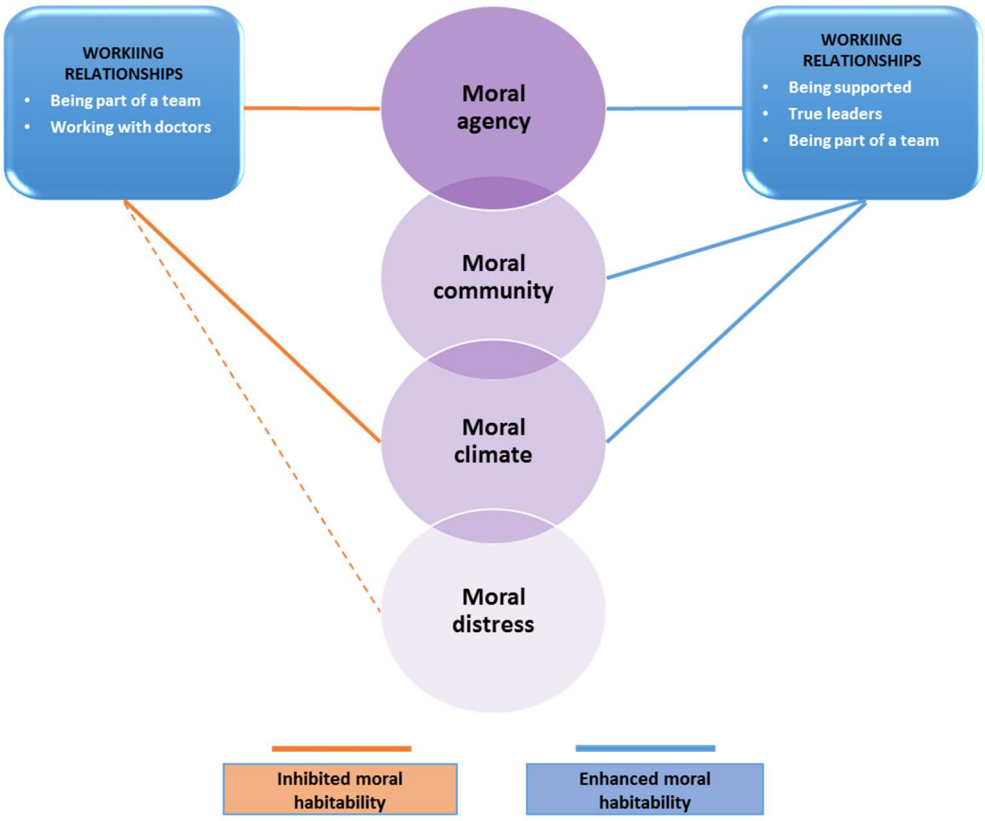
The qualities of the new graduate nurses that influenced moral identity and moral agency were a strong service-oriented approach to care that was principled and holistic. An innate sensitivity to vulnerability was evident. Maintaining moral agency resulted in moral satisfaction. However, context was highly influential in limiting moral agency through a task orientation and limits to time spent with patients. This produced dissatisfaction and an erosion of moral identity. Of key importance was the fluctuating state of moral habitability through interactions with other nurses which limited moral agency. The interactions with other staff were the central feature of the following synthesis of the Phase One concepts and the experiences of the new graduate nurses in their practice environments.

Moral Habitability and Working Relationships

'Working Relationships' was the second theme of the Phase Two findings. This theme highlighted the interconnected, relational nature of the new graduate nurses' experiences with colleagues within the workplace. In synthesising the Phase One concepts with this theme, there were clear associations with the concepts of moral agency, moral climate and moral community, and a less dominant association with moral distress (see Figure 15).

In addition, the theme 'Working Relationships' emphasises the importance of culture and context as an influence of the new graduate nurses' moral habitability in the workplace, not only through these strong associations, but also through the links between the concepts.

Figure 15. Working Relationships: Associations with Phase One Concepts



Moral agency, moral community and moral climate

The Phase Two findings illustrated how the interactions with colleagues, predominantly with other, more experienced nurses, influenced the new graduate nurses' provision of good nursing care as enactment of their moral agency. This was consistent with the Phase One findings, which identified that moral agency requires consideration of workplace relationships, power differentials and dialogue within that workplace (Peter, 2011; Rodney, 1997) to understand what enhances or inhibits action. In the findings of the theme 'Working Relationships', four main features were related to enhancing or inhibiting moral agency. The following section discusses these features.

The first feature that enhanced moral agency was the nature of communication with colleagues, particularly where it was proactive and supportive. In the Phase Two findings,

the new graduate nurses' reports in interviews and focus groups of the importance of working with colleagues who offered proactive support were countered by a lack of observational evidence. The integrative literature review did not highlight the nature of proactive support in supporting moral agency. However, the experiences or perceptions of the new graduate nurses' interactions with other nurses who provided proactive support were reported by the new graduates as being essential to the enablement of their moral agency.

The second feature of their interactions with nursing colleagues that was viewed as imperative to enhancing moral agency, was communication which was perceived as supportive, with the specific attributes of openness, approachability and patience. In the Phase Two findings, other nurses with more experience, termed 'leaders', who were viewed as open and demonstrated high levels of patience and approachability, facilitated the new graduate nurses' moral agency. This was evident in their reports of how their interactions with these nurses heightened their self-esteem and their confidence in being able to provide the care they wanted to provide. This heightened sense of confidence gained through dialogical exchanges with nurses who held these attributes, was not overtly evident in the Phase One integrative literature review, but was imperative to the new graduate nurses' moral agency. In nurses new to the profession, this heightened confidence enabled the new graduate nurses to provide what they perceived was good care, that is, acting as moral agents. Interactions with nurses who promoted moral agency through attributes of openness, approachability and patience also resonated with the Phase One findings regarding moral communities. Strategies to enhance moral communities included providing open, safe spaces for dialogue about concerns (Scott et al., 2011). This highlights the

interrelated nature of the concepts within the conceptual framework of Phase One as well as the Phase Two experiences in practice.

This interrelated nature is also evident in the third feature of the theme of 'Working Relationships' that enhanced moral agency. The sub-theme 'being part of a team' illustrated an enhanced moral agency in moral climates where there was a sense of having a shared responsibility for patient care. There were synergies with the findings of the integrative literature review, which found moral agency could be enhanced through an inclusive moral climate where interactions that provoked a sense of sharing patient care responsibilities between nurses provided a sense of community (Storch et al., 2009). This was particularly evident in the critical care units, and less evident in the ward context. While the Phase One concept of moral community was reflected in the Phase Two findings, one feature of building relationships that was not overtly evident in Phase One was the integral importance of sharing aspects of their lives outside the workplace. The new graduate nurses saw this as being a key element of becoming part of the team.

The final feature of the Phase Two findings related to the theme of 'Working Relationships' was the importance afforded by the new graduate nurses to other staff demonstrating a courteous attitude to them and a caring attitude to all team members. Phase One findings with regard to moral communities highlighted that where respect is evident, moral agency is enhanced (Pavlish et al., 2014). The new graduate nurses also expressed a sense of job satisfaction in these environments. However, the theme 'Working Relationships' also illuminated a contrast in these experiences, specifically in contexts where the moral climates did not reflect respect for the new graduate nurses. In these workplaces, even where it was only some staff who did not demonstrate respect, the new graduates reported

feeling less satisfaction with their work. This exemplified the complexity and diversity of the experiences of the new graduate nurses' in different workplace environments over time.

The findings of the Phase One integrative literature review identified interpersonal dialogue as being a conduit to conveying implicit values. Moral climates in which values reflected a lack of respect for the new graduate nurses conveyed this through nursing staff who were dismissive and who did not share patient care, and through medical staff who were repeatedly unavailable to respond to requests for assistance. The new graduate nurses perceived this as a culture of not caring about the individuals within it, and this inhibited their moral agency. In the findings of Phase One, inhibited moral agency contributes to moral distress. The links between the two concepts and the experiences of the new graduate nurse were apparent and are discussed in the following section.

Moral distress

Moral distress is a powerful concept in the nursing literature as evidenced by the exponential increase in interest over the last two decades (Eizenberg, Desivilya, & Hirschfeld, 2009; Hamric, 2012; Lamiani, Setti, Barlascini, Vegni, & Argentero, 2017; Rodney, 2017). While the Phase One concept of moral distress was predominantly associated with other themes identified in Phase Two, in the theme 'Working Relationships', the associations were inferred or not as evident in the data and the link was therefore not as strong.

As Phase One demonstrated, the moral climate of a workplace can contribute to moral distress (Corley, Minick, Elswick, & Jacobs, 2005; Humphries & Woods, 2016; Lutzen et al., 2010). The new graduate nurses' perceptions of their workplace culture in relation to poor communication and working relationships reflected a difficult moral climate. What was

particularly pertinent to the link with the concept of moral distress was that these difficulties contributed to the inability to fulfil their ideals regarding patient care. As a result, adverse outcomes of inhibited moral agency and subsequent discomfort were experienced by the new graduate nurses. This was particularly reflected in the new graduate nurses' comments regarding the frustration and discomfort they felt in interacting with medical staff who did not respond to their requests. The interdependence between the new graduate nurses and disengaged medical staff meant they felt they could not provide adequate care for their patients, which resulted in an ongoing uneasiness.

Also evident were their experiences of nursing teams which did not value joint responsibility for the care of patients, and so they needed to 'go it alone'. The new graduate nurses perceived that this resulted in poor care for their patients and contributed to the nurses' feelings of distress. This was not static, but rather a shifting experience of the new graduate nurses which occurred throughout the day in various interactions with nursing staff.

The findings of Phase Two also highlighted the influence of the internal aspects of the nurse in their experience of moral distress. While the external contextual influences that constrained moral agency with the resultant moral distress were consistent with the findings of Phase One, constraints internal to the moral agent can also be a feature (Newton, Storch, Schick-Makaroff, & Pauly, 2012). This was evident in the perceptions and definitions of the new graduate nurses of what it means to be part of a team. When their needs were not met by the nursing team, this contributed to a sense of constrained agency.

Finally, the findings of Phase One highlighted the ambiguity of definitions of moral distress, with outcomes of distress ranging from mild to a more severe experience (Dudzinski, 2016). While this was consistent with the experiences of the new graduate nurses througout the

12-month data collection period, in the theme 'Working Relationships', the outcomes of constrained agency were associated with discomfort rather than more serious potential impacts of moral distress.

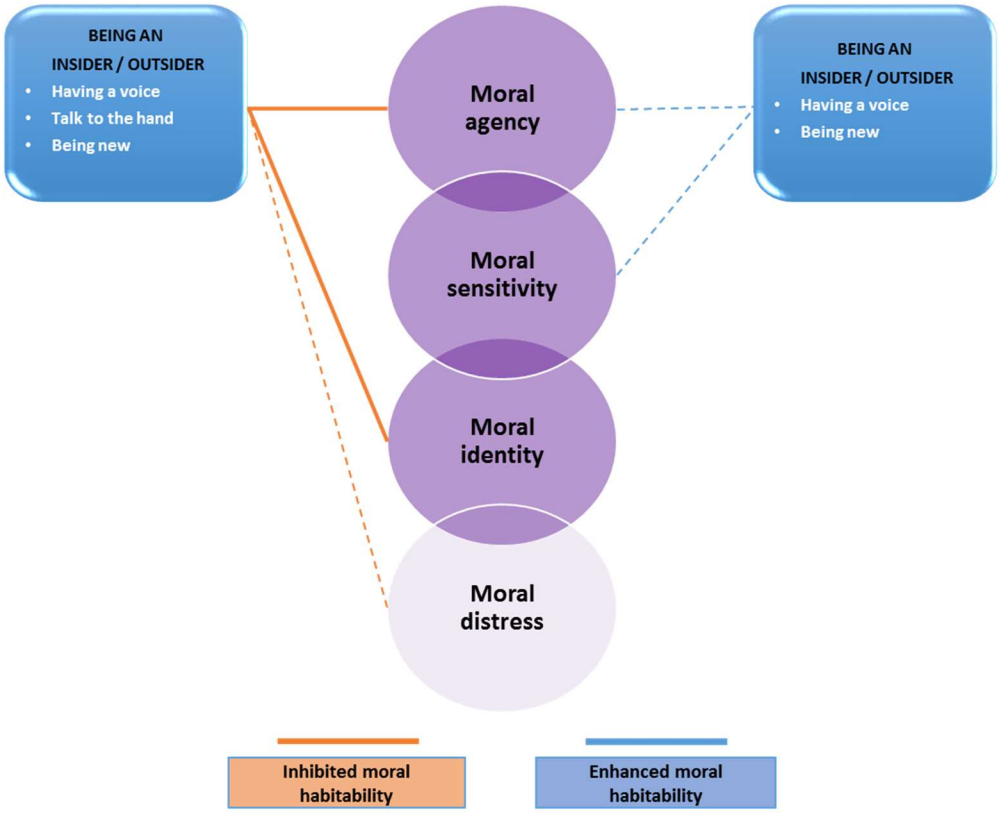
In summary, the associations with the concepts identified in Phase One and the theme 'Working Relationships' contributed to a deeper understanding of moral habitability in nursing. This was through an expanded view of moral agency informed by the complex interplay between the relational interactions within the environment of practice. In the previous theme, 'Being a Nurse', the internal characteristics of how the new graduate nurses' perceived their roles and made decisions influenced their actions. When there was a mismatch of their internal values with those of the environment of practice, agency was thwarted. In the synthesis of the theme 'Working Relationships' and the concepts of Phase One, the external features that influenced the new graduate nurses' experience of moral habitability was exhibited by how relationships enhanced or constrained their experiences of caring for their patients. Respectful, proactively supportive colleagues who shared the care responsibilities were associated with heightened confidence and self-esteem in the new graduate nurses, and this contributed to enhanced moral agency and sense of moral community. Moral climates that reflected a disrespectful and unsupportive culture had negative connotations for moral habitability.

Moral Habitability and Being an Insider/Outsider

An important finding from Phase Two concerned the new graduate nurses' experiences of being new, not only to the nursing profession but also to the multiple clinical contexts they worked in over their new graduate year. These experiences were captured in the theme 'Insider/Outsider'. The new graduate nurses' social encounters were profoundly difficult in

many of the contexts of practice during their experience of trying to 'fit in'. Perceptions of power imbalances and poor treatment by staff were common in the data. The synthesis of the Phase Two data with the findings of Phase One is diagrammatically represented in Figure 16.

Figure 16. Being an Insider/Outsider: Associations with Phase One Concepts



The concepts of moral agency and moral identity were predominantly and adversely associated with the experiences of the new graduate nurses in the Phase Two findings. The data exhibited many features of distress in the new graduate nurses, particularly as a result of poor treatment by other staff. However, the associations with the concept of moral distress were weaker, since their experiences of distress in this theme were not always related to their moral agency, a key concept associated with moral distress. The complexity of the new graduate nurses' experiences is further illustrated by the favourable though

weaker associations with moral agency and moral sensitivity. The following section details the synthesis between the concepts of moral agency and moral distress and the theme 'Insider/Outsider'.

Moral agency and moral distress

The nursing literature reviewed in Phase One emphasises that an understanding of moral agency requires consideration of context, the relationships and dialogue within the context and the differing levels of power at play (Peter, 2011; Rodney, 1997). This reflects that nurses, doctors, other healthcare workers, patients and other staff have differing levels of power within the healthcare environment. This dialogical, relational and conceptual view of moral agency is particularly relevant to the understanding of moral habitability in nursing, and the integrative literature review findings highlighted the need for consideration of the context, the relationships within the context and the nurses working within that context.

These influences were predominantly expressed in the Phase Two theme 'Insider/Outsider' as inhibiting an experience of moral habitability. In this theme, relational interchanges between some nursing staff and the new graduate nurses either enhanced or, more evident in the data, inhibited moral agency.

