Mitigating Moral Distress in Dementia Care: Implications for Leaders in the Residential Care Sector

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Abstract

In 2012, the World Health Organization estimated that the number of people living with dementia worldwide was approximately 35.6 million; they projected a doubling of this number by 2030, and tripling by 2050. Although the majority of people living with a dementia live in the community, residential facility care by nursing providers is a common part of the dementia journey in most countries. Previously published research confirms that caring for people living with dementia in such facilities often creates moral distress for nursing care providers. In this paper, the authors share additional findings from a two-year, two-phase, mixed methods study of moral distress as experienced by nursing caregivers of residents with dementia

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in residential care settings in a Western Canadian province. The findings relate to strategies to reduce moral distress in this caregiving group, with a particular focus on the role of supportive and responsive leadership. Important implications for practice and for leadership in the residential care sector are presented.

Introduction

In 2012, the World Health Organization estimated that the number of people living with dementia worldwide was approximately 35.6 million; they projected a doubling of this number by 2030, and tripling by 2050 (WHO 2012). Although the majority of people living with dementia live in the community, residential facility care by nursing providers is a common part of the dementia journey in most countries.

Indeed, literature from around the world confirms that of those people requiring supportive living environments such as long-term care (LTC) or assisted living (AL), nearly half are living with some form of dementia (Global Observatory for Ageing and Dementia Care 2013). In one study in a Canadian province, Strain et al. (2011) reported that 58% of AL residents lived with a diagnosis of dementia, as did 71% of residents in LTC. Research has also shown that caring for persons with dementia can be emotionally, physically and ethically challenging on a daily basis (Bolmsjö et al. 2006) and that turnover in nursing staff in these settings tends to be high (McGilton et al. 2013b; Utley et al. 2011).

Findings for this paper were derived from a mixed methods study of moral distress among nearly 400 nursing staff caring for people with dementia in LTC and AL facilities (collectively referred to as residential care facilities or RCFs) in one Western Canadian province. Nathaniel (2004) defined moral distress as the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, cannot do what is thought to be right. In this paper, we report findings that specifically relate to the mitigation of moral distress in dementia care, and most particularly on the role of leadership in such efforts.

Background

Much of the background for this paper resides in our own previously published findings. Therefore, a brief overview of those original findings is warranted here (although the reader is directed to these publications for full details) (Pijl-Zieber et al. 2016; Spenceley et al. 2017).

In this two-year, mixed method study, we found high levels of moral distress in all levels of nursing care staff (registered nurses, licensed practical nurses and unregulated healthcare aides) providing care to people living with dementia. The top five causes of severe and frequent moral distress are in Table 1. Canadian research has revealed that unregulated workers such as healthcare aides (HCAs) (also called nurses' aides, nursing attendants or personal support workers) provide 75–80% of direct care to LTC residents (Estabrooks et al. 2015). We found that invariably, the severity and frequency of moral distress increased with proximity to the provision of bedside care, with HCAs reporting the highest levels of moral distress (Table 2). We also found that all providers of all designations reported consequences of feeling morally distressed. Indeed, at least weekly, approximately 49% of participants reported feeling frustrated, 44% reported feeling physically exhausted, 42% reported feeling emotionally drained, 39% reported feeling powerless and 33% reported engaging in coping behaviours that were not healthy (Spenceley et al. 2017). In relation to job satisfaction, we learned that despite approximately 40% of the sample reporting that moral distress reduced their job satisfaction by either a large or extremely large amount, and over 25% of the sample indicating that moral distress contributed to them wanting to quit their job in either a large or extremely large amount, approximately 85% of the sample indicated that they did not intend to quit their job in the next year (Pijl-Zieber et al. 2016). Qualitative findings also painted a compelling picture of a nursing workforce feeling stuck in conflicting expectations around care in a resource-strapped environment, in a context that privileged tasks over touch. These findings also revealed feelings of unheard outrage and powerlessness in nursing providers who reported seeing repetitive failures around accountability for the care delivered by colleagues, and failures of leadership to advocate, listen, follow up and manage performance issues (Spenceley et al. 2017). Within the context of these findings, we found ourselves repeatedly circling back to the notion of leadership in residential care settings, particularly as a factor to consider in the mitigation of moral distress.

