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The experience of moral distress by chief nurse officers during the COVID-19 pandemic: A descriptive phenomenological study

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Abstract

Aim: The aim of this study is to explore the moral distress experiences of nurse officers during the COVID-19 pandemic.

Background: Moral distress has emerged as a challenge for nurses ad nurse leaders, revealing the need for health professionals and health care managers to examine, understand and deal with moral distress un Nurse leaders.

Methods: It is a descriptive phenomenological study that used content analysis.

Results: Thirteen chief/assistant nurse officers were interviewed, and four themes were identified: being a manager in the pandemic, situations that cause moral distress, effects of moral distress and factors that reduce moral distress.

Conclusion: Faced with various expectations, such as the management of unusual and uncertain processes, and the management of the psychological responses of both employees and themselves, chief nurse officers struggled significantly to maintain their moral integrity and experienced moral distress during the COVID-19 pandemic.

Implications for Nursing Management: Extraordinary situations such as pandemics have factors that led to moral distress for a Chief Nursing Officer (CNO). Health care systems in which nurse managers are excluded from decision-making processes have a traditional hierarchical structure that ignores CNOs professional autonomy, contributing to the development of moral distress. Therefore, CNOs should engage in self-reflection to recognize their own moral distress experiences, examine the existing health system to identify the factors that cause moral distress and take actions to implement changes to eliminate these factors. To cope with moral distress, CNOs should also improve their communication skills, team collaboration skills and the use of scientific knowledge and take responsibility in their managerial role.

KEYWORDS
Covid-19, moral distress, nurse managers, nursing

1 | INTRODUCTION

In addition to causing many psychological, logistical, social and economic problems globally, the coronavirus pandemic has led to interruptions and alterations in health care services because of the increased demand for health care delivery (Fernandez et al., 2020; Ness et al., 2021). Despite the introduction of COVID-19 vaccines and mass vaccinations in many countries, new cases keep occurring with increasing pressure on the health care system, health care professionals and other health care providers (Ulrich et al., 2020; World Health Organization, WHO, 2022). Health care service administrators and chief nurse officers (CNOs) accountable for the management of the delivery of nursing services have assumed tremendous responsibility to solve problems and adjust to changes in health care delivery (Newham & Hewison, 2021).

During the COVID-19 pandemic, the responsibilities of CNOs have become more important than ever regarding workforce planning for nurses, the provision of appropriate physical conditions and adequate equipment, and the maintenance of occupational health and safety, team cooperation and coordination (Poortaghi et al., 2021). Health services in Turkey are carried out by the public and private sectors. However, more than 75% of the health service delivery is undertaken, and 85% of the nurses are employed by public hospitals (Health Statistics Yearbook, 2020). Public hospitals are managed by a chief physician officer and operate under provincial health directorates that operate under the ministry of health. CNOs are responsible for 'planning health care services; ensuring health care provision effectively and efficiently; conducting, supervising, and evaluating health care services, and working in cooperation and harmony with their subordinates and other relevant units'. (Ministry of Health, 2021). CNOs plan the workforce of nurses and other health care staff; manage the supply, tracking and storage of all kinds of drugs, medical consumables, materials, personal protection equipment and devices; and manage sterilization and disinfection processes and infection control measures besides the cleaning, catering services. In addition to these, she/he is obliged to perform other duties assigned by the chief physician officer. Chief nurse officers are appointed by the chief physician officer on a contractual basis for 2 years (Ministry of Health, 2021).

Chief nurse officers, who have already been fulfilling these responsibilities routinely, have been forced to perform the same tasks faster and resolve emerging acute problems more quickly than before and make important decisions during this unfamiliar crisis process of the pandemic, which is full of uncertainties (Zeneli et al., 2020). Moreover, other responsibilities have been introduced such as organizing testing, screening and treatment procedures for COVID-19 in an effective, equal and sensitive way, ensuring the sustainability of services with limited materials and employees, guaranteeing the quality of the service and taking protective measures for the wellbeing of patients and public health (Morley, Sese, et al., 2020).

Changes and developments occurring during the COVID-19 pandemic have brought many ethical issues to attention (Laventhal et al., 2020; Morley, Sese, et al., 2020; Newham & Hewison, 2021). The Covid-19 pandemic has caused difficulties such as fair treatment among health care professionals, fair and equitable provision of resources to patients and the ability of health care professionals to ensure individual well-being and to provide effective and adequate care may have never been intensively and frequently experienced as much as in the COVID-19 pandemic process (Cacchione, 2020; Moyo et al., 2021; Ness et al., 2021). This new process has revealed the need for health workers and health care managers to adapt and has caused a shift in ethical priorities and led to the emergence of conditions that would interfere with the routine actions to be taken in the context of the usual ethical framework (Cacchione, 2020; Gab Allah, 2021; Morley, Grady, et al., 2020; Silverman et al., 2021). Therefore, whether the COVID-19 pandemic caused moral distress for administrators, because of challenges such as an excessive increase in demand for health services and the necessity of maintaining the health services with a lack of intensive care beds, inpatient bed availability even personal protective equipment, medicine, medical equipment and having health workers, or not, has become a critical issue. This is a highly relevant question because moral distress is an experience that has negative effects on both the individual and the institution (Morley, Sese, et al., 2020; Moyo et al., 2021).