The new graduate nurses spoke of how their influence in providing good nursing care was enhanced by nursing staff who allowed them to have a voice in care decisions. However, if their dialogue was constrained or they were silenced, their ability to act on what they perceived were the right care decisions was impeded. Another factor that hindered their ability to provide good nursing care was their experiences of being ignored, excluded and undervalued by some nursing staff. Rather than reflecting an external conflict between organisational values and the personal values of the new graduate nurses, as suggested in

the literature associated with moral agency in the Phase One findings, it was the more experienced nurses themselves who caused the discordance. The resultant constrained agency experienced by the new graduate nurses and created stress which was exhibited by expressions of anxiety and discomfort. The response to the behaviour by the other nurses created an internal constraint from an external source. Significant writers in the literature reviewed in Phase One highlighted this reciprocity of both internal and external constraints in the enactment of moral agency (Storch, Rodney, & Starzomski, 2013; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012).

Not addressing the behaviour of the nurses identified in the theme 'Insider/Outsider' as being 'big personalities' or bullies indicated a broader culture of acceptance of this behaviour. The impacts of interactions with these nursing staff who typically coerced and intimidated were very powerful. This interaction created feelings of isolation and episodes of crying that were repeatedly reflected in the data gathered in Phase Two. These expressions of distress had some coherence with the concept of moral distress.

While the Phase One integrative literature review highlighted the lack of delineation in terms such as moral stress and moral distress, the new graduates' experience of constrained agency and its subsequent psychological effects is consistent with the concept of moral distress in much of the nursing literature examined (Epstein & Hamric, 2009; McCarthy & Gastmans, 2015; Rodney, 2017). This was further supported by the findings of the conceptual map and subsequent integrative literature review, where the concept of moral distress was found to be linked to decreased job satisfaction (Dyo et al., 2016), potential attrition (Woods et al., 2015) and inhibited decision-making (Rushton, Caldwell, & Kurtz,

2016). Although these findings resonated with the experiences of the new graduate nurses in this theme, they were not dominant.

While the Phase One concept of moral distress was consistent with the experiences of constrained agency at times, in the theme 'Insider/Outsider' the reactions of the new graduate nurses were not dominantly associated with this concept. This was because their common response, rather than being related to the provision of patient care, was the feeling they had of being treated so badly by some nursing staff. The findings of Phase One emphasised the need to examine the interplay between moral identities with the concept of moral distress (Peter & Liaschenko, 2013). The new graduate nurses' experiences relate to the concept of moral identity, rather than the concept of moral distress, through the erosion of confidence in their internal perception of their ability to nurse effectively.

Moral identity

In the Phase One findings, participants' descriptions of their moral identity were found to include that being a good or moral nurse required the ability to provide quality nursing care (Catlett & Lovan, 2011). Another finding was that the process of moral identity development was influenced by internally-critiqued comparisons with nursing ideals through inner dialogue (Doane, 2002). This finding was strongly associated with the theme 'Being a Nurse'. However, in this theme, what was of considerable relevance was that changes to moral identity could occur through contextual relational influences (Doane, 2002) rather than a comparative internal dialogue.

As previously discussed, the earlier findings of the theme 'Insider/Outsider' demonstrated the power of dialogical exchanges with other nursing staff, where hurtful comments made to the new graduate nurses were internalised, reduced their moral agency and created

stress. What was particularly evident in the data from the theme was the impact of these interactions on eroding the new graduates' confidence in their ability to nurse effectively, and the subsequent feelings of incompetence expressed. The impact of reduced confidence and feelings of incompetence suggested possible changes to their moral identity. While frequent in the data, the experience of reduced confidence and subsequent feelings of incompetence were related to specific experiences with certain nursing staff at a moment of time. That is, on the same day, the new graduate nurses could vacillate between feelings of competence and incompetence depending on the interactions they had with other nurses. This represented the external influences to moral identity and the new graduate nurses' perceptions of the ability to enact moral agency. In the following section a characteristic of the new graduate nurses associated with an enhanced experience of moral agency is detailed.

Moral sensitivity and moral agency

The ability to recognise the morally-relevant care needs of patients was acknowledged in the Phase One integrative literature review as a characteristic of the concept of moral sensitivity (Weaver et al., 2008). The concept of moral sensitivity was also found to enhance moral agency through this recognition of the moral aspects of care (Weaver et al., 2008).The sub-theme 'being new' provided another insight into the new graduate nurses' enhanced sensitivity to the moral aspects of care. By being new to the workplace, the new graduate nurses perceived that they were able to identify the moral aspects of care that they believed other staff did not always sense. That is, the perception of the new graduate nurses was that at times their nursing care was more comprehensive in meeting the needs of the patients because they recognised important moral elements that had been missed by

others. That being new could enhance moral sensitivity was not found in the findings of Phase One. While this finding resonates with the Phase One concepts of moral agency and moral sensitivity, it was not as closely associated as the data related to this sub-theme were limited.

Finally, another aspect of moral sensitivity which was not evident in the Phase Two data was the Phase One finding that a heightened moral sensitivity may be a predictor of increased susceptibility to moral stress (Begat et al., 2004; Lutzen et al., 2010). As previously described in this theme, stress was predominantly triggered by the poor treatment of the new graduate nurses by other nursing staff.

In summary, the associations between the Phase One concepts and the Phase Two theme 'Insider/Outsider' were valuable to an understanding of moral habitability through the interplay of the contextual relationships and characteristics of the new graduate nurses. What enhanced the new graduate nurses' experience of moral habitability was their internal perception of a heightened sensitivity to patient needs through having 'fresh eyes'. By constantly being the new staff member in their workplaces, the new graduate nurses perceived they saw and could act on moral aspects of care that may have been missed by others.

This theme particularly highlighted the external factors that impeded moral agency through the emphasis of the power of adverse interactions with some nursing staff in the context of the workplace. Interactions of this nature contributed to the experience of moral distress. However, the high levels of stress evident in the data related to this theme were primarily related to the experience of being treated badly and at times bullied.

In the following discussion about the Phase Two theme 'Toughening Up', the associations with the Phase One concepts highlight the coping and adaptive strategies employed by the new graduate nurses in their experience of moral habitability in their first year of practice.

Moral Habitability and Toughening Up

The theme 'Toughening Up' identified patterns in the data related to strategies used by the new graduate nurses to maintain their experience of moral habitability in their workplace. Their ability to adapt and cope is also highlighted. One area of particular ongoing tension was their attempts to maintain their values without compromise, or at least what they perceived as not compromise too much.

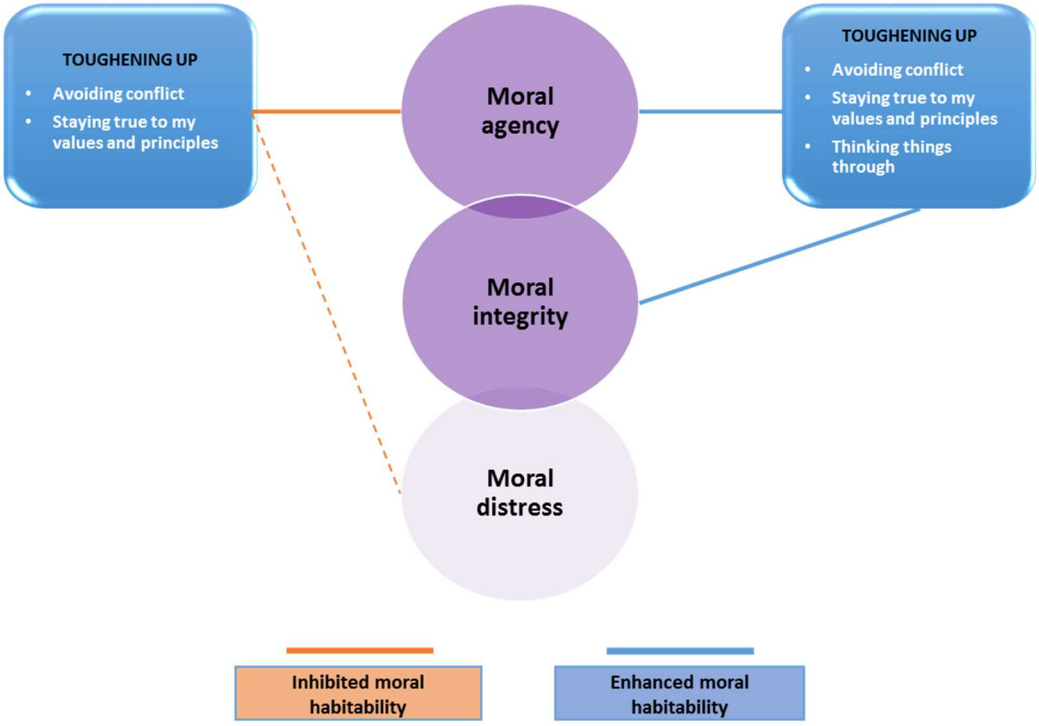
In the synthesis of this theme with the concepts identified in Phase One, there were dominant associations with moral agency and moral integrity. However, the links in the data of Phase Two were not as strong to the concept of moral distress. Figure 17 depicts the synthesis of the Phase One concepts with this Phase Two theme 'Toughening Up'. The strategies used by the new graduate nurses to enhance moral habitability are discussed in the following section which presents the dominant associations with the concept of moral agency and weaker associations with moral distress.

Moral distress and moral agency

Moral behaviour is the action result of the process of reasoning and making the right decisions (Goethals et al., 2010). The overall ability to make moral decisions and then act on them to fulfil responsibilities was referred to in the Phase One findings as moral agency (Rodney & Varcoe, 2012). The integrative literature review identified that for nurses to enact moral agency, they often needed to work 'in between' their own values and a shifting

moral context with competing values of the organisation and individuals in it (Varcoe et al., 2004).

Figure 17. Toughening Up: Associations with Phase One Concepts



This working the 'in-betweens' echoed the experiences of the new graduate nurses in practice, particularly in relation to how they found ways to navigate through their workplace experiences.

One finding of Phase Two central to the new graduate nurses' enactment of their moral agency was the strong influence of their personal and professional values and principles. The tension of competing values with those of the workplace meant that the new graduate nurses sometimes felt compromised and this lead to anxiety. While the theme 'Toughening Up' at times highlighted the anxiety the new graduates experienced when they felt they had compromised their values and consequently their moral agency, it was not a dominant

feature of the data. Compared to the link with moral agency, the link with the concept of moral distress was more tentative.

The Phase Two data provided examples of how the new graduate nurses found ways to maintain their moral agency by 'avoiding conflict'. The data particularly highlighted the adaptive strategies used to minimise the influence of specific nursing staff, key among which was to stay away from them. By staying away from 'difficult' nursing staff, the new graduate nurses could better meet what they perceived to be their patients' comprehensive needs, rather than the smaller subset of needs deemed necessary by the difficult nurse.

The new graduate nurses also chose on occasion to stay silent to avoid conflict. At other times, the choice was to speak out in what they believed was in the best interests of the patient, rather than what was required of them by the other nursing staff. This strategy of staying silent did not enhance their moral agency but rather was an act of self-preservation in maintaining their social place within the workplace environment. Having to make this choice created an internal tension in the new graduate nurses.

What was not as evident in the Phase Two data was the influence of organisational values on the new graduate nurses' moral agency. While there were examples in the data of finding different mechanisms to avoid the organisationally-espoused hierarchical constraints, for example, finding ways to circumnavigate high-ranking medical staff, the dominant aspect was avoiding individuals, usually nurses. Consistent with the findings of Phase One, this adaptive mechanism, whether avoiding conflict or embracing it, highlighted the competing values of self and others within the context of their workplaces.

The Phase One findings revealed a strong link between moral agency and moral integrity, particularly in a commitment to act in a principled way and the tension caused when this was hindered. The following section discusses the characteristics of the new graduate nurses and their strategies to maintain moral integrity.

Moral integrity

The findings of Phase One highlighted the dynamic, relational nature of the concept of moral integrity, particularly through the personal internal critique regarding values coherence and the external influences of social interactions (Hardingham, 2004). The Phase Two findings amplified the importance of how values and principles underscored the new graduate nurses' practice. The findings of the theme 'Toughening Up' highlighted the adaptive strategies used by the new graduate nurses to maintain their moral integrity. The strategies were reflexive and dialogical. Talking about their experiences with trusted people was pivotal and reflecting on practice provided a means to maintain their integrity through the consideration of a coherence with the values in practice. While their primary focus was on the promotion of the better patient care, the strategies were also employed when faced with moral challenges. An example of this was in confronting moral conflicts related to upholding choices for palliative care patients or consent for patients with dementia.

Self-reflective strategies were also a coping mechanism. In the Phase Two data it was evident that for new graduate nurses, talking with trusted people often involved working through the impact of social encounters in their workplace. The reflective nature of these strategies has some coherence with the concept of maintaining moral integrity through perceptions of enhanced moral agency in the care of patients. What was strongly evident in the Phase Two findings was that these strategies, rather than being linked to the concept of

moral integrity, were implemented as an act of self-preservation in being able to cope with the poor behaviour directed at the new graduate nurses by others in their work environments.

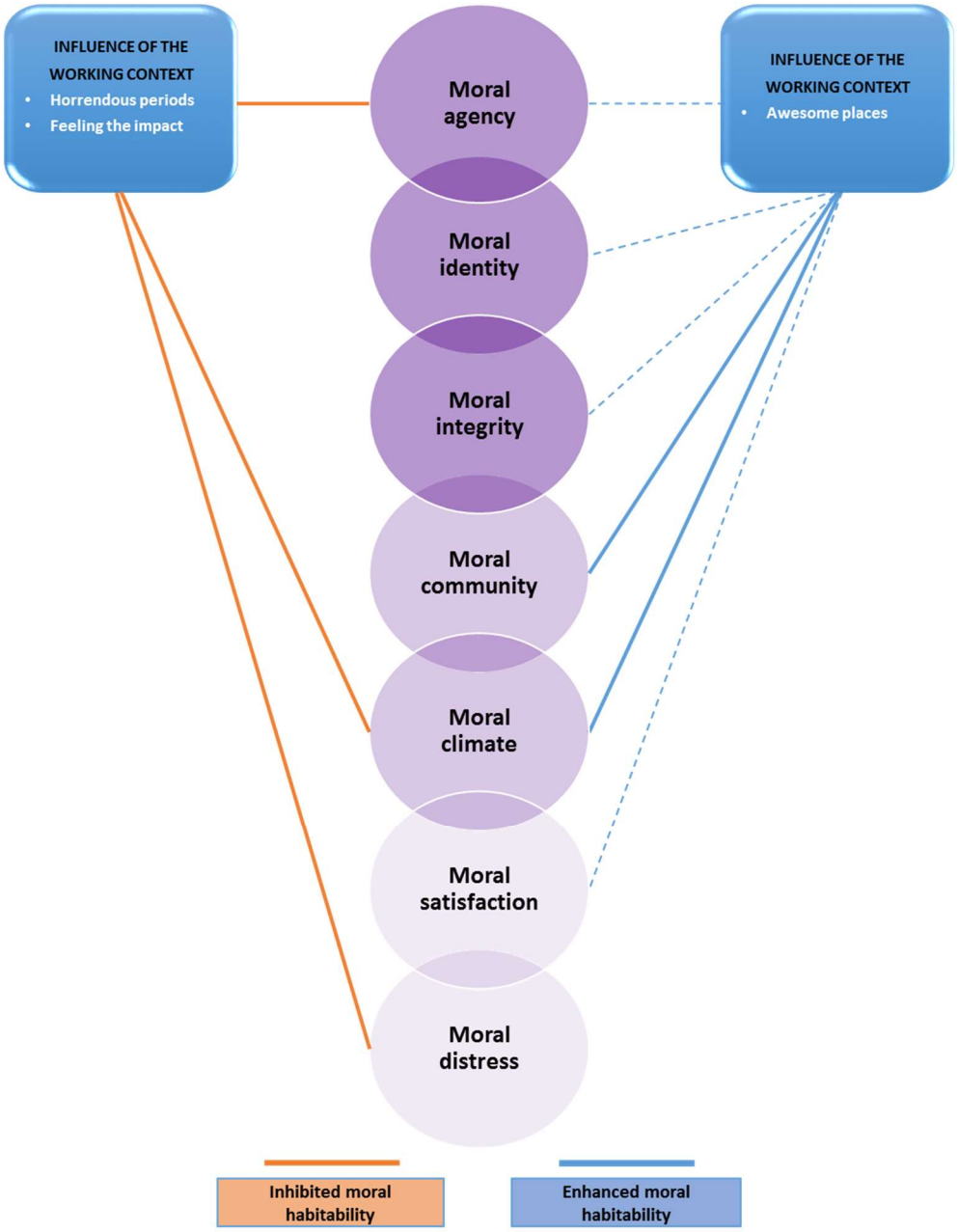
In summary, the synthesis of the Phase One findings and the theme 'Toughening Up' identified areas of coherence between the findings; and also highlighted other aspects of the new graduate nurses' experiences that did not resonate with the concepts identified in Phase One. The mechanisms employed by the new graduate nurses to 'avoid conflict' and remain authentic to their values and principles, provided an insight into the adaptive processes used to enhance their experience of moral habitability by enacting their moral agency and in maintaining their moral integrity. At times however, the focus of these strategies was instead on self-preservation related to socialisation within their new workplaces. The final synthesis of the outcomes of Phase One and Phase Two draws attention to both the synergies between the two phases and aspects of the new graduate nurses' experiences which contribute to an understanding of moral habitability that were not linked.