Table 1. Top five situations that caused the most severe and frequent moral distress

	Severity		Frequency	
Situation	**Mean (*SD*)***	**% Who experience large or very large amount**	**Mean (*SD*)§**	**% Who experience daily or weekly**
Seeing the care of residents with dementia suffer because there are not enough staff to do the work	3.84 (1.39)	71.9	2.61 (1.28)	58.2
Having to rush the care of residents with dementia because of lack of time – even though I know it might upset them	3.44 (1.61)	59.6	2.44 (1.41)	53.9
Seeing the care suffer for residents with dementia because families do not provide basic necessities such as clothing and other supplies	3.38 (1.48)	53.8	2.04 (1.28)	35.1
Seeing a low quality of life for residents with dementia because there are not enough activities	3.30 (1.62)	52.7	2.56 (1.43)	59.4
Having to provide care to aggressive residents with dementia without the supports I need to feel safe	2.89 (1.95)	49.7	1.66 (1.46)	33.0

SD = standard deviation. *Scale 0–5. §Scale 0–4.

Literature Review

In the existing literature, there have been numerous calls for leadership development in RCFs resulting from the rising demand for residential care services and the "staggering" turnover in staff (Utley et al. 2011: 212), the heavily regulated environment, the predominantly non-professional workforce (Davis 2016) and the importance of competent leadership for monitoring, maintaining and improving the quality of care in RCFs (McGilton et al. 2013a). Further, it has been observed that there is a growing, and often "hidden complexity" to care in these settings: the vast majority of residents have dementia, resources are scarce, environments are often not physically well set up for the population needing

Table 2. Frequency of causes of moral distress by role designation (RN, LPN, HCA)

Situation	Role	*n*	% Weekly or daily	Mean	*SD*	Test statistic	*df*	Post hoc test§
Telling the resident with dementia things that are not true so he/she won't get upset	RN	72	41.6	2.15	1.329	18.589	2	RN < HCA**
	LPN	53	60.4	2.58	1.379			
	HCA	249	69.5	2.90	1.253			
	Total	374		2.71	1.315			
Having to make a resident with dementia wait for care because another resident needs me just as much, at the same time	RN	71	32.4	1.59	1.430	42.200	2	RN < HCA** RN < LPN*
	LPN	53	52.8	2.42	1.379			
	HCA	250	69.2	2.85	1.305			
	Total	374		2.55	1.422			
Having to rush the care of residents with dementia because of lack of time – even though I know it might upset them	RN	72	31.9	1.68	1.402	25.863	2	RN < HCA* RN < LPN*
	LPN	53	49.1	2.45	1.353			
	HCA	250	61.6	2.65	1.357			
	Total	375		2.44	1.413			
Having to provide care that I think is against the wishes of the resident with dementia	RN	72	8.4	.92	1.097	10.631	2	RN < HCA* RN < LPN*
	LPN	52	23.0	1.50	1.321			
	HCA	246	29.2	1.49	1.363			
	Total	370		1.38	1.326			
Having to provide care to aggressive residents with dementia without the supports I need to feel safe	RN	72	18.0	1.13	1.288	13.476	2	RN < HCA**
	LPN	52	28.9	1.65	1.399			
	HCA	247	38.9	1.84	1.496			
	Total	371		1.68	1.468			
Having to work without the supports I need to prevent residents with dementia from hurting other residents	RN	72	19.4	1.19	1.307	6.395	2	RN < HCA*
	LPN	52	28.9	1.52	1.407			
	HCA	247	31.6	1.67	1.443			
	Total	371		1.56	1.421			
Seeing the care suffer for residents with dementia because families do not provide basic necessities	RN	72	19.4	1.46	1.198	20.886	2	RN < HCA*
	LPN	53	26.4	1.91	1.148			
	HCA	249	41.4	2.24	1.282			
	Total	374		2.04	1.282			

df = degrees of freedom; HCA = healthcare aide; LPN = licensed practical nurse; RN = registered nurse; SD = standard deviation.
§ Post hoc tests with Bonferroni correction reveal which designations had the more frequent causes of moral distress.
* ≤ 0.05;
** ≤ 0.001

care, and care providers often report being torn between the espoused and the enacted philosophies of care (Cammer et al. 2014: 1013). Among the contextual factors identified as critical to helping staff navigate this growing complexity, Cammer and colleagues (2014) noted the importance of empowering leadership and supportive mentoring.