Moral Habitability and the Influence of the Working Context

As illustrated by the synthesis of the previous Phase Two themes with the conceptual findings of Phase One, the working environments of the study participants were not linear extremes. Rather, they represented a combination of influences that both enhanced and inhibited the experience of moral habitability which varied during their time working in the environment. However, the theme 'Influence of the Working Context' revealed patterns in the data that described two very distinct workplace environments, each of which had a considerable impact on the experiences of the new graduate nurses. The following synthesis

(Figure 18) details the dominant and less dominant associations between the Phase One concepts and the Phase Two findings.

Figure 18. Influence of the Working Context: Associations with Phase One Concepts



The final theme, 'Influence of the Working Context', captures the organisational and cultural influences which shaped the new graduate nurses' experiences and the consequences of these experiences. The sub-theme 'awesome places' was predominantly associated with the

concepts of moral climate and moral community. The links to the concepts of moral agency, moral identity, moral integrity and moral satisfaction are less dominant, as the associations were inferred rather than explicit in the data. The following section describes these associations with the sub-theme 'awesome places'.

The morally habitable environment - 'awesome places'

The sub-theme 'awesome places' represented the findings from Phase Two that described work environments where the new graduate nurses flourished. The key features were the internalised social impact of being appreciated and respected by their peers and patients rather than being directly related to their patient care experiences. Therefore, the associations between the concepts of moral climate and moral community with the sub-theme 'awesome places' are strong. The key finding was that workplaces which reflected a culture that valued staff, were inclusive, and which demonstrated respect for all within the environment, were valued highly by the new graduate nurses. This is consistent with the findings associated with the concept of moral climate, where organisational values are not always explicitly conveyed and can instead be revealed through implicit mechanisms such as interpersonal discourse (Rodney, Buckley, Street, Serrano & Martin, 2013). The findings of the sub-theme 'awesome places' also highlighted explicit examples of organisational values in the wall displays of staff appreciation located in the wards.

Workplaces with a moral climate that reflects values of respect and appreciation are also consistent with the Phase One findings related to the concept of moral community since the attitudes of the nursing staff and their interactions within the workplace resonate with this concept. The primary purpose of a moral community is to influence moral behaviour, and therefore moral agency, through enhanced interactions between the members of that

community (Schick-Makaroff et al., 2010). The inhibiting aspects to the moral agency of poor moral climates were dominant in the Phase One findings and the advantageous influence of a positive moral climate was not as evident. The Phase Two data related to the sub-theme 'awesome places' inferred a sense of enhanced moral agency through the new graduate nurses' experiences in these workplaces, and this was particularly apparent in data obtained during the observation periods.

The links between the concepts of moral agency, moral identity and moral integrity were discussed previously in this chapter. The findings of Phase Two identified that new graduate nurses reported moral agency when the best holistic care outcomes for their patients were achieved by acting on their strong sense of values and principles. In the findings related to the sub-theme 'awesome places', this inferred moral agency could also be linked to the maintenance of moral integrity. The concept of moral identity was also linked weakly by inference with this sub-theme by the data highlighting the powerful impact of being appreciated for their contributions in the workplace.

Finally, the concept map of Phase One linked the concepts of moral agency and moral integrity with quality patient care. The findings of Phase One also suggested that a moral climate that enhanced moral agency was associated with job satisfaction. This provides a tenuous link with the concept of moral satisfaction. The new graduate nurses consistently revealed in the sub-theme 'awesome places' the satisfaction they found in working in the environment. They also spoke of flourishing within environments that enhanced their practice. Conversely, the Phase Two subtheme 'horrendous periods' demonstrated the impact of a substantially adverse workplace.

The morally uninhabitable environment - 'horrendous periods'

Only a few of the nurses who participated in this study experienced a workplace that was perceived as 'awesome'. However, almost all of the new graduate nurses involved in the data collection for Phase Two experienced a workplace that inhibited their moral habitability. The sub-theme 'horrendous periods' captured the impact of their experiences. The association with the Phase One concept of moral distress was particularly compelling. The associations with the concepts of moral agency and moral climate also dominated.

The antithesis of the experiences detailed in the subtheme 'awesome places' was the experiences shared by the new graduate nurses of a workplace context where they perceived the implicit cultural values were exhibited by being under-resourced, focused on culpability and, at times, outright hostility by other staff. This reflected the Phase One findings of moral climates which inhibit practice through both organisational and inter-relational constraints. In these contexts, there was a strong association with inhibiting the new graduate nurses' moral agency through a task rather than person-centred orientation and the resultant outcome of exhaustion in trying to do what the nurses perceived as the right thing in an environment which did not value this. For example, the Phase Two findings highlighted the workplaces where there were no breaks from meeting a long list of patient care tasks rather than offering more comprehensive nursing care, coupled by a lack of nursing staff and where the necessary physical resources (for example wound dressing materials or functioning sphygmomanometers) were lacking.

While the relational impact of the staff in these workplaces was perceived as detrimental by the new graduate nurses, one aspect that was prevalent was that the study participants generally believed nurses in this environment were doing the best they could under the

circumstances. This implied that the new graduate nurses perceived that organisational constraints were pivotal rather than the individuals working within the environment. While both organisational and interpersonal aspects of a moral climate that inhibits moral agency were evident in the Phase One findings, the findings were contradicted by the overall findings of Phase Two that highlighted the significance of interactional influences. The impact of these workplace moral climates was considerable. This subtheme reflected the experiences of the new graduate nurses' inhibited moral agency, but what dominated was the impact this had. The Phase One concept of moral distress was strongly associated with the Phase Two findings of this theme.

In the process of reviewing the nursing literature related to nurses' moral experiences in Phase One, the concept of moral distress was a major finding and continues to dominate the field (Kennedy, 2017; Lamiani et al., 2017; Rodney, 2017). The findings of Phase One identified that the effects of moral distress could include emotional, psychological and physical symptoms. The experience of moral distress could occur through either perceived or real internal constraints of moral agency of the nurses experiencing these effects as well as external factors (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Varcoe, Pauly, Storch, et al., 2012). In the findings related to the subtheme 'horrendous periods', the new graduate nurses graphically described their experiences of working in environments with a poor moral climate and how this inhibited their moral agency. They also shared numerous stories regarding what they perceived to be very poor nursing care by other staff. They described the impact of these experiences as including high levels of stress and anxiety, hunger, sleeplessness, personality changes, loss of libido and some attributed a susceptibility to infections as being linked to their experiences.

The association with the concept of moral distress in previous themes described in this chapter fluctuated, depending on intermittent interactions with staff perceived as difficult by the new graduate nurses. However, what was highlighted in this theme was that the experiences of moral climates with perpetual resource issues, poor staff interaction and consistently poor patient care created an ongoing experience of moral distress.

In summary, the synthesis of the theme 'Influence of the Working Context' with the Phase One concepts provided further understanding of moral habitability in nursing by presenting a dichotomous view of how the nurse, the context and the impact of the context interact at the two extremes of the work experiences of the new graduate nurses. Workplaces that were viewed as 'awesome' exhibited strong elements of the concept of moral community particularly through the impact of a moral climate that enhanced moral agency.

In workplaces that were described as 'horrendous', an inhibited experience of moral habitability was evident and had a considerable impact. The psychological and physical outcomes for the new graduate nurses working in contexts that were under-resourced and focused on output rather than staff needs were considerable and displayed strong associations with the concept of moral distress. The final section of this chapter provides a summary of the key features identified in the synthesis of the two phases of this study as they relate to a further understanding of moral habitability in nursing.

Agent, Context and Outcomes of the Action - Revisited

The end-product of the synthesis of the findings is a rich interpretive description of moral habitability in nursing. Informed by the conceptual outcomes of Phase One, questions were developed to guide Phase Two by focusing on the qualities of the nurse (agent), the contextual features of the work environment where action takes place and the outcomes of

this action. Exploring the real world of practice exemplified by the situated experiences of the new graduate nurses provided a contextualised understanding of both the individual nurse qualities and the interactions of aspects in the workplace that influenced moral habitability in nursing.

As a result it is evident that moral habitability involves a multifaceted dynamic interplay between the individual qualities of the nurse and the workplace context. This complex interplay was particularly evident in the dialogical interactions between the new graduate nurses and other nursing staff. The outcomes of these interactions could produce different and at times diametrically opposed experiences of moral habitability. The key features of the synthesis are provided in the following summary.

Qualities of the new graduate nurse (moral agent)

Moral agency for the new graduate nurses was primarily understood through relationships with patients. Developing a rapport with patients was viewed as imperative to understanding their holistic needs, and this took time. Action was guided by a strong sense of personal values, underpinned by professional and moral principles and a vocational and service-oriented impetus to practice. Moral agency was demonstrated when they could spend time with their patients in developing a rapport that assisted in the ability to identify their holistic needs and act on this. Feeling satisfied with their work was dependent on this. The new graduate nurses demonstrated moral sensitivity through empathy and a strong sense of understanding of the vulnerability of patients. The data from Phase Two provided additional knowledge about new graduate nurses' moral sensitivity. Mainly because they were new, they could perceive aspects of patient care needs more clearly than their more

experienced colleagues. Internal aspects of individual nurses contributed to an enhanced understanding of their moral agency.

The links between moral agency, moral identity and moral integrity were highly evident in the synthesis. Not only relationships with patients, but also those with nursing staff were pivotal to the new graduates' understanding. The dynamic nature of moral habitability was evident in the fluctuating experiences of their moral identity and moral integrity. Qualities of the new graduate nurses that made development or maintenance of moral identity difficult were an internal conflict between meeting their ideals of holistic care, underpinned by a strong values-based approach and a belief that nursing care responsibilities are shared, while feeling constrained by contextual features. This resulted in a self-evaluation of inadequacy. Even when the feedback from those they cared for was glowing the internal critique dominated.

Another aspect of the synthesis that was dominant was how the associations with the concepts of Phase One and the thematic data of Phase Two often exhibited features of the new graduate nurses that both inhibited and enhanced their experience of moral habitability. Adaptive strategies employed by the new graduate nurses to sustain their experience of moral habitability included avoidance of certain staff and finding covert ways to manage systematic challenges. However, at times this inhibited moral habitability through a sense of values compromise. The new graduate nurses were highly reflective and coping strategies included a strong need to debrief. The ability to sustain their experience of moral habitability was evident in the outcomes. The interplay between the internal qualities of the new graduate nurses' experiences and the context of practice had strong links between the concepts of moral agency, moral identity, moral integrity and moral climate.

Features of the context where action takes place

The influence of moral climate was at the micro level, i.e. ward or unit, and was particularly evident in interactions with staff. The external influence of dialogical exchanges between the new graduate nurses and other nursing staff was very powerful. Moral habitability was enhanced by supportive, inclusive, and respectful nursing staff and was reflected in the overall workplace culture. Support needed to be proactive and, teams that shared responsibility enhanced the new graduate nurses' experience of moral habitability. Staff interactions that exhibited these qualities contributed to a sense of moral community and directly influenced the level of satisfaction of the new graduate nurses.

Moral habitability could also be inhibited by interactions with nursing staff. Exchanges with nursing staff that challenged their moral agency, moral identity and moral integrity occurred three ways. The first was through intermittent comments by nursing staff that could reduce confidence in their practice and resulted in a perception of incompetence that influenced their ability to follow through with optimal nursing care. Maintaining confidence and a perception of competency was dependent on intermittent interactions with nursing staff; this made moral identity development and maintenance tenuous.

The second was a broader sense of a culture, exhibited through communication with other nursing staff, which had a focus on task completion rather than holistic patient care. This had an impact on moral integrity, as reflected by the values conflicts exhibited by the data. There was constant tension of between compromising by bending to the needs of others or upholding their values. The final interactional influence was the non-verbal as well as verbal interactions with nursing staff. Being ignored, silenced, excluded and at times, treated with hostility, inhibited a sense of moral habitability.

The influence of nursing staff interactions on the experience of moral habitability dominated the synthesis. While the two extremes of workplaces were evident in the data, overall the concept of moral habitability fluctuated in their day-to-day experiences. The power of certain intermittent interactions with staff that could significantly reduce confidence produced a need to find adaptive or coping measures to sustain their experience of moral habitability.

Outcomes of the action

Moral satisfaction fluctuated within a day, hour or minute and related to the fulfilment of the role expectations of providing quality care when enhanced by contextual influences. This contrasted with the prevalent outcome of the experience of distress and moral distress. Harm was not always related to moral distress and at times the distress experienced was a direct ramification of being treated so badly. Overall, this experience of distress or moral distress fluctuated. However, the experience was consistent in workplaces described as 'horrendous'.

In summary, an interpretive description of moral habitability in nursing has been provided by synthesising the commonalities and contrasting examples with the conceptual outcomes of Phase One and the 'real world' experience of Phase Two. This synthesis has highlighted the dynamic and complex interplay of the internal aspects of the individual nurse and the external influences from the context. In the next chapter a discussion highlighting the key outcomes and implications of this study is presented.

CHAPTER 10 DISCUSSION

In the previous chapter an interpretive description of moral habitability in nursing was presented. This was achieved by the synthesis of findings from two key sources: the conceptual literature and the new graduate nurses' workplace experiences. In keeping with the objectives of the interpretive description methodology, this chapter provides a final layer of interpretation by presenting the "main messages" (Thorne, 2016, p. 218) as they pertain to application within the discipline of nursing.

Three key messages emerge from the findings of this study. First, a definition of moral habitability in nursing and morally uninhabitable environments has been developed. The second is that the linkages discovered between the concepts of Phase One and the field experiences of Phase Two emphasise the importance of considering both aspects when studying a complex moral phenomenon such as moral habitability. The third key message is that moral habitability in nursing is a dynamic concept that is particularly influenced by interrelational interactions.

The chapter begins with a discussion of these key messages and the implications for the discipline of nursing. This is followed by a discussion of the methodological implications of the use of interpretive description and a two-phase research design. The strengths and limitations of using this specific conceptual approach to explore an under-researched concept are also examined.

Defining Moral Habitability in Nursing

The findings of Phase One culminated in a working definition of morally habitable environments which was subsequently published in a joint paper focused on moral distress:

> *Morally habitable environments are a space where internal and external constraints to action by the nurse are minimised, difference is embraced and moral wellbeing is promoted through shared understandings of responsibility (Musto et al., 2015, p. 97).*

This definition captures the notion that constraints may be both internal to the nurse and from external sources. It also suggests that in a morally habitable environment, difference can be 'embraced', for example, where values of individual nurses may differ and yet successfully coexist with nurses working as a collective. In addition, morally habitable environments foster wellbeing for those who work there.

The definition above was derived from the conceptualisation of Phase One and subsequently published, as noted in Chapter 3. This conceptualisation considered the nursing literature and the nurse, the context and the outcomes of this interaction. What was not portrayed in this original definition, were the lived expectations and experiences of nurses.

In Phase Two, exploration of the real world of practice exemplified by the situated experiences of the new graduate nurses provided a contextualised understanding of both the expectations and experiences in the workplace that influenced moral habitability. When the new graduate nurses were asked to define moral habitability, they depicted their ideal workplaces from a morally habitable perspective. The new graduate nurses' definitions focused on a number of key aspects: the attitudes of and interactions with work colleagues; working consistently to a personal standard; and how these made them feel. They highlighted the importance of warm, respectful and open communication with staff. Upholding values in enacting their practice in congruence with the values supported by the workplace culture was linked with feelings of safety, satisfaction and, for some, flourishing

as nurses. Because the new graduate nurses were asked to define moral habitability while they participated in focus groups, these definitions generated collective views of what mattered to them. While the definitions were important in developing an overall understanding, they represented something of a static idealised view, and did not capture the dynamic nature of moral habitability that was revealed subsequently by the field component of the study.

The synthesis of the two phases provided a means to develop a definition of moral habitability in nursing that includes the findings from the literature, the expectations of the new graduate nurses, and their experiences in the field:

> *Moral habitability in nursing manifests in a dynamic interplay between the individual nurse, the context of their practice and the interactions with others in their practice setting. It is characterised by strong values congruence between the nurse and their environment, empathic care distinguished by being with patients, and a culture of engagement that is inclusive and respectful. In the nursing context, moral habitability builds confidence, enhances moral agency and assists nurses to flourish.*

In contrast, the following definition of morally uninhabitable nursing environments is offered:

> *A morally uninhabitable nursing environment is manifested through a dynamic interplay between the individual nurse, the context of their practice and the interactions with others in their practice setting. It is characterised by the need to compromise personal values in order to 'fit in', task-driven provision of care to patients and the exercise of power among co-workers to exclude and silence. In the*

nursing context, experiences of morally uninhabitable environments erode confidence, limit moral agency and contribute to moral distress.

These definitions capture the internal qualities of the nurse, the context of nursing practice and the outcomes of moral action, which were the key areas identified in the findings of Phase One and the Phase Two thematic analysis.

Links between Concepts

A key discovery of the research is the importance of linkages between the conceptual literature and real-world fieldwork. In Chapter Nine, different degrees of association were identified and described. In addition, it was identified that linking multiple concepts is useful in studying a complex phenomenon.

The links between the concepts in Phase One emphasised the importance of considering the different aspects of moral experience when describing moral habitability in nursing. While the research relevant to moral habitability was identified in the literature, the fieldwork undertaken in Phase Two confirmed the conceptualisation and linkages were applicable and important.

Consistent with the findings of Phase One, the importance of considering links between multiple concepts has been argued in the nursing literature. For example, Atabay, Cangarli, and Penbek (2015) discuss the importance of multiple concepts in considering moral distress and ethical climate. Lutzen et al. (2010) consider moral stress in relation to moral sensitivity and the influence of moral climate in the context of mental health nurses. Rushton et al. (2016) also promote a wider consideration of the multifaceted nature of the

conceptual links when they argue the importance of considering moral resilience in relation to moral distress.

The reader will recall that for moral habitability there were conceptual associations between the qualities of the nurse (moral agency, moral identity, moral integrity and moral sensitivity); context where the action takes place (moral climate and moral community); and, outcomes of the action (moral satisfaction and moral distress). Furthermore, the experiences of the participating nurses afforded accounts in relation to each of the above in relation to being a nurse, having working relationships, being an insider/outsider, toughening up and the influence of the working context. All these aspects of moral habitability were interlinked with the concepts. The complex interrelationship of the concepts exhibited by the new graduate nurses' experiences in the field illustrated that maintaining moral agency may at best be tenuous because of the dynamic nature of moral habitability. This has implications for the consistent provision of safe, quality patient care.

This study has produced original findings regarding these linkages. Not only were new findings realised in each of the phases of the study, but the synthesis supported the strengths and connections between the findings in the two phases. Most particularly, the fieldwork component revealed much complexity in the phenomenon of moral habitability in nursing. There is a need for further theorising and further fieldwork to identify interlinkages among the qualities of the nurse, the context where the action takes place and the outcomes of the action in relation to being a nurse, having working relationships, being and insider/outsider, toughening up and the potent influence of the working context.

Moreover, there is a need for research on the interactive nature of the qualities of the nurse, the context where action takes place and the outcomes of the action in combination

with the moral concepts. For example, studies linking moral agency, moral community and moral satisfaction could be devised, particularly with a focus on the wellbeing and retention of nurses.

To gain further understanding, research which considers the different conceptual links, the different levels of nursing experience and varied contexts will develop a further understanding of moral habitability. The concepts of moral satisfaction and moral community are under-developed and need consideration, particularly in relation to the effects on the provision of quality patient care.

Moral Habitability in Nursing is Dynamic

The synthesis of the conceptual phase and the field component highlight the dynamic nature of the experience of moral habitability during moments of nursing practice. Context and relationships are inseparable. The key aspects of moral habitability are the dynamic interplay of interactions within the workplace, the internal attributes and adaptive processes of the individual nurses, and the shifting states of moral habitability as a consequence of these interactions. Interactional aspects of the environment may shift moral habitability from being enhanced to being diminished in the space of a moment. For example, a supportive nursing co-worker may shift another nurse's experience of diminished habitability to enhanced moral habitability.

Interchange: Enhanced and inhibited moral agency

One of the keys to understanding moral habitability is that the dynamic nature of the interplay between agent and context would not have been revealed from the literature alone. The field component highlighted the fluctuating nature of the experience.

Much of the empirical and commentary literature reviewed for Phase One is influenced by a relational approach to ethics (Austin, 2008; Varcoe & Rodney, 2009). The approach taken in this study highlights the inseparable links between the environment and the individual, and how reciprocity between the two influences action; that is, each is affected by the other (Bergum, 2013). The findings of this study both conceptually and in the fieldwork support the existence of this interaction and specifically highlight the dynamic effects of its influence.

The fieldwork component highlighted that experiences of moral habitability and contrasting experiences of the morally uninhabitable, happened on an hour-to-hour and, at times, minute-to-minute basis. For example, the new graduate nurses' experience fluctuated between feeling supported and satisfied, and then unsupported, then attempting to normalise their experience. This occurred through internal critique and through dialogue with others in the workplace, and influenced their actions, specifically, their patient care. The complexity of context and moral agency is apparent in this interchange, and since it has implications for the efficiency of nursing care delivery, it is apparent that morally habitable experiences should be enhanced. The fieldwork identified two workplace extremes and highlighted the importance that context plays in moral habitability in nursing. There are implications for nursing research. Specifically, there needs to be further investigation and theorising about the factors that generate enhanced and inhibited moral agency.

The importance of context: Morally habitable and uninhabitable workplaces

The importance of context particularly in relation to moral climate is established in the literature (Humphries & Woods, 2016; Sauerland et al., 2014; Ulrich et al., 2007) as argued

in Chapter Three. This study has added findings in relation to the significance of context in moral climate, particularly based on the new graduate nurses' experiences.

Chapter Three highlighted that the concept of moral climate has three levels: micro, meso and macro. For example, at the macro level, socio-political influences such as a push for a market place ideology in addressing healthcare policy should be considered in relation to the effects on workplace moral climate (Rodney et al., 2013). Political influence of this kind can have a flow-on effect to organisational policy, such as heightened workloads caused by reduced staffing levels and is associated with a negative moral climate (Sauerland et al., 2014).

However, the data generated by Phase Two were mainly situated at the micro or the individuals within the ward/unit level. Even when the new graduate nurses worked in the same institutions, their experiences were very different, depending on the ward or unit's moral climate. Of particular concern in relation to moral climate were the variable experiences of the new graduate nurses. As described in the findings and synthesis chapters, experiencing workplaces as horrendous, even if just for a short period of time, requires further investigation and intervention.

The morally habitable workplace

Moral habitability is best demonstrated by positive workplace interactions with nursing staff. This was most evident in workplaces where interactions were consistently respectful, supportive, and welcoming and which promoted moral agency through being with patients. The characteristics of a moral community highlight the interdependence of respectful team relationships and communication (Pavlish et al., 2014). Shared values between colleagues and feeling empowered to have a voice also feature (Aroskar, 1995; Storch, 2007). This

study contributes to the dialogue around moral communities and also provides an understanding of the impact of these features. The descriptions of morally habitable workplaces particularly emphasised the nature of the individual within the interactions of the context and, when consistently positive moral agency was enhanced, confidence was heightened and the nurses flourished.

In particular, findings concerning the impact when nurses work in morally habitable workplaces are important outcomes of this study. Moral habitability was enhanced when the nurses experienced support and were able to exercise their philosophy and values associated with patient care. Consistent with being morally habitable, at these times working relationships were generally experienced as being supportive and the new graduate nurses experienced being 'insiders' in the team. Affirmation in the workplace led to strengthening of confidence and competence. When the nurses were confident and able to use their personal qualities associated with being a nurse in their workplace context and their actions were valued and supported, the outcomes led to enhanced satisfaction and moral agency. This has implications for the development of nursing leadership strategies that enhance confidence in nursing staff.

The morally uninhabitable workplace

The antithesis of the experience of moral habitability was the morally uninhabitable workplace. In the morally uninhabitable workplace, the influence of inadequate human and physical resources contributed to the harmful effects on the nurse, and as the new graduate nurses reported, on patient care. However, the experiences that diminished moral habitability were still predominantly about the working relationships between the new

graduates and more senior nursing colleagues. This was experienced by the new graduate nurses when they were being silenced, unsupported and excluded.

Moral habitability was inhibited when the new graduate nurses could not enact their moral agency and were forced to compromise their personal values with those espoused by others in the workplace. When environments were experienced as morally uninhabitable, the new graduate nurses had reduced capacity to express their internal qualities and to shape their actions with freedom, and the consequences were undesirable.

The synthesis of moral habitability in nursing revealed the dichotomous experience of workplace environments being sometimes morally habitable and at other times being uninhabitable. The dynamic and fluid relationships that exist between the two states of enhanced or inhibited moral habitability in nursing require further investigation and education to raise awareness of the implication of this experience.

Expressions of distress

In the fieldwork, senior nurses were revealed as being complicit in contributing to the distress of the new graduate nurses. In this study, the highly detrimental outcomes of working relationships that were damaging were emphasised. Highlighting the importance of context was particularly useful as it confirmed the link between the context of practice and the moral distress literature (Atabay et al., 2015; Corley et al., 2005).

The concept of moral distress has dominated the nursing ethics literature empirically, theoretically and in commentary (Corley et al., 2005; Jameton, 2013; Lutzen & Ewalds-Kvist, 2013; Rodney, 2017) and continues to be a dominant topic (Blazun Vosner, Zeleznik, Kokol, Vosner, & Zavrsnik, 2016) with a range of definitions (McCarthy & Gastmans, 2015). The

synthesised findings of this study highlight that distress and moral distress are features of nurses' experiences of moral habitability but also emphasise that the nature of the experience fluctuates.

Fluctuating moral distress

In the present study, distress experienced by the new graduate nurses fluctuated on an hour to hour, minute-to-minute basis. At times this distress was evident when trying to cope with the poor behaviour directed at them by other nursing staff. Moral distress was experienced when the impact of this poor behaviour was felt to have an outcome directly associated with patient welfare. In the numerous definitions of moral distress, this is a key feature (Dudzinski, 2016).

The dynamic nature of the nurses' experiences of distress was seen in the tension created by values compromise, by their internal critique of their own perceived inadequacy and in the need to balance the external constraints of the expectations of others. This observation adds to the moral distress literature, since the dynamic nature of the concept of moral distress, although evident in the literature, is underplayed (Butters, 2008; Woods, 1997).

In recent work, the fluctuating nature of moral distress is gaining further interest (Rathert et al., 2016). In a study conducted in New Zealand, the variability of moral distress on a daily basis is evident (Woods et al., 2015). By viewing moral distress through the lens of moral habitability it may be possible to gain a further understanding of its fluctuating nature and the implications for those nurses who experience moral distress. Furthermore, there are implications for nursing leaders and educators to develop strategies and interventions to address moral distress on a daily basis.

Focus on moral habitability and moral distress

The nursing ethics literature is dominated by a focus on the adverse outcomes for nurses, particularly in the area of moral distress (Ando, 2016; Austin, 2012; Hamric, 2012). Rushton et al. (2016) propose a positive connotation of moral distress suggesting it offers an opportunity to build resilience in nurses. The present study afforded a new opportunity to view moral distress through its inclusion in the wider conceptualisation of moral habitability. Future investigations that focus on moral habitability and its relationship to moral distress may provide additional insights.

The findings of the present study are consistent with those in the field of moral distress research in that specific issues such as constraints in providing adequate pain relief and issues related to death and dying are evident (Sauerland et al., 2014). Furthermore, the findings on moral habitability lend support to the recommendations for interventions to address moral distress generated by Musto et al. (2015).

However, the key features contributing to moral distress in the present study are not related to moral conflict, but rather task-orientated cultures and poor staff interactions. Based on a survey of registered nurses in New Zealand, Woods et al. (2015) identified that concerns about inadequate nursing care due to management pressures related to efficiency could contribute to moral distress, and that young nurses were more likely to suffer moral distress than more experienced nurses. The present study provides further insight to how new graduate nurses (many of whom are young) experience moral distress.

The experiences of moral distress of the nurses in the present study were the result of the complex and dynamic interplay between internal and external constraints. Given the findings of this study regarding the connected concepts of moral distress and moral climate,

there is a need for further investigation of how these concepts influence moral habitability in nursing. Based on the outcomes of this study, a key to the enhancement of moral habitability is improved interactions with other nursing staff. This has implications for both leadership and educational strategies in organisations relating to enhancing communication. The relationship of moral habitability in nursing as a dynamic entity to moral distress needs further dialogue and investigation.

The 'power' of inter-relationships

The dynamic nature of moral habitability in nursing was influenced by power in the workplace. The term 'power' in this thesis is used in two ways; first, to illustrate that the new graduate nurses were 'powerfully' affected by relationships with patients and staff and second, in relation to the perceptions of the new graduate nurses regarding the power exhibited by some nurses.

The synthesis demonstrated that the individual characteristics of the nurses included being motivated by compassionate awareness and sensitivity to patients' holistic needs. These personal values created a focus on actions that were in the best interests of patients. Being a nurse and working in relationship with patients were important aspects which were influenced by the dynamic nature of moral habitability. The findings reveal that when the workplace supports the values identified as part of being a nurse, nurses' confidence and competence are positively and powerfully impacted. The converse is also evident.

There was a strong imperative to being a moral agent evident in all of the data sets and there were challenges in maintaining moral integrity when the nurses were pushed to prioritise care in ways that were not congruent with their personal value sets. The intentions of the nurses were complicated by people pressures and organisational tensions.