Studies exploring the connection between moral distress and leadership in RCFs are very rare. In one such study, de Veer and colleagues (2012) explored individual and job characteristics associated with moral distress in nursing staff in nursing homes, elder care homes, home care and acute care hospitals in the Netherlands. Situations found to be associated with the most moral distress included being caught between the expectations of family, the physician and the wishes of the person in terms of desired care and working with staffing levels perceived as unsafe. It is also notable that the highest mean level of moral distress was found in nursing home staff (de Veer et al. 2012). As part of their study, two aspects of leadership were explored: supportive leadership (employee-oriented, considerate, approachable and friendly) and instrumental leadership (focusing on tasks, setting boundaries, targets and standards). It is interesting to note that instrumental leadership was found, more often, to trigger moral distress, whereas a more supportive leadership style tended to buffer the intensity of moral distress. Further, de Veer and colleagues (2012) noted that nursing staff could benefit from being able to talk to and reflect with other nurses about the problems they face, and encouraged managers to empower staff by creating opportunities for staff to talk with each other and with management about their views and experiences.

In this paper, we will first describe the design and methods of a two-year, mixed methods exploratory study of moral distress experienced by nursing care providers. Next, we will share the findings from that study that were specifically related to potential mitigation strategies for moral distress, with a particular focus on the role of leadership. It is our purpose to offer insights into the role of leadership in relation to its importance in helping to address the morally distressing challenges faced by those providing nursing care to some of the most vulnerable citizens in Canadian society. Finally, we will offer a discussion of the implications of our findings for leadership in residential care environments.

The Study

Setting and sample

The study was conducted in one health authority of a Western Canadian province, serving the healthcare needs of approximately 298,000 people. The region has two main population centers with populations of 95,000 and 62,000, situated within a largely rural geography in the southern part of the province. The study was conducted in RCFs including LTC and AL facilities. LTC facilities are homes for the most medically complex, and these residents are cared for by a mix of regulated and unregulated nursing staff. AL facilities house older people with moderately complex health needs, who are cared for in a home-like setting, with scheduled support by home care nurses and unregulated nursing providers (Strain et al. 2011). We also included AL sites that provided care to individuals with dementia or other mental illnesses who required a secured environment. The study encompassed 30 different care facilities across both rural and urban settings.

The nursing staff we sampled in this study included registered nurses (RNs), licensed practical nurses (LPNs) and HCAs (Table 3). Approximately two-thirds of the sample was constituted by HCAs, reflecting their prevalence in the residential care workforce in Canada. Indeed, it is estimated that HCAs constitute approximately 75–80% of the long-term care workforce (Roulston 2008). Although comparable proportionate data are unavailable related to AL settings, it would be reasonable to assume that unregulated nursing staff provide an even higher proportion of direct care in AL settings – given that

Table 3. Demographics of sample

Characteristic	n*	%
Gender of nursing staff		
Female	356	92.5
Male	29	7.5
Professional designation of nursing staff		
RN	72	18.9
LPN	53	13.9
HCA	255	67.1
Years of experience in dementia care		
Less than 10 years	233	60.7
10–20 years	111	28.9
More than 20 years	40	10.4
Total	389	100

*Totals may not match in each category because of missing data.

staffing levels are lower and a smaller proportion of the staff is constituted by regulated nursing providers in these settings (Maxwell et al. 2015).