These tensions were particularly evident in the pressure to prioritise the execution of technical nursing skills over the recognition of the importance and purpose of connecting meaningfully with patients at a time of what was often significant vulnerability. Conflicts of this nature eroded nurses' confidence and freedom to be moral agents. There is a need for further investigation of how nurses' moral agency is affected by relationships with patients and is complicated by the need for technical execution of skills.

As previously reported, when working relationships were mutually respectful, the participating nurses experienced heightened confidence, which empowered their moral agency. However, in the same environments when other nurses disregarded them in a moment of practice, this resulted in disempowerment. Some nurses were described as having 'big personalities' and their interactions had the capacity to erode the new graduate nurses' sense of moral habitability. These interactions lowered the self-confidence of the new graduate nurses and their subsequent perception of their competence. The support of staff, particularly new staff, is therefore imperative to ensure empowered care. Moral agency was also diminished by external, contextual and social pressures, and by negative interactions with others in moments of practice. The dynamic state of moral habitability in nursing was influenced by the power of these two forms of inter-relationships.

The dynamic nature of moral habitability in nursing has not previously been reported. In this discussion, the factors which enhance or inhibit moral agency have been identified. The importance of context and the influence of factors that make workplaces morally habitable or uninhabitable have been acknowledged. Relationships between moral habitability and moral distress have been recognised. Further, the influence of interrelationships on moral

habitability was detected. Together these aspects shape the dynamism of moral habitability and they involve characteristics of the individuals in interplay with the context.

There are clear implications for ongoing theory development and research. It is important that moral habitability in nursing be investigated in other contexts and temporalities, as this may result in quite different findings. It is important that the dynamics of moral habitability are properly investigated. This will include how the dynamics are affected by the conceptual linkages as well as how the elements of being a nurse, exercising moral agency and working in context affect the capacity of nurses to create and sustain morally habitable workplaces.

Methodological and Design Limitations and Implications

The choice of interpretive description as a methodological approach provided an overall framework that could accommodate the two-phase conceptual approach for this study. This design model has proved to be practical and can be used for similar forms of inquiry regarding under-developed and related concepts.

The major strengths in using interpretive description for this study were threefold. First, this methodology emphasises the generation of data directly relevant to nursing practice (Thorne et al., 2016). This two-phase study about moral habitability in nursing required the need for engagement with and analysis of data from both the literature and practice. The design was consistent with the methodological approach. Second, interpretive description does not require unquestioning adherence to methods (Thorne, 2016). This flexibility in methodology supported different forms of data collection in this study. Third, interpretive description provided an inherent logical structure for rigour which paid attention to disciplinary biases and obligations (Thorne, 2016). Like all qualitative research, interpretive

description provides interpretations that are situated experiences specific to a particular cohort and a particular researcher's co-constructions (Thorne, 2016).

There are a number of strengths and limitations in the conceptual approach taken by this study. By using a two-phase approach it was possible to view the interplay of the related moral concepts identified in Phase One. For example, rather than simply exploring moral climate and moral distress, a wider exploration of all eight of the related moral concepts created a unique lens for the development of an understanding of moral habitability in nursing. The study of moral habitability in one type of workplace (acute care hospitals in two different settings) with one group of nurses (first year new graduate nurses n=44) over a 12-month period, using multiple qualitative methods for data collection and analysis, has resulted in major insights. The synthesis of and relationships between the concepts and thematic findings resulted in an interpretive description of moral habitability in nursing. While this outcome was beneficial for the study, the strengths and limitations of using the two-phase conceptual approach of this study are considered in the following discussion.

Because moral habitability in nursing has been under-researched to date and is central to the nursing discipline, a creative approach to the research was required. New understandings of moral habitability in nursing as a concept were generated in Phase One of the study. Linkages between the moral concepts of moral agency, moral identity, moral integrity, moral sensitivity, moral climate, moral community, moral satisfaction and moral distress, were able to be articulated. The findings of Phase One demonstrated that the literature related to moral habitability in nursing has focused on the qualities of the agent (nurse), the context where the action takes place and the outcomes of the action.

The nursing literature that was examined had an over-emphasis on the adverse aspects of moral habitability. Some focal areas dominated in quantity and in empiricism, which was evident, for example, with the concept of moral distress, while other areas of the literature, such as moral sensitivity, were under-developed.

The process employed in Phase One linked concepts which are relevant to an understanding of moral habitability. However, the crescendo of research and nursing ethics literature production changes over time (Blazun Vosner et al., 2016) and therefore the focal areas of interest also change. As a result, it is possible that some aspects of importance to an understanding of the concept of moral habitability in nursing may have been either missed or over-emphasised. This poses the question of whether another approach like, for example, a Delphi study, would have been better than an integrative literature review in developing an initial understanding of the concept under scrutiny. Different approaches provide different knowledge (Liamputtong, 2013). This limitation could be addressed in further research by using different conceptual approaches to gain a deeper understanding of the phenomenon. For example, the use of a focus group of expert nurses to discuss what the concept of moral habitability in nursing entails, may produce a different conceptualisation than that developed for this study.

Similarly, if this study had used the work of Margaret Urban Walker (Walker, 1998, 2003) as a theoretical base or framework to guide the construction of moral habitability in nursing, it is likely that different interpretations and results would have been achieved. As it was important to establish a baseline of moral habitability in nursing inductively, it is argued that the research design as undertaken was the appropriate approach. The significance of the findings of this study affirm the decision not to use Walker's influence and to use

interpretive description as a methodology. Future studies may consider the merits of using the Margaret Urban Walker theoretical lens.

The results of the conceptualisation in Phase One were used iteratively to influence the choice of methods used in Phase Two of the study. The field component of the study produced a rich data-set by utilising multiple strategies, with multiple groups of new graduate nurses over a 12-month period. Of particular relevance was the interaction with eight participants, who were engaged with each strategy over the entire period of data collection. This allowed different perspectives and depths of experience over different timeframes to be uncovered.

Some of the concepts identified in Phase One were strongly linked to the experiences of the new graduate nurses which were presented in strong narratives or commonly repeated exemplars. However, other concepts were not as clearly demonstrated and this represented limitations for the second phase of the study.

The second phase of the study, the field component, was limited by the state of nursing ethics literature at the time of conducting Phase One, the group chosen to conduct Phase Two, and what it was possible to achieve within the specific timeframe of a doctoral study. The integrative literature review in Phase One revealed gaps in the literature. As the outcome of Phase One influenced the field component of the study, there was the potential to miss important aspects of the new graduate experiences of moral habitability. By choosing one particular subset of nurses to address a wider conceptualisation of moral habitability in nursing, there was potential that some of the findings would only be representative of this group. While eight participants were involved in all data collection over the 12-month period, the other participants did not continue, and it is possible that the

choice of a subset of nurses in a transitional phase with the pressures associated with a new role may have limited participation. This could be addressed in further studies by involving different subsets of nurses and contexts.

Finally, the findings for the new graduate nurses practice domain were in a specific temporal period and a specific context, and provided one angular view of the experience of moral habitability in nursing. The participants' experiences of the moral dimensions of their practice were specific to a time of transition into the nursing profession. The findings are original in relation to moral habitability in nursing. However, they are limited in time and space to one cohort of new graduate nurses working in two acute care hospitals in Victoria, Australia. The new and original results from this study are as yet untested in terms of their transferability to other study contexts.

To conclude, this study has generated an interpretive description of moral habitability in nursing. Recommendations for research, practice, education and policy follow in the next chapter, the conclusion of the thesis.

CHAPTER 11 CONCLUSION

The aim of this study was to provide an interpretive description of moral habitability in nursing. This was achieved using a two-phase design with the atheoretical methodology which interpretive description offers.

In keeping with the aim of this study, in Phase One concepts that related to moral habitability in nursing were identified in the contemporary nursing ethics literature through consideration of the nurse and the social world of practice. Using concept mapping strategies, key concepts were identified. The concepts moral agent, moral identity, moral integrity and moral sensitivity related to the qualities of the nurse. The concepts moral climate and moral community related to the context of practice where the moral action of nursing occurs. The concepts of moral satisfaction and moral distress were outcomes of this action. This phase of the study resulted in a published integrative literature review.

The concepts were then utilised in Phase Two as a framework to explore moral habitability in a real-world context with new graduate nurses, using focus groups, observations and interviews. The results of Phase Two were five key themes: being a nurse; working relationships; being an insider/outsider; toughening up; and, the influence of the working context.

Prior to this study, the concept of moral habitability had been under-developed and untested in the field. Through the synthesis of the findings of the two-phase approach used in this study, the connections between the concepts and the new graduate nurses' experiences were found to be strong and an interpretive description of moral habitability in nursing was produced. Definitions of moral habitability and morally uninhabitable

environments were developed from the key components of the synthesis. This encapsulated a description of moral habitability in nursing based on the consideration of the qualities of the nurse found in three of the themes previously identified, being a nurse, being an insider/outsider and toughening up. The resultant definition also captured the context where action takes place through the concepts moral climate and moral community and, the outcomes of this action through the concepts of moral satisfaction and moral distress.

Using the conceptual approach of this study provided a means to elicit understanding of the complexity of the phenomenon. Moral habitability in nursing was found to be a dynamic entity which shifted constantly through experiences within the workplace. Inter-relationships and interactions with patients and nursing staff coupled with the internal critique of the new graduate nurses, enhanced or inhibited moral agency and moral satisfaction. The context of practice was pivotal to the experience of moral habitability. In workplaces with moral climates that exhibited a sense of community, the interdependence of the nursing team enhanced moral habitability. However, moral habitability was inhibited when the nurses were treated as outsiders in their workplace. The new graduate nurses tried to maintain their values by utilising adaptive and coping mechanisms. When this was ineffective, moral distress occurred. The associations with the concept of moral distress were found to fluctuate depending on interactions with other nursing staff and whether the new graduate nurses had to compromise their understanding of being a nurse.

Being new to the profession is not a prerequisite for the experience of moral habitability in nursing. Therefore the results of this study, while limited to new graduate nurses, have implications for the wider nursing profession.

Recommendations from this Study

Multiple recommendations for research, practice, education and policy arise from the study findings.

Research

The outcomes of this study and the design approach taken give rise to several recommendations for future work related to moral habitability in nursing and, more generally, for other research into under-developed concepts.

- New graduate nurses were chosen as a particularly salient subset of nurses to explore moral habitability in nursing. Other subsets of nurses and other nursing contexts should be studied to develop the concept further.
    - Because the context of this study was acute hospitals and the participants were drawn from multiple units and clinical environments in the hospitals, this study had no capacity to distinguish moral habitability in nursing by particular clinical contexts. Therefore, there is a need for studies in moral habitability in nursing in different contexts, in order to determine if there are particular features associated with specific contexts, for example, mental health and critical care environments.
    - Different cohorts of participants, such as more experienced nurses, managers and educators, could provide another lens on the concept of moral habitability. This could be extended to other health professions within the workplace to provide further understanding.

- The research design afforded a specific lens on the experience that may not have been possible if another approach had been utilised.
    - The use of a different design or methodological approach may further the concept of moral habitability in nursing. For example, a Delphi study seeking what moral habitability means to nurses, or a grounded theory approach, may confirm, strengthen or challenge the understandings derived from this study.
    - Using a theoretical (e.g. Margaret Urban Walker) rather than an atheoretical framework as a basis for the investigation of moral habitability in nursing would not only provide a different lens but is likely to yield different results from those gained from this study.
- The definitions of moral habitability developed in this study and the dynamic nature of the concept are key findings.
    - Studies with different designs may show variations to both the definitions and the dynamic nature of the concept. Alternatively, these features may be reinforced.
- The links between the concepts of Phase One and the findings of Phase Two revealed the complexity of the concept of moral habitability in nursing. Further exploration of the concepts associated with the qualities of the nurse, the context where action takes place and the outcomes of the action may provide additional understanding.

    - For example, a study focused on the qualities of the nurse would include moral agency, moral identity, moral integrity and moral sensitivity.
    - The development of a tool using the concepts associated with moral habitability in nursing could be used to assess workplace environments.

- The conceptual exploration and field component identified both well-defined and empirically-supported concepts as well as under-developed concepts.
    - For example, the concept of moral satisfaction was undetermined in the nursing literature. This concept may be an important feature and relate to the satisfaction and possible retention of nurses. Further research to develop this concept as a clear entity in the nursing literature is needed.
    - The concept of moral distress dominates the contemporary empirical nursing literature. Studying moral distress through a lens of moral habitability may provide further insight into this complicated phenomenon.
- In this study the concepts identified in Phase One had direct resonance with the experiences of the new graduate nurses in Phase Two. This may be useful in other studies.
    - The two-phase research design utilised in this study provides a potential template for future research related to emergent concepts.
- In addition, the associations between the theoretical concepts and experiences of the new graduate nurses provide a platform for workforce research on the moral component of everyday practice.

- For example, the moral aspects of new graduate nurse practice is under-researched despite being of crucial importance. The understanding of new graduate nurse moral agency is as yet under-developed and should be explored.

Practice

Sustaining and promoting moral habitability in the workplace is important for all nurses. The study of the concept of moral habitability in nursing raises awareness of the moral nature of the everyday practice of nurses. Recommendations for practice derived from the new knowledge generated from the conceptual and field components of this study follow:

- The direct implications of this study include the need to heighten awareness of the definitions, conceptual linkages and the dynamic nature of moral habitability in nursing. This could be used to strengthen clinical practice and encourage active interventions in morally habitable environments achieved by:
    - Promoting understanding of the definitions of moral habitability and morally uninhabitable environments and the links between the moral concepts, particularly the implications for the nursing workplace.
    - Sensitisation to and the development of knowledge of the impact of moral habitability in nursing staff with leadership positions, and the development of interventions to promote morally habitable environments. Particular emphasis could be placed on the dynamic nature of moral habitability to promote role modelling behaviour that enhances the workplace environment.

- Furthermore, nurse leaders should encourage open dialogue and recognition of the implications of focusing on a task-oriented approach to patient care in the workplace at a ward/unit level.
    - Managers and nurse leaders should actively promote therapeutic communication and relationships with patients by highlighting their importance.
    - During performance appraisals, nursing staff who focus on all aspects of care, not solely tasks, should be recognised and rewarded.
    - The strong affinity for promoting communication and patient relationships should be strengthened through feedback from nurse leaders and followed by additional support.
- Creating morally habitable environments requires a responsiveness to the importance of the moral component of everyday practice. This can be achieved by:
    - Prioritising and making overt the need for conversations about what enhances and constrains nurses' moral agency.
    - Providing reflective support within the ward/unit through dedicated and trained 'moral support' nursing staff and the provision of workplace spaces which are safe for interactions to take place.
- The strong influence of intermittent interactions with nurses and the subsequent impact on the moral agency of the new graduate nurses was evident in this study.

- Managing and addressing nursing staff whose interactions with other nurses cause harm and reduce confidence is imperative.
- Nursing staff who proactively support other nurses should be rewarded.

Education

This study has highlighted the dynamic nature of the concepts associated with moral habitability. Ongoing education is important for all nurses and raising awareness of the concepts associated with moral habitability and moral practice can be achieved by:

- Providing education for both undergraduate and graduate nurses regarding the power of interrelationships and the potential effects on their moral agency and patient care.
- Moral identity and moral integrity were adversely linked with a mismatch of expectations in this study.
    - Workshops that explore the enhancing and inhibiting influences of the contemporary socio-political contextual influences that influence nursing practice are needed in order to maintain a realistic view of what it is possible to achieve.
- As personal and professional values are central to the experience of moral habitability in nursing, workshops on both the internal exploration of personal and professional values and values clarification exercises in the workplace are needed.
- There is also a need for education of nursing staff regarding the impact of feedback in relation to the moral agency of nurses.

Policy

Finally, the findings of this study have implications for workforce policy in relation to the underplayed moral aspect of everyday practice. By raising awareness of morally habitable and uninhabitable workplace environments, strategies to address both the individual within the workplace and the collective should be addressed by:

- Creating policy that overtly recognises the importance of raising awareness of moral aspects of practice and,
- Developing and, most importantly, *implementing* policy that addresses bullying.