Methods

We conducted a mixed methods, exploratory sequential study in two phases to explore the nature, causes, prevalence and intensity of moral distress as experienced by nursing staff providing dementia care in RCFs. First, we used a qualitative exploratory descriptive approach with staff in six RCFs and three home care sites (central offices for home care RNs serving one or more care facilities). Purposeful sampling of nursing caregivers at these sites who were interested in participating was undertaken, such that we obtained participants across all three designations, different genders and with varying years of experience providing dementia care. Trained research assistants collected qualitative data through semi-structured interviews of 60–90 min in length with 18 nursing care providers; it was at this point that we noted no new information emerging. The interviews began with a discussion of the meaning of moral distress, followed by prompting questions asking participants to recall specific events or times when they were providing care to a resident with dementia and they experienced moral distress, how they felt during and after an experience, what effects they experienced that they could attribute to moral distress and what helped, or could help, to reduce moral distress. Thematic analysis of qualitative data and review of the existing literature informed the development of the Moral Distress in Dementia Care Survey (MDDCS; instrument available from the researchers). The MDDCS was piloted in seven sites with a 62% response rate (n = 68). Data from the pilot helped us assess the validity and reliability of the MDDCS and informed minor changes to the survey prior to its final distribution to the remaining 23 sites, where it was completed by approximately 400 nursing care providers (Pijl-Zieber et al. 2016; Spenceley et al. 2015).

Data analysis

In phase one, transcribed interview data were subjected to a descriptive, data-near qualitative thematic analysis (Clarke and Braun 2014). Categories of response were identified in the data, including sources of moral distress, consequences for care providers and potential mitigating strategies. Thematic coding within each of these categories was undertaken. Three rounds of team discussion resulted in a final list of themes in each category of response, and the resulting list of themes and their definitions were verified in individual follow-up discussions with each interviewed participant. Subsequently, the team developed survey items that reflected these themes, staying as close as possible to the language used by participants. This rigorous qualitative analysis and participant validation helped to ensure content validity; further confidence in the instrument was also gained by having two nursing experts in the field assess the first version of the instrument for clarity, comprehensiveness and appropriateness to the setting.

In phase two, quantitative data were gathered from participants using the MDDCS in the areas of sources of moral distress, its consequences, as well as potential mitigating strategies. Research assistants entered the data from the completed surveys and the research team as a whole analyzed the data using statistical software (Statistical Package of the Social Sciences (SPSS), v. 21. The overall Cronbach's alpha for the MDDCS tool was found to be 0.95. Intraclass correlation coefficients revealed a high Cronbach's alpha for frequency of moral distress (0.938), severity of moral distress (0.924), effects (0.928) and mitigating factors (0.825). A full discussion of findings is published elsewhere (Pijl-Zieber et al. 2016).

Ethical considerations and approval

Ethical approval for the study was obtained through two university research ethics boards in the province. All participants gave written, informed consent prior to interviews, and full information was provided as part of the survey instrument, with completion being accepted as implied consent.

Findings: Mitigating Moral Distress

Qualitative findings: Phase one

Several themes emerged in each of the three data categories (sources of moral distress, consequences for care providers and mitigating strategies) in phase one. Please see the qualitative thematic overview provided in Table 4. Of particular relevance for our purposes in this paper are the themes that emerged related to mitigation strategies for moral distress; these are reported in greater depth here.

Table 4. Major themes

Category	Theme
Sources of moral distress	**Managing dementia behaviors** (e.g., conflict regarding the need for medication; providing care to aggressive residents without supports)
	Lack of resources (e.g., lack of staff; time; activities; education about dementia care)
	Inconsistent care expectations (e.g., inconsistent care planning; delayed care; inconsistent follow-up on with staff who do not meet expectations; inconsistent staffing patterns)
	Seeing residents treated disrespectfully (e.g., like children; doing the fast thing instead of the right thing)
	Family issues/reactions (e.g., disagreements between staff and families regarding aspects of care; bearing brunt of family anger)
Impacts of moral distress	**Emotional reactions** (e.g., powerlessness; guilt; anger; frustration sadness; anxiety)
	Physical reactions (e.g., physical exhaustion; body pain)
	Relationship effects (e.g., taking out frustration on own family members; withdrawing from residents)
	Quitting (e.g., wanting to or planning to quit working at the RCF)
	Sick time (e.g., taking sick time to cope with moral distress)
Factors to reduce moral distress	**Increased administrative/leadership support** (e.g., having leadership that understands the work and who connect with staff; leaders that listen and follow up on issues)
	Increased education (e.g., on dementia care)
	Peer support (e.g., venting with other staff; sharing humour)
	More resources for care (e.g., more manageable resident assignments and case loads; more staff)
	Attention to self-care (e.g., laughter, exercise, positive thinking)

Five themes emerged from thematic analysis around those things that may ease moral distress: more resources for care, increased leadership support and followup, increased opportunities for peer support, increased training/education for staff around dementia care, and attention to physical self-care.

Resources for care

This theme was broadly represented in the data, with numerous variations on these words:

> … because they try to get by with as little people to do the job as they can. You just have to bite the bullet and pay to have more people. Because sometimes not enough staffing is, it's so bad … and it's hard. It's so emotionally taxing, and physically taxing to take care … they just really need to make sure that they have appropriate amount of staff … my number one for sure. (HCA participant)

Further, participants were clear that they counted on their leaders to have their fingers on the pulse of what was going on in the workplace, understand the work and keep their eye on things by "more closely monitoring their people, and people in their facilities and if they need better staffing." (LPN participant)

Leadership support

The support of leadership was perceived when care leaders in positions of power took the time to connect with, and listen to the concerns of staff:

> Not all managers are accessible. Or you know, willing … there's a power thing. But if you connect at the right time with the right person, the right manager, the right powers that be, you feel better. Because at least you are sharing ideas or you are suggesting well, why don't we try this? Or could we try this? … because then it kind of pumps you up again, and you think "okay, we could do something here." (RN participant)

This was perceived as supportive even if the leader could not address the concern raised:

> I'll go and talk to my boss even if she doesn't do anything about it. At least I got it off my chest … I'm not worrying about it every day. She knows about it. She has to deal with it, because it's not my job … (LPN participant)

Staff also reported that it reduced their moral distress when managers stepped in to assist with resident care, as noted by an LPN participant:

> [it helps to have a manager helping with …] each different floor … [taking] a certain number of residents … deal with all their needs so that you're not dealing with almost a whole facility worth of residents. So kind of dividing things up a little more to make it easier to make sure everybody has what they need …

Peer support

The power of connecting in positive ways with co-workers was another resonant theme in the data. The opportunity to share feelings, experiences, ideas and sometimes a laugh were described as powerful ways to reduce moral distress:

> One of the best things about our office is we're a great group of nurses. So I think that that helps us sometimes, because we do like vent, and talk to each other and there's a lot of support there from co-workers. We do support each other and so that's really nice and I do appreciate that a lot. (RN participant)

> … we sit around the table and sometimes we vent. Sometimes we throw around ideas, sometimes we throw out there certain issues that are going on. Just kind of getting it out … talking about it with your peers that are there. They witness it, they see it. (LPN participant)

> I think that my coworkers really help for sure … and there's always kind of a lightheartedness and goofiness about the coworkers … Everyone that I've worked with in this setting, is kind of a little bit quirky or has like a weird sense of humor and … you just need to bring kind of a lightheartedness … (HCA participant)

Education

This theme emerged particularly in relation to the work of HCAs, who perform the bulk of direct care in RCFs, and have the least education. In particular, the notion was shared that HCAs were being placed in situations for which they were not well prepared, as was the belief that more "hands on" training was needed:

> And I think that more hands on … practicum type settings … those would be a lot better … I just think that a lot of people don't really get

> trained for what they are coming in for. Like when people are coming out of the college and just finishing their HCA program they really have no idea what the actual job is like. I feel like there is a really big disconnect between the books and the real job. (HCA participant)

> … maybe some more training [is needed for HCAs] on how to deal with the residents that are a little more aggressive … someone needs to talk to them and ask them what their reasons are for not wanting to help these residents and work with them to show them that the care does need to be done and how to go about it properly, and that sort of thing. (LPN participant)

Self-care

Finally, although less widespread in the data, a theme emerged related to the value of self-care strategies in mitigating moral distress.