In conclusion, this study is the first to directly study moral habitability in nursing and two peer reviewed papers for publication contribute to the moral dimensions of nursing practice. This thesis provided an interpretive description of moral habitability in nursing and, based on the findings of the study, the importance of morally habitable workplaces cannot be overstated. The generosity of the nurses and their workplaces in sharing realities of everyday experiences enabled significant new insights. Overall, the findings of this research challenge theorists, researchers, clinicians and policy makers to find ways to strengthen and advance knowledge and practice to create greater moral habitability in nursing.

The final words are from a participant in this study:

> *I hope as a result of your PhD, nurses will think about how they work together so we can make our workplaces morally habitable.*

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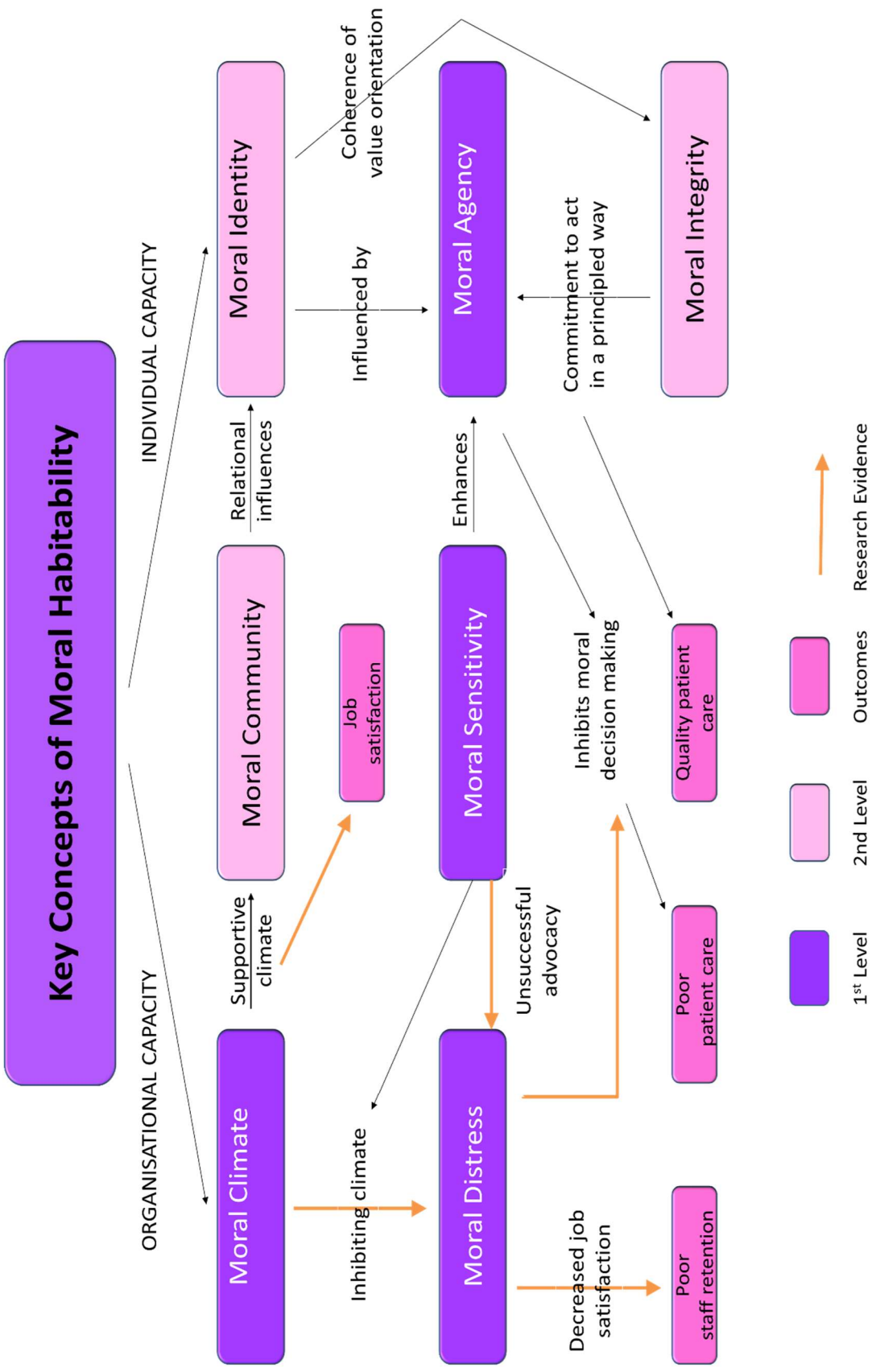
APPENDICES

Appendix 1 - Concept Map



Appendix 2 - Publication

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Toward interventions to address moral distress: Navigating structure and agency

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Abstract

Background: The concept of moral distress has been the subject of nursing research for the past 30 years. Recently, there has been a call to move from developing an understanding of the concept to developing interventions to help ameliorate the experience. At the same time, the use of the term moral distress has been critiqued for a lack of clarity about the concepts that underpin the experience.

Discussion: Some researchers suggest that a closer examination of how socio-political structures influence healthcare delivery will move moral distress from being seen as located in the individual to an experience that is also located in broader healthcare structures. Informed by new thinking in relational ethics, we draw on research findings from neuroscience and attachment literature to examine the reciprocal relationship between structures and agents and frame the experience of moral distress.

Conclusion: We posit moral distress as a form of relational trauma and subsequently point to the need to better understand how nurses as moral agents are influenced by—and influence—the complex socio-political structures they inhabit. In so doing, we identify this reciprocity as a framework for interventions.

Keywords

Interventions, moral distress, moral habitability, relational trauma, structure and agency

Introduction

On a daily basis, nurses and other healthcare providers are faced with decisions that have moral implications. Moral decision making requires that healthcare providers grapple with a myriad of tensions when attempting to address questions about what is in the patient's, family's, and community's best interests. This takes place in the context of complex and sometimes conflicting personal, professional, and organizational values. Increasingly reductionist demands for a cost-effective and efficient healthcare system have resulted in an exacerbation of conflicting professional and corporate values that make it progressively more difficult

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for healthcare providers to balance such tensions.[1–5] One result of being unable to successfully negotiate these intersecting values has been identified as *moral distress*, a term first introduced as a concept in the nursing literature by philosopher Andrew Jameton in 1984. Jameton's initial conceptualization of moral distress pointed to a disjuncture between moral choice and moral action as a consequence of external constraints with the moral agent experiencing anger, frustration, guilt, and powerlessness as a result. Since Jameton's initial work, researchers have sought to further explicate the concept.[6–10] Moral distress is now recognized as a phenomenon that affects nurses and other healthcare providers in diverse arenas of practice, and as a phenomenon that reflects providers' difficulties enacting their moral agency (fulfilling their moral responsibility) for a diverse range of reasons.[11,12] Such reasons include conflict with other healthcare providers, excessive workloads, and challenges with end-of-life care decision making.[7,9,13–15]

As our empirical and theoretical understanding of moral distress has grown in nursing and other healthcare professions, we have come to realize that the experience can have a significant impact not only on individual healthcare providers but also on patients, families, communities, and the wider healthcare system.[5,13] It is important to note that while the concept of moral distress originated in nursing, "more recent research has also shown that this distress is shared by physicians and other members of the healthcare team in various arenas of practice."[3,7,12,16–19] It has been suggested that the potential impact of moral distress on healthcare providers includes *moral disengagement*[20] with subsequent erosions in the quality of healthcare team relationships as well as erosions in the quality and safety of patient and family care.[12] Furthermore, there has been empirical data indicating that the potential impact of moral distress on healthcare providers includes *moral residue*, which reflects a progressive and accelerating impact of cumulative incidents of moral distress.[7,21] In light of these concerns, there is a growing attention to the physiological and psychological effects of moral distress,[13] including attrition from the practice area or profession.[13,18,22]

Given our increasing empirical and theoretical understanding of moral distress, there has been a call to develop interventions for healthcare providers who experience moral distress both to ameliorate and, where possible, preempt the experience.[7,13,23–26] Indeed, such is the current interest in moral distress that there have been three recent full ethical journal issues devoted to the topic—the *HEC Forum* (2012, Vol. 24, issue 1), the *Journal of Bioethical Inquiry* (2013, Vol. 10, issue 2), and this issue of *Nursing Ethics*.

Notwithstanding the empirical and conceptual progress we have noted above, recent critiques have revealed that our understanding of moral distress both continues to evolve yet simultaneously lacks conceptual clarity. This paradoxical progress has hindered our attempts to effectively measure moral distress as a clear construct, and it has hindered the development of effective interventions to prevent and ameliorate moral distress.[7,24,27] Some gaps in our understanding include an overemphasis on the psychological distress that results from an ethically challenging situation without an equal focus on the moral dimensions of the experience.[27] There is also an over emphasis on the negative aspects of moral distress while ignoring nurses' possible complicity in situations that lead to moral distress,[4] and also ignoring the potential learning that may result from the experience of moral distress.[21,27,28] Furthermore, the concept of moral distress has been critiqued for having an overly individualistic focus and for not addressing the larger socio-political power dynamics (such as healthcare cost constraints) that contribute to moral distress.[5,24] To date, there have been few intervention studies conducted to address the experience of moral distress,[7,13] and most that do exist have been conducted with small sample sizes, with specific population groups (largely adult or pediatric acute care), and report inconclusive or mixed results. An intervention study by Beumer[29] that used a small sample size reported a good effect at diminishing participants' experience of moral distress. Another study reported that although participants expressed appreciation for the intervention, there was no measurable change in their experience of moral distress.[30] Given such challenges, one leader in nursing ethics has recently claimed that "[u]ntil further inquiries are made, the assumed credibility of 'moral distress' as a bona fide problem in nursing will remain dubious."[31] Rather than dubious, we see the concept as under-

developed yet still highly salient. In this article, we therefore join colleagues who are working to clarify conceptual approaches to moral distress, thereby providing a cohesive view from which to plan, implement, and evaluate interventions to address moral distress.[5,7,24]

Understanding the reciprocity of structure and agency

A significant feature of the critiques we have noted above is a persistent lack of clarity regarding the interplay between social structures and providers' enactment of their moral agency.[5,12,32] *In this article, it is therefore our premise that a promising way forward is to better understand how nurses as moral agents are influenced by—and influence—the complex socio-political structures they inhabit.* Our premise is informed by the writing of William Sewell,[33] a sociologist who argued that

> Structures . . . are constituted by mutually sustaining cultural schemas and sets of resources that empower and constrain social action and tend to be reproduced by that action . . . But the same resourceful agency that sustains the reproduction of structures also makes possible their transformation . . .

What we take this to mean is that while nurses are moral agents who are expected to enact their professional ethical mandates, they are too often constrained by complex socio-political healthcare contexts. These contexts include, for example, fiscally driven corporate agendas that decrease registered nurse staffing and increase workloads, and the dominance of a biomedical model that emphasizes cure over health promotion, equitable access, caring, and palliation.[1–3,12,24,34–40] Moving toward a practical understanding of how reciprocity between structures and agents works may be a starting place for developing effective intervention in moral distress. We have found that the area of neuroscience may help us to explain how external structures, such as institutional culture and professional codes of ethics, influence and shape the internal brain and body responses that prompt agency. In what follows, we will be drawing on research in neuroscience to suggest that the experience of moral distress is a result of *relational trauma*.[41] While our focus in this article is on nurses, we acknowledge that *all* healthcare providers are affected by such contexts.

A recent landmark report from the United Kingdom provides a chilling warning here, serving as a powerful example of how structures and agents can influence each other in a negative way. In 2013, the United Kingdom reported on the latest in a series of public inquiries revealing serious breaches of duty on the part of the *Mid Staffordshire National Health Service (NHS) Foundation Trust*.[42] The failures cited included an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern; standards and methods of measuring compliance which did not focus on the effect of a service on patients; too great a degree of tolerance of poor standards and of risk to patients; a failure of communications and monitoring between the many agencies to share their knowledge of concerns; a failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession; and a failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganization.[42]

The UK *Mid Staffordshire NHS Foundation Trust* Report (the UK Report) serves as a warning to nurses and other healthcare providers around the globe that they may seriously fail in the fulfillment of their moral obligations if they are overly constrained by socio-political healthcare contexts driven by fiscal or other non-health-related values.

The reciprocity is such that nurses can also be complicit in reinforcing the structures that constrain their own practices.[4,13] For example, they may criticize or bully their junior colleagues,[12,43] thereby worsening nursing team cohesion and effectiveness. Furthermore, nurses may fail to support healthcare leaders[1] who may themselves be experiencing moral distress because such leaders are caught "in between" the mandates of administration and the concerns of point of care healthcare providers.[44,45] What this means is that we

ought to understand nurses' complicity in sometimes contributing to organizational conditions that worsen their own moral distress. Yet, we also ought not to demonize them, but work toward a balanced critique of the reciprocity between the structures nurses work in and their own ability to enact their agency. For example, as one nurse expert in the United Kingdom, Hayter,[46] notes in his commentary on the UK Report, "often, deficiencies in care are not because nurses 'lack compassion' or lack the necessary skills – it is because they are over-stretched and struggle to provide the rudiments of care to inappropriately large groups of patients."

Addressing the reciprocity between the structures that nurses work in and the enactment of their moral agency can help us to better support nurses as moral agents and the structures within which they practice so that they can deliver safe, compassionate, competent, and ethical care.[47] To do so requires that we have a fuller appreciation of both nurses' agency and the socio-political structures they work in. In what follows, we will unpack some of what scholars in nursing and other fields are continuing to learn about the complexity of that agency and structure. We will take up Sewell's promise of reciprocity to subsequently point toward types of interventions that could not only support nurses as moral agents but also improve the moral climates of their workplaces so that the safety and quality of care they provide to individuals, families, and communities is promoted. The UK *Mid Staffordshire NHS Foundation Trust* Report indicates that such interventions are badly needed in many areas of healthcare delivery in the United Kingdom and beyond.[ii]

Agency as embodied

We require a deeper understanding of moral agents as embodied individuals, not just moral actors.[41] In attempting to gain a greater depth of understanding of the experience of moral distress, we must recognize that it begins as a *felt* experience in the body. Foundational to the history of the development of the concept of moral distress is Jameton's[8] identification of the need to make a distinction between a moral dilemma and moral distress. He identified this distinction when he observed the level of *emotional* distress that occurred in the individual nurse as they recounted their story. It was the emotional experience of the nurse that provided a signal that something deeply disturbing was going on. We build on Jameton's work and point to the importance of understanding the experience of moral distress as embodied. By embodied, we mean an experience that reflects integration of mind, brain and body, and emotions. In unpacking the significance of embodiment, we draw on research in neuroscience that is beginning to further explain the interconnection between structures and agents.

Neuroscience, relationship, and trauma. Research in the area of neuroscience may provide insight into the reciprocity that occurs between structures and agents that may help guide the development of intentional interventions for moral distress. A significant concept in brain science is that of neuroplasticity, or the capacity for neural growth across the life span.[48] Neuroplasticity is based on the principle that neurons that fire together, wire together.[48] This principle has been used to demonstrate that neural growth is *experience dependent*: experiences based on both our surrounding environment and our attachment relationships.[49] For our purposes, the concept of neuroplasticity holds significance for a relational approach to interventions in moral distress. Research into early attachment relationships and the attachment environment is beginning to demonstrate the impact of relationship on the developing brain.[50,51] Researchers in attachment have linked the concept of neuroplasticity and the capacity for neural growth across the life span to ongoing and significant relationships in adulthood to speculate about the impact of positive relationships on brain structures of adults[iii] [52] This suggests to us that the quality of relationships in a healthcare environment may have neurological affects on healthcare providers as well as the patients/families they serve. Clearly this is an area in need of further research.