> I run a lot on my own at home. So that's probably like my meditation time where I'll probably be a bit wound up until I go home and take the dogs out for a run. Come home, have a shower, and I'll be ready for tomorrow again. (LPN participant)

> I go to the weight room and really that's how I deal with things. Sometimes I just go and lift weights. And that's a pretty good release for me. Or running … exercise I find is the best release. (HCA participant)

Quantitative data: Phase two

From the survey data in phase two, we discovered the strategies that were reported to have the greatest impact on moral distress for participants. Strategies to reduce moral distress by a large or extremely large amount, as suggested by over half of the sample, are summarized in Table 5. Of particular note, the top three strategies selected by more than three-quarters of the participants were: "Having enough staff to provide good care for residents" (87.9% of participants); "Sharing laughter and humour with colleagues" (82.4%) and "Having a manager who will listen to my concerns, look into them and get back to me with possible solutions" (78.2%).

Table 5. Strategies to reduce moral distress

Strategy	% "Large amount"	% "Extremely large amount"	% Total
Having enough staff to provide good care for residents	22.2	65.7	87.9
Sharing laughter and humour with colleagues	32.8	49.6	82.4
Having a manager who will listen to my concerns, look into them, and get back to me with possible solutions	34.4	43.8	78.2
More education and training of staff about how to better care for people with dementia	29.6	41.3	70.9
Co-workers that you can talk to and vent to	39.5	29.2	68.7
Better management policies and procedures for reporting and disciplining poor staff performance	28.9	38.5	67.4
A manager that listens to your difficulties and frustrations, even if not able to do anything about them	29.7	22.9	52.6

The experience of moral distress was amplified with increasing proximity to the bedside. Thus, HCAs were most likely to experience frequent and severe moral distress. LPNs experienced moral distress, but not to the same degree as HCAs. RNs experienced the lowest rates of and least severe moral distress, compared to LPNs and HCAs. These differences were statistically significant. For example, "Having to make a resident with dementia wait for care because another resident needs me just as much, at the same time" was a source of high levels of moral distress for HCAs (73.8%, mean = 3.25), to a lesser extent for LPNs (70.0%, mean = 2.82) and to a much lesser extent, RNs (39.4%, mean = 1.89). These differences by role designation were statistically significant ($p < 0.01$).

Discussion

Overwhelmingly, participants in this study told us that not having enough staff to provide what they believed to be good care to residents was a frequent situation, and associated with very high levels of moral distress. This finding has surfaced repeatedly in relation to moral distress and in many different healthcare settings. McAndrew and Garcia (2011) surveyed critical care nurses about their experiences with moral distress and found that circumstances such as inadequate staffing and inadequately prepared/trained staff were associated with moral distress. Cummings (2010) noted that nurses in acute care settings experienced moral distress when they went unheard in decisions around staffing, workflow and patient care structures and processes – noting that these decisions were often made by people without clinical knowledge, who often made ostensibly cost-reducing decisions that actually ended up being a "detriment to the bottom line" (p. 39). The current study informs us that these findings are applicable to residential care settings as well.

Participants in our study also indicated that they felt powerless, with little to no ability to enact change in their work environments that could improve the quality of care. This finding is consistent with those in other healthcare sectors. Cummings (2010) noted that moral distress was an everyday occurrence for many nurses and was caused in many instances by care decisions beyond the nurse's control that caused patient suffering despite the nurse's efforts to advocate for the patient. Edmonson (2015) also discussed the problem of moral distress in acute care environments, and cited the most common causes of moral distress as feeling trapped in providing futile and/ or poor quality care, and feeling unsuccessful in advocacy for patients and families. Edmonson (2015) further cited a gap in the literature related to what he saw as an essential step in addressing the issue of moral distress – developing supportive and responsive leaders who could nurture moral courage in healthcare environments. This gap is an important one that highlights the work needed to be done around enabling a culture of empowerment in the workplace and the role of leadership in creating opportunities for staff to become involved in developing strategies to mitigate moral distress.

The notion that supportive and responsive leadership could provide an effective means by which to mitigate moral distress is strongly supported by our findings.