The second area of neuroscience that may have significance for understanding the processes involved in the experience of moral distress is research findings in the area of trauma. Trauma can be understood as an event that overwhelms the nervous system so that the individual cannot launch an effective response to threat.[53,54] Research on attachment has also been brought together with research on trauma resulting in a deeper understanding of how negative relational experience can have a lasting physiological impact.[55]

Moral distress as relational trauma

At the same time, as progress in neuroscience is helping us to better appreciate the complexity of stress in moral distress and the physical effects on moral agents, evolving trends in ethical theory are asking us to broaden our philosophical understanding of what it means to be a moral agent. Such developments in theory have led us to come to see that moral distress is a form of *relational* trauma.[41]

Feminist and other relational theorists have challenged the traditional view of an agent as an independent, self-determining individual who makes decisions based solely on rationality.[12,56–58] Following the lead of such theorists, over the past two decades, scholars in nursing have explored what it means to be a moral agent from a relational context, acknowledging that individuals are contextually situated and that actions and decision making are inseparable from context.[1,12,59,60] It is important to note that the term "relational" is taken up in two distinct ways in the nursing practice and nursing ethics literature. The first way refers primarily to *interpersonal relationships*, or the quality of the relationships that exist between individuals.[61,62] A difficulty we see with an exclusive focus on this interpersonal relationship perspective of relational is that it emphasizes the *individual* nurse's responsibility for developing and maintaining the therapeutic relationship, as well as to affect change within the health system.[59] That focus is necessary, but not sufficient to acknowledge how broader systems impact a nurse's ability to form interpersonal relationships. The repercussions of focusing on the ability of the individual nurse is that the causes and experiences of moral distress can be viewed primarily at the individual level, leaving the healthcare organization absolved of its responsibility to provide an environment that supports nurses' enactment of their moral agency.

The second way that relational has been taken up in the nursing literature refers to the "reflective examination of the multitude of factors that shape the relationship between the individual patient and the nurse."[59] These factors include, but are not limited to, the context of the situation, the environment, and the socio-political and economic ideologies and power dynamics that influence healthcare delivery.[4,63,64] Viewing nursing practice from this broader relational perspective addresses the quality of the relationships that exist between individuals, and also encourages us to examine how power is imbued in the healthcare system and how that system supports or places barriers to the development of interpersonal relationships and healthcare practice in general. The UK Report we cited at the beginning of this article is a stark example of how socio-political contexts influence individual capacity in the provision of care. In examining broader structural power dynamics, responsibility for better health and healthcare outcomes shifts from being merely the responsibility of the individual care provider to being a responsibility shared, at least to some extent, with all stakeholders at all levels of the healthcare and social system. Bringing together both uses of the term relational and the idea of the agent as embodied when considering moral distress, we are able to explore the reciprocal relationship with greater understanding of how structures and agents influence each other, as well as the responsibility they each have to the other as they engage in the provision of healthcare.

Work being done in organizations outside of healthcare may inform our understanding of moral distress and the development of interventions that address the complex reciprocity of structure and agency. In his work with war veterans, Shay[65] examined the lasting impact the experiences of battle had on veterans who returned from war with significant mental health issues. Shay found that a contributing factor to post-traumatic stress disorder[iv] was *moral injury*, "the soul wound inflicted by doing something that violates one's ethics, ideal, or attachments." Moral injury, according to Shay, comprises three elements: it is a

betrayal of *what's right*, by someone who holds legitimate authority, in a high stakes situation.[66] Shay[65,67] defines *what's right* in the world of a soldier as being that which his culture understands to be right, and as locally and culturally defined. Shay[65] argues that the military is "social construction defined by shared expectations and values" (p. 6) and as such is a moral construction. He goes on to explain that the expectations and values are embodied both formally and informally as

> regulations, defined authority, written orders, ranks, incentives, punishments, and formal task and occupational definitions. Others circulate as traditions, archetypal stories of things to be emulated or shunned, and accepted truth about what is praiseworthy and what is culpable. All together, these form a moral world that most of the participants most of the time regard as legitimate, "natural," and personally binding.[65]

The two assumptions of *what's right* that were betrayed were the assumption of fairness and the fiduciary assumption. Shay describes the assumption of fairness as the belief that the risk of death would be fairly distributed. Encapsulated in the fiduciary assumption was the belief that what was required in order to carry out the soldier's job, indeed survive, would be provided. Also significant in Shay's view of moral injury is that the violator is the power holder,[66] in his analysis, the power holder was the military organization.

We believe that the healthcare system is also a moral construction as defined by Shay. Healthcare certainly has regulations, defined authority, written orders, ranks, incentives, punishments, formal task and occupational definitions, archetypal stories, and so forth. In healthcare, the power holders, in varying degrees, include healthcare providers, healthcare organizations, regional health authorities, and regional and national governments. Given the recent UK Report,[42] it is useful to learn from the military in order to better understand and address what is currently happening in healthcare systems and organizations. The importance of Shay's work is that it highlights both our understanding of *relational* as including interpersonal and institutions and the responsibility of morally constructed organizations in supporting staff in the provision of quality service. In pointing to the relevance of Shay's work with soldiers, we are not meaning to equate nurses' work environments with the work environments of soldiers. However, we do believe that Shay's notion of moral injury is highly salient for a deeper understanding of moral distress.

In summary, from a place of understanding agents embodied and in a reciprocal relationship with structures, we have come to see moral distress as a form of relational trauma.[41] We believe that the trauma experienced by individual healthcare providers is a response to both interpersonal interactions and organizational practices. Some words commonly used to describe the experience of trauma are helpless, powerless, and hopeless.[54] Indeed, researchers working with individuals who describe their experience of moral distress report similar language being used by their participants.[10,68,69] From an embodied perspective, betrayal of *what's right* could be perceived as a threat to the individual's survival and the body responds accordingly.[66,70] We suggest that healthcare providers' experience of moral distress is a result of their experiences in (and sometimes reciprocal contributions to) interpersonal and institutional situations that violate their core values of practice, against which they are unable to launch an effective defense.

Improving the moral climate of nursing workplaces

Research findings in neuroscience can help us understand the underlying physiological processes involved in reciprocity between structures and agents; however, to better understand how nurses as moral agents are influenced by and themselves influence the complex socio-political structures they inhabit, it is important to appreciate the moral dimensions of their workplaces.[71] Recent nursing research has increasingly focused on work environments and the influence those environments have on the moral outcomes for the individual working with in them.[3,19,32,72] One component of the work environment that has particular significance to this work is the concept of "moral climate." Rodney et al.[73] define moral climate as "the implicit and

explicit values that drive health-care delivery and shape the workplaces in which care is delivered."[47] In a positive moral climate, the explicit values of the organization would be coherent with the moral agents who practice within[21] it and would support an equitable and socially just approach to patients, families, and communities.[59,74] Positive changes to the moral climate within the workplace have been demonstrated to reduce moral distress, enhance job satisfaction, and reduce staff attrition.[75,76] Conversely, in a negative moral climate, challenges to moral agency can contribute to moral distress and a lack of job satisfaction.[75] Clearly, interventions focused on preventing these outcomes and sustaining positive moral climates are needed.

The related concept of *morally habitable work environments* has promise for interventional work in moral distress. Peter et al.[77] explain that morally habitable environments "are those in which differently situated people experience their responsibilities as intelligible and coherent. They also foster recognition, cooperation and shared benefits" (p. 358). An understanding of this concept requires a focus on the individual participant within the environment, their capacity to adapt, and how the environment itself impinges upon the individual.[78] We propose that habitable environments are a space where internal and external constraints to moral agency are minimized, difference is embraced, and moral well-being is promoted through shared understandings of responsibility. While this concept is emergent, there is a growing base of empirical literature related to the capacity of the organization and the individual participant practicing within the environment that may further illuminate the concept of moral habitability and influence interventional work in moral distress.

Toward interventions to address moral distress

Throughout this article, we have noted challenges to nurses' ability to fulfill their moral obligations as well as associated impacts on the safety and quality of care and on the well-being of nurses themselves. It is clear that a conscious focus on interventions ought to guide future theoretical, empirical, and policy work related to moral distress. This work is starting; however, as noted in a recent comprehensive review of moral distress research by Burston and Tuckett it is preliminary and "few intervention studies appear to have been undertaken."[13]

We agree with Burston and Tuckett[13] that more intervention studies are a crucial next step. To this end, we have posited that an overall conceptual schema guided by an understanding of how nurses as moral agents are influenced by—and themselves influence—the complex socio-political structures they inhabit would offer salient direction for future work. In this article, we have therefore worked to unpack some of the complexity of nurses' embodied moral agency, and we have suggested that seeing moral distress as relational trauma offers us new perspectives from which to both prevent and ameliorate moral distress. Here, we offer some preliminary ideas about how our profession can purposefully work with the reciprocity of structure and agency both to help to improve the moral climate of nurses' workplaces and also better support nurses as embodied moral agents.

Supporting nurses as embodied moral agents in complex organizational structures

Based on the relational concepts we have reviewed, it is likely that a morally habitable work environment that is supportive of and encourages discussion on ethical issues intentionally fosters a positive, reciprocal relationship between healthcare structures and moral agents. Furthermore, given that nurses can be complicit in reinforcing the structures that constrain their own practices and may fail to support healthcare leaders who may themselves be experiencing moral distress, we ought to help nurses to understand their own complicity in sometimes contributing to organizational conditions that worsen their own moral distress. This requires recognition of moral challenges, and the ability to self-reflect as individuals and members of teams.[12,79] Clearly, these are areas in need of further empirical investigation and professional action.[5] For

example, the means by which values clarification and exchange can be achieved and the mechanisms to strengthen values explication have been under-explored in nursing.[71] In the meanwhile, we do know that discussions around personal and professional values can facilitate change in workplace culture: developing agreement on shared beliefs and team building[80,81] to better support nurses as moral agents.

Nurses, physicians, and other healthcare providers also need time to critically reflect on the quality of their interactions within and between professions, and with patients as well as their family members.[12,79] Interest in such issues has led to health ethicists discussing the importance of creating new means for the articulation of values within the workplace.[82] In a participatory action research study to trial such interventions in an ambulatory oncology care context, interprofessional team members[24] found the following strategies to be helpful:

- Regular, pre-structured debriefing sessions with safe facilitators (primarily the agency domain);
- Built in rounds to learn "from, with and about" each other (primarily the agency domain);[v]
- Transparent, reciprocal feedback between all levels of staff and administration (the agency and structural domains);
- Ethics support and related policy initiatives for complex end-of-life situations (the agency and structural domains);
- Advocacy work through professional associations to improve resources for cancer care (primarily the structural domain).

In research on moral distress, participants often describe talking to others as a strategy for making sense of, and working through, the experience.[69,79] Many of the interventions described above derived from the participatory action research involve some form of dialogue. It behooves us as researchers to explore what aspects of dialogue healthcare providers find supportive in working through the experience of moral distress. This will make it easier to discern aspects of the environment that support positive dialogue. As well, understanding what qualities of the dialogue help providers make sense of the experience will aide in determining what kinds of interventions, and at what levels of healthcare, will potentially be effective.

Interestingly, Burston and Tuckett[13] provide a summary of a range of educational and dialogical interventions directed at individual and organizational levels that are similar to the ones we have noted above. The interventions they identify include education to improve ethical understanding, skills, and communication; provision of morally sensitive support mechanisms; individual engagement in critical self-reflection; interdisciplinary dialogue and education; collection of narratives or storytelling; and mentorship and enablement of a supportive organizational culture. We fully agree with Burston and Tuckett's list.[13] Further research into organizational and individual values explication, exchange, and clarification is also needed. If nurses are to successfully negotiate their moral understandings and responsibilities (agency), a more robust identification of the characteristics of habitable work environments (structure) will promote future interventional work aiming to reduce moral distress and its concomitant relational trauma.

Finding a way forward

As we noted at the outset of this article, in exploring the reciprocity of structure and agency, Sewell[33] claims that "the same resourceful agency that sustains the reproduction of structures also makes possible their transformation." Given that current trends in healthcare such as increasingly reductionist demands for a cost-effective and efficient healthcare system have resulted in an exacerbation of conflicting professional and corporate values, the hope in this message is timely. We have suggested that moral distress is a result of an event in a moral agent's interpersonal or institutional relationship(s) that is experienced as embodied, which includes the emotional as well as moral and cognitive domains. Furthermore, we have suggested that the quality of relationships in a healthcare environment may have neurological affects on healthcare

providers as well as the patients/families they serve. Overall, we find that seeing moral distress as a form of relational trauma can help us to better appreciate the complexity of the concept.

Incorporating such knowledge into planning interventions may help researchers develop targeted interventions for moral distress. We are also suggesting, along with other researchers,[7] that effective interventions for moral distress will need to be multi-pronged and directed toward the relationships between healthcare organizations as structures and individuals as agents. If we focus only on agents as individuals or only on larger-scale system problems, we will miss the reciprocity between the two, and ultimately fail to address the serious challenges identified in the research studies we have cited earlier in this article and that were chronicled in the UK Report. The interventions we have pointed to above hold significant promise but need much more attention within nursing, other health professions, and the wider healthcare system.

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Conflict of interest

The authors declare that there is no conflict of interest.

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Notes

i. Healthcare leaders are another group under-represented in research related to moral distress.
ii. One of Hayter's[46] other warnings is that the structure of nursing education is being held up for question by the UK government as a result of reported nursing practice failures. This means that our profession's regulatory autonomy may also be under threat (Duncan et al., in preparation[2]).
iii. Readers are directed to the seminal works of Allan Schore[52] for further information on attachment.
iv. Shay argues convincingly that post-traumatic stress disorder (PTSD) does not capture the devastating and long-lasting impact moral injury has on the character of soldiers returning from war. For more information on moral injury, the reader is referred to Shay.[65,66]
v. This three part phrasing was adapted from the University of British Columbia's Interprofessional Studies program.

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Appendix 3 - Monash University Ethics Approval

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

This is to certify that the project below has been approved by the Monash University Human Research Ethics Committee under the Memorandum of Agreement with [redacted]

Project Number:	**CF14/26 - 2014000008**
Project Title:	**Moral habitability and the new graduate nurse**
Chief Investigator:	**Assoc Prof Cheryle Moss**
Approved:	**From: 6 January 2014 to 6 January 2019**

Terms of approval - ***Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.***

1. Approval is only valid whilst you hold a position at Monash University and approval at the primary HREC is current.
2. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
3. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
4. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Nip Thomson
Chair, MUHREC

cc: Dr Susan Lee; Ms Rebecca Vanderheide

[redacted]

Appendix 4 - Participant Explanatory Statement

Participant Explanatory Statement

This information sheet is for you to keep.

My name is Rebecca Vanderheide and I am a PhD candidate in the School of Nursing and Midwifery, Monash University.

I invite you to participate as a new graduate nurse at xxxxxxxx in the research project, Moral Habitability in Nursing, which is a part of the requirements of my PhD.

Background and aim of the study

Moral habitability is an under-theorised and under-researched aspect of practice in nursing and in other health professions. Research into the moral issues which arise reside for nurses in their everyday practice, especially in regard to the work environment, is gaining momentum internationally. Little research in this area has occurred in the context of Australian nursing. This study will make a contribution theoretically and practically to these global research efforts. Specifically, there is a need to understand what makes a workplace morally habitable from individual, interrelational and contextual viewpoints. This study will focus on the experience of new graduate nurses entering the workforce and the impact of, and their impact on, the moral habitability of that environment.

The aim of this study is to: Provide an interpretive description of moral habitability in nursing, both conceptually and in practice.

What does the research involve?