Participants indicated that having managers listen to concerns and follow up with possible solutions, or simply listen even in the absence of the ability to address the concern, were actions that would help them mitigate feelings of moral distress. This is consistent with the research of McAndrew and Garcia (2011), who found that, in addition to perceived collaborative relationships with other staff and physicians, and having adequate resources to provide good care, moral distress was mitigated when staff felt supported by a visible and responsive leader with high standards. In addition, Lachman (2016) noted that morally resilient nurse leaders influence those they lead and can nurture resilience in specific ways by: creating opportunities for interprofessional dialogue about morally complex cases; formulating policies to support and require staff to share their concerns in such cases; and creating an ethical work environment where leaders model consistency in words and actions that support staff to navigate complex moral issues. Cummings (2010) further noted the importance of nurse leaders listening and acknowledging the causes of moral distress, providing safe outlets for staff to express their feelings and providing opportunities for ethical reflection and input into making positive change in the practice environment.

Finally, as researchers, it is always exciting when a finding emerges that is unexpected or novel. For us, this was the significant proportion of participants (82%) who indicated that "Sharing laughter and humour with colleagues" would be an effective strategy to help mitigate their experience of moral distress. We believe this finding is associated with two factors: care providers' desire to have positive and enjoyable relationships with colleagues and their need to release stress and tension through the therapeutic use of laugher and humour. It is well documented that laughter and humour can provide a safe and effective means by which to reduce the negative effects of stress and improve health and well-being (Lefcourt et al. 2012; Romero et al. 2006). In addition, previous research has also demonstrated that the quality of workplace relationships in LTC facilities has a direct and meaningful influence on care staffs' ability to provide high-quality, individualized care (Caspar and O'Rourke 2008).

There are limitations to this study. For example, we found limitations in the tool as a measurement device, i.e., a high degree of multi-collinearity, particularly in the first scale of the instrument. We assessed this limitation as likely an outcome of constructing the items in the first scale to reflect, as completely as possible, the situations nursing care providers told us caused moral distress. These situations are inherently complex and have overlapping elements, which may limit conclusions that can be drawn "per situation" but accurately capture (in our view) the complex construct of moral distress in this context. Also, this study is descriptive and geographically limited. However, despite these limitations, we believe that the findings provide valuable lessons and contain important practice implications for leaders in the residential care sector.

Conclusion

In our experience, it is an all-too-common mindset that "nothing can be done" about workload and staffing levels in this sector. Perhaps to a degree this is the case in all sectors of care; indeed, perhaps this is also a cause of moral distress in those who are charged with making the resource allocation decisions. However, it appears to us that too often, this care sector is more likely to go unheard in the debates around resource allocation. We speculate that one factor contributing to this situation is the relative lack of status accorded to HCAs – the majority of the residential care workforce. In a sector that cares for some of society's most vulnerable, complex and frail citizens, we believe it must be a priority for leaders, decision-makers and policy makers to listen to the voices of those providing care, and advocate persistently for adequate resources to make it possible for staff to consistently provide good quality care to this growing segment of our population.

The findings of this study also give us confidence in asserting the value of supportive and responsive leadership in confronting and addressing moral distress in the residential care sector. Our findings indicate that leadership focused on creating a culture where all providers of care feel empowered, connected to one another and heard when they have concerns, is a significant part of addressing moral distress, and that this is true regardless of sector, and regardless of status in the care provider hierarchy. We also assert that the development of innovative initiatives aimed at increasing the experience of joy, laughter, connection and teamwork among care team members in residential care facilities may prove to be an additional effective means by which to mitigate the negative effects of moral distress in these settings. Finally, from the perspective of this study, perhaps the most important message is that the voices and perspectives of those providing care need to be consulted and authentically engaged as leaders seek strategies to address the issue of moral distress.

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Longwoods Publishing Corporation

Announcement

It is with great pleasure that Longwoods Publishing Corporation announces that Jason M. Sutherland, Professor, Centre for Health Services and Policy Research, University of British Columbia, has accepted the appointment as Editor-in-Chief of our journal, *Healthcare Policy*.

Prof. Sutherland succeeds Prof. Jennifer Zelmer who has led the journal for more than 10 years, building its reputation and strengthening its readership.

We encourage you to communicate to Prof. Zelmer, President and CEO at The Canadian Foundation for Healthcare Improvement, your thanks and gratitude for her successes with the journal.

Please also join Longwoods in welcoming Jason to the role of Editor-in-Chief. We look forward to his leadership and implementing his renewed vision for the journal.

Thank you,

MATTHEW HART, CEO, LONGWOODS PUBLISHING

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