The study involves your participation in ***at least one*** of the following activities:

FOCUS GROUPS*:* The focus groups will take place in one of the scheduled new graduate information sessions. The focus group will include activities that will be both informative and interactive.

OBSERVATION: This will include being observed during a mutually agreed time during your everyday nursing practice. During this time, the researcher may ask you some questions and will write down field notes. At no time will the researcher interrupt your patient care.

INTERVIEWS: At a time and place suitable to you, the researcher will conduct an interview, which will take no longer than one hour and will be audio-taped. During that time you will be asked questions about your everyday moral nursing experiences as a new graduate. At the conclusion of the interview, you will be asked if you are interested in being involved in a second interview later in your new graduate program.

If you are interested in taking part as a participant in this research study, please complete the consent form and indicate by ticking the box **yes** for each of the activities you would like to participate in.

Possible benefits

Being involved in a research study that has a focus on the moral component of your work and includes an interactive focus group may be useful to you. The potential benefits include enhanced theoretical and ethical knowledge, and through the process of professional reflection regarding personal and organisational moral components of practice, an enhanced moral sensitivity to patients' care needs**.** This project will extend contemporary knowledge about what shapes and challenges habitability in the new graduate nurse, and has the potential to shape future new graduate nurse programs and work environments.

Inconvenience/discomfort

There is little potential for psychological stress in any of the three activities. However, in the event of any distress arising from discussions about your work, the activity can be paused or stopped at your request. Should further support be required, the xxxxxxxx, a free counselling service, is available to support employees.

Confidentiality

Any data collected will be de-identified. Anonymity of the data collected will be managed by using pseudonyms and/or codes. Any published data will be managed in the same way. Observed or disclosed situations which are not in accordance with the expected standard of conduct of new graduate nurses will be discussed with the individual involved and s/he will be referred to appropriate hospital policy regarding such matters.

Payment

There is no payment or reward, financial or otherwise, offered for participation in this project.

Can I withdraw from the research?

Participating in this study is voluntary. You are under no obligation to consent to participate. You can withdraw from any or all of the activities at any time. Information you provide during the workshop may not be withdrawn as the data recording is unidentified. Information you provide during interviews may be withdrawn up to 24 hours following the interview.

Storage of data

The focus groups and interviews will be audio-recorded, transcribed and then immediately de-identified. Observation notes will be transcribed and de-identified. Original recordings and transcripts will be stored electronically in password-protected files to which only the researcher and her supervisors have access. Storage of the data collected will adhere to the University and xxxx and xxxx regulations, and be kept on University premises in a locked cupboard/filing cabinet for seven years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Results

If you would like to be informed of the aggregate research findings, please contact the Chief Investigator as below.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research is being conducted, please contact:
Chief Investigator Rebecca Vanderheide Phone: xxxxx Fax: xxxxx Email: Rebecca.Vanderheide@monash.edu	**Research Governance Officer** Ms xxxxx and Ms xxxxx Office of Ethics and Research Governance Xxxxx and xxxxx Phone: xxxxx and xxxxx Email: xxxxx and xxxxx

Rebecca Vanderheide, PhD Candidate, School of Nursing and Midwifery, Monash University.

Appendix 5 - Participant Consent Form

Note: *This consent form will remain with the Monash University researcher for their secure records and so that the researcher can contact you.*

Title: Moral habitability in nursing

I agree to take part in the research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records.

I understand that agreeing to take part means that:

I agree to participate in an interactive focus group and for this interaction to be audio-taped. In agreeing to participate in the focus group, I undertake not to disclose the names of other participants or the discussion that occurs to other parties. ☐ Yes ☐ No

AND/OR

I agree to being observed during my normal nursing duties at a time that is suitable to me.

☐ Yes ☐ No

AND/OR

I agree to be interviewed by the researcher and be audio-taped ☐ Yes ☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I understand that if I withdraw at any stage of the project, my information may not be able to be withdrawn (focus groups), and that interview information I provide may only be withdrawn up to 24 hours following the interview.

I understand that any data that the researcher extracts from the interviews, observation and workshop for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics.

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party.

I understand that the audio-taped and transcribed data from the interviews, observation and workshop will be kept in secure storage and accessible only to the research team. I also understand that the data will be destroyed after a 7-year period.

Participant's name: ……..

Signature: ……

Date: ……..

PLEASE NOTE: If you have agreed to being observed or interviewed, you need to complete the contact details below so that the researcher can contact you to organise a time for these activities.

Email: ……..

Phone :……..

Appendix 6 - Focus Group Handout

Qualities internal to the agent (nurse)

Concept	Definition
Moral identity	Moral identity is the way in which our values, attitudes and beliefs are central to our identity as people and how we act. Moral identity is dynamic and happens through interaction and relationships with others (Doane, 2002).
Moral agency	Moral agency can be referred to as the overall ability to recognise, think about, then make moral decisions and act on those decisions (Peter & Liaschenko, 2004).
Moral sensitivity	Moral sensitivity describes the compassionate awareness of the moral implications of decisions. It is an ability to recognise vulnerability and take into account all aspects of the patients' needs such as culture, spirituality, psychosocial as well as physical, and to make the right decision. Moral sensitivity draws on the attitudes of the nurse, their clinical experience, academic learning and it requires courage to act when faced with constraints (Weaver et al., 2008).
Moral integrity	Moral integrity has been described as living up to your personal and professional moral identity. This happens through thinking critically about your values and then trying to stay true to these values (Hardingham, 2004).

Context where action is taking place (workplace)

Concept	Definition
Moral climate	Moral climate describes the values that are "implicit and explicit" (p.24) within an organisation and forms part of the overall culture of an organisation (Rodney et al., 2006). The tone of verbal and non-verbal communications (at all levels) is also a constituent of moral climate. The moral climate can enhance, support or constrain aspects of the nurses' moral practice. Examples include policies, procedures, codes of ethics and education (Rodney et al., 2013). Influences of moral climate in nursing have been linked to job satisfaction and staff attrition (Ulrich et al., 2007).
Moral community	A moral community is a workplace where moral values are clear and are shared, where moral values direct action, and where individuals feel safe to be heard (Austin, 2007).

Outcomes after the action

Concept	Definition
Moral satisfaction	Nurses want to provide good care for patients and this promotes satisfaction (Pask, 2003). Moral satisfaction can be seen as what nurses' experience when they are satisfied in their moral choices and feel they are able to act appropriately in their care for their patients.
Moral distress	Moral distress is a complex phenomenon of what nurses' experience when they are constrained from moving from a moral choice to the appropriate action. It can be experienced by single individuals or a wider group and is shaped through relationships and the context of the workplace. Emotional, physical and psychological effects can be experienced by nurses with moral distress (Varcoe, Pauly, Webster, & Storch, 2012).

Concept	Working definition
Moral habitability	Morally habitable environments are spaces where internal and external constraints to action by the nurse are minimised, difference is embraced and moral wellbeing is promoted through shared understandings of responsibility. Internal constraints are those related to the individual nurse such as attitudes, beliefs and behaviours that limit optimal moral action. External constraints are organisational, such as work policies and procedures, and relational, such as interactions with other nurses and managers (Musto et al., 2015).

Appendix 7 - Focus Group Activity 1

Script for addressing privacy issues at the beginning of the focus group

"We will be working in small groups. The whole group will discuss and share examples and insights about how these concepts are experienced or are relevant to you as a new graduate in your first year of professional practice. These discussions are being audio-taped and will be used as part of the de-identified research data. It is imperative that you do not disclose either the names of, or any comments expressed by, your colleagues. You will remember that during the consent process, you signed a form indicating your willingness to respect the privacy of those involved. Thank you for your cooperation."

What is the morally habitable workplace like? (25 minutes)

For this activity we want, as a group, to gather our individual and collective ideas about what a morally habitable workplace is like.

Part A – 5 minutes (Individual ideas)

Each person is to take some coloured 'Post-it-notes'. Take some time to think about what you think are the three best features of a morally habitable environment. Write each feature on a single Post-it-note – one Post-it for every feature. Please head each Post-it-note with your allocated number (not your name) and then make your point.

When you have finished, put your Post-it-notes on the relevant sheet of butchers' paper. Everyone in the small group will then share the features they have identified.

Part B - 10 minutes (Group drawing/diagram)

Challenge yourselves, within a 10-minute time period, to, as a group, creatively draw a representation of the morally habitable workplace that encompasses all of your group's features/ideas (everyone should participate equally). When your diagram is completed,

please write all your individual numbers down the side or at the bottom of the butchers' paper.

Part C - 10 minutes (Summary of the themes as represented in the diagram)

Each group will present a summary of their diagram to the other groups. At the end of the activity, please hand both sheets of butchers' paper to the facilitator.

Appendix 8 - Focus Group Activity 2

How is moral habitability experienced in the workplace? (25 minutes)

For this activity, we want as a group to gather our individual and collective insights about how moral habitability is experienced in the workplace.

Look at the topics and associated questions projected on the screen (and below). As a group choose three of the topics, different from other group/s' selections.

Part A – 15 minutes

In a small group, discuss your chosen topic/questions and capture your thoughts and discussion on the butchers' paper provided. Please ensure you sign the butchers' paper with your allocated numbers to indicate your membership of the group.

Consider the following as you are now working as a new health professional at xxxxxxxx.

	Qualities internal to the nurse
Constraints on moral agency/ moral integrity	What happens when what you believe is important is different for your patients? How do you think about this? What do you do in these situations? What happens when what you believe is important is different to the beliefs of the other staff in your workplace? How do you think about this? What do you do in these situations?
Moral integrity/ moral agency	How do you decide what is right or wrong in a nursing situation? What do you do if you have doubts about what is the best course of action? What factors in your workplace affect your decisions?
Moral sensitivity	Tell us how you sense the needs of your patients. How do you feel if a patient is suffering? How do you feel if the patient is recovering?
Moral satisfaction	Sometimes in your practice things go so well that everything is congruent and synchronised. You feel morally satisfied. In which situations are you most likely to experience moral satisfaction? What does moral satisfaction look like, sound like and/or feel like?
Moral climate/moral agency	Sometimes we fit into workplace and professional cultures. Sometimes the fit between us and the workplace is less good. We may experience difference, lack of fit and/or misunderstandings. In which situations are you most likely to experience this? What does lack of fit look like, sound like and/or feel like?

	Context where the action is taking place (workplace)
Moral climate	Is the moral climate in your workplace one which encourages truth telling? Can you provide some examples where truth telling has been encouraged and other examples where truth telling has been discouraged? Why are truth telling and/or censorship important in professional practice?
Moral community	A moral community works by talking together, sharing together, valuing together and growing together. Have you ever experienced a workplace like this? What did it look and feel like? What do you think helps workplaces to grow as moral communities?

	Interactions between the qualities of the nurse and the workplace
Moral sensitivity/moral climate	Tell us how you work with patients with aspects of social difference e.g. different cultures/sexuality/class/jobs? What actions do you take to respond to inequality? What actions do you take to address equity? In which situations are you most likely to experience inequality? In which situations are you most likely to experience equity? What does equity look like, sound like and/or feel like?
Moral sensitivity/moral climate	Have you received in your education or your workplaces training and support and increased your skills in moral sensitivity? What do you think is needed to support nurses' skills in this area?
Moral sensitivity/moral climate/moral community	Tell us how you work with staff aspects of social difference e.g. roles/level of hierarchy? What actions do you take to respond to inequality? What actions do you take to address equity? In which situations are you most likely to experience inequality? In which situations are you most likely to experience equity? What does equity or inequality look like, sound like and/or feel like?

	Outcomes after the action
Moral distress/moral climate	Have you ever experienced or seen moral distress in your workplace? Without divulging the situation what do you think contributes to or sustains moral distress in the workplace? What do you think can be done to avoid or alleviate moral distress in the workplace?

Part B - 10 minutes (Summary of themes)

Each group will present a summary of their thoughts written on butchers' paper to the whole group.

Appendix 9 - Focus Group Activity 3

Managing self in the workplace and privately (25 minutes)

How do you keep yourself whole as a person and as a professional?

We all have and we all develop strategies for sustaining our integrity as professional people. We maintain integrity in the workplace and we manage the interfaces of this publicly and privately. In this part of the workshop we would like you to share your strategies for maintaining your integrity and ways of achieving this.

Part A – 5 minutes

The facilitator will ask you the following question: What strategies do you use in the workplace to keep your integrity?

Share your ideas of what this means to you with your group, in an open but safe way. Each member of the group will share their answer and listen to responses to this question.

Part B - 5 minutes

The facilitator will ask you the following questions: What kinds of things in the workplace help you keep your integrity? What kinds of things in the workplace hinder you in keeping your integrity?

Share your ideas of what this means to you with your group, in an open but safe way. Each member of the group will share their answers and listen to responses to this question.

Part C - 5 minutes

The facilitator will ask you the following questions: During private times and in reflection, how do you reconcile the things that enhance or hinder integrity, and prepare for future practice?

Share your ideas of what this means to you with your group, in an open but safe way. Each member of the group will share their answer and listen to responses to this question.

Part D – 10 minutes (Summary of the themes)

Each group will present a summary of their ideas to the wider group***.***

Appendix 10 - Interview Guide

Schedule for In-depth Interviews

The interview schedule has been structured to meet the overall aim of the study and the exploratory questions of Phase Two, the field component of the study of moral habitability in nursing.

Primary probes and prompts will generate secondary and tertiary probes and prompts which are designed to gain insights and stories that illustrate:

- The characteristics of new graduate nurses which affect moral habitability in the workplace;
- How moral habitability is experienced by new graduates working in the acute setting;
- How contextual features (e.g. patients, teams, organisational policy) in the new graduate nurses' moral world affect moral habitability;

  and

- The outcomes of moral habitability in the workplace.

Interview process

1. State that the interview will be recorded.
2. Introduction – Remind the participant of the work done in the focus groups.
3. Opening question – Tell me about what it is like to be a new graduate nurse (*overall experience)*.

4. The following direct questions could be used to follow the opening question and other primary and secondary probes.
    a. Do you mean…?
    b. You said this is happening….tell me more.
    c. How did that come about?
    d. Tell me specifically about how that made you feel when….
    e. That is helpful. I would appreciate it if you could give me more detail.
    f. I think that is very important. To be sure that I understand what you are trying to say, please explain some more.
5. Primary probes and prompts

The following questions have been developed from the data collected at the four focus groups and two episodes of observation to date. The key questions will be used, but the secondary questions may change during the interview depending on the participant's response.

- What situations in everyday practice would you consider to be moral in nature? *(Moral identity, moral sensitivity)*
- How do you decide what is right or wrong in a nursing situation? (Secondary) What do you do if you have doubts about what is the best course of action? What factors in your workplace affect your decisions? What factors about yourself affect your decisions? (Tertiary) Can you describe how that feels? *(Moral agency, moral integrity, moral climate)*
- How would you describe your workplace culture? (Secondary) What aspects of your workplace's particular culture foster your new graduate experience? What aspects of

your particular workplace culture hinder your new graduate experience? *(Moral climate, moral agency, moral community)*

- What does good teamwork look like in your workplace? (Secondary) What factors are most important to you? What attitudes do you look for in those your work with? What things hinder good teamwork? *(Moral community, moral climate)*
- How do you know what is important for your patients? *(Moral sensitivity)*
- How do you look after yourself? *(Moral integrity)*
- Can you describe what a good day when you felt you met all your patients' needs, would look and feel like? (Secondary) What was it about that day that was satisfying? *(Moral satisfaction)*

Structuring questions

To change to another topic:

- I would now like to introduce another topic…..
- We have been talking about…..I would now like to talk about…..

6. Finishing the interview

The interview will end with a short summary of the main points the participant has given and a final question "*I have no further questions at this point. Is there anything else you would like to add before we finish?"*

The participant will also be asked if they would be willing to do a further interview later in their new graduate year.