Moral distress (MD) was first defined by Jameton in 1984 as 'the distress experienced by a person when, despite knowing the right action to take, it is almost impossible to follow the right course of action due to institutional constraints' (Corley, 2002; Jameton, 2017). Moral distress arises from the individual's inability to act in cases where he or she cannot perform the action that is considered morally and ethically right (Welborn, 2019). Various studies have shown that moral distress negatively affects the health institution, health workers and the individual receiving care (Austin et al., 2003; McCarthy & Gastmans, 2015). The effects of moral distress are seen in three important areas: health care professionals' well-being, quality of care and being able to achieve the aims of the institution. The effects of moral distress on health workers are seen at physical, psychological, social and spiritual levels (Deady & McCarthy, 2010). Moral distress, which causes situations such as stress, burnout (Hamaideh, 2014), job dissatisfaction and the desire to quit (Af Sandeberg et al., 2017; Oh & Gastmans, 2015), leads to a decrease in the quality of care and causes a decrease in the quality of care for both the health workers and the patient as well as harming the institution (Cavaliere et al., 2010; Jameton, 2017). CNOs who are responsible for these three important areas are key persons to be aware of and manage moral distress, not only for themselves but also for their institution and their staff.

Chief Nurse Officers, as decision-makers, face difficulties continuing their practices in a moral framework (Whitehead et al., 2021). Despite the availability of studies examining problems experienced by nurse managers during the COVID-19 pandemic (DiCuccio et al., 2020; Greenberg et al., 2020; Poortaghi et al., 2021), the literature reveals that little work has been done on ethical issues and moral distress, and most of these studies have been done with middle-level nurse managers. (Gab Allah, 2021; Moyo et al., 2021; Whitehead et al., 2021). This study aims to determine the factors that cause moral distress in extraordinary situations, contribute to coping with moral distress and offer suggestions to legislators and executive nurses on

this issue, by exploring the moral distress experiences of Chief Nurse Officers in the context of The Covid 19 Pandemic.

2 | METHOD

2.1 | Design

This is a descriptive phenomenological study with content analysis. This research design allowed researchers to illuminate the experiences of CNOs in moral distress during the Covid-19 pandemic (Lindseth & Norberg, 2004). Phenomenology involves bracketing, in which researchers set aside any preconceptions they may have about the phenomenon. Accordingly, the researchers focused on the experiences of the participants and the common features of these experiences rather than their own thoughts and judgements (Sorsa et al., 2015). This study was reported according to the consolidated criteria for qualitative studies (COREQ) checklist (Tong et al., 2007).

2.2 | Research team and reflexivity

The research team consisted of two academician nurses, who are experts in the field of nursing. Both researchers have training in qualitative research methods and experience in conducting research.

2.3 | Participants

Purposive sampling was used (Polit & Beck, 2021). Purposive sampling is a sampling technique in which the researcher relies on his or her own judgement when choosing members of the population to participate in the study for determining the in-depth experiences. The recommendation that the sample size for qualitative study be between 5 and 25 people was followed (Polit & Beck, 2021). Participants were reached through the national association of executive nurses. The participants who agreed to participate in the study were contacted verbally (by phone) or in writing (email) with the researchers. An appointment was made for the interview on the day and time specified by the participants. Before the interview started, the participants were informed about the research, and their consent was obtained. Inclusion criteria: Potential participants were required to have served as chief/assistant nurse officers during the pandemic, have been working in the current position for at least 1 year and volunteered to participate in the study. Thirteen chief/assistant nurse officers were reached, who were working in 13 different hospitals from six different cities and met the inclusion criteria of the study.

2.4 | Data collection

Data were collected face to face on an online platform in the period between October 2021 and January 2022, using a semi-structured questionnaire (Table 1). After reading the relevant literature, the researchers developed a semi-structured questionnaire, using their knowledge and field experience. During the interviews, the researchers maintained the validity by carefully evaluating the citations of the participants in order to confirm that the questions were understood correctly. In the interviews, in-depth questions such as 'Are you saying that …?' and 'Could you say some more about that?' were asked according to the answers of the participants. Before the interview started, the participants were informed about the research, and their consent was obtained. Data saturation was reached, which means there was no more new relevant information that could be found (Corbin & Strauss, 2015). When there is enough information to reveal data appropriate for the study's aim, the ability to gather additional new information, and further coding is no longer practicable in qualitative investigations, data saturation is attained. After the 11th interview, the researchers realized that there were no new data on repetition and moral distress in the participants' answers. Two additional confirmation interviews were conducted (Polit & Beck, 2021). The interviews were recorded and took 23′ to 44′ (30′ on average).

TABLE 1 Semi-structured questionnaire

1. Could you tell us about yourself?
2. Can you tell us about your main roles and responsibilities in your current position?
3. What were the effects of the pandemic process on you?
4. Can you tell us about the situations that conflict with your personal and professional values while performing your job?
5. Can you tell us about the situations that you faced while performing your job, and the situations, where you experienced difficulties in making a decision or you felt you were in a dilemma?
6. Could you tell us about the issues you would like to add if we did not ask?

2.5 | Data analysis

In the content analysis, a seven-stage phenomenological analysis method developed by Colaizzi was used (Morrow et al., 2015). Recorded interviews were independently coded by the researchers listening repeatedly through the Maxqda (version 18) program.

In Step 1, each recording was listened to at least twice by the researchers for full immersion in the data. In Step 2, each interview was analysed individually, and words, phrases or phrases describing the phenomenon were identified to preserve contextuality and subjectivity. In Step 3, initial codes were generated to interpret the context and reveal meanings. In Step 4, the initial codes were organized into sets of themes. In Step 5, similar meanings and codes were first grouped independently and then grouped together to form themes and sub-themes by the researchers. In Step 6, the researchers made broad definitions of the theme and sub-themes. In Step 7, the researchers reviewed the content and grouping of the themes and sub-themes, and the participant expressions describing the

phenomenon were determined. In the study, 4 themes and 18 sub-themes were identified (Figure 1).

2.6 | Rigour

This study's rigour was achieved by applying the criteria of confirmability, credibility, dependability and transferability strategies recommended by Guba and Lincoln (1989). To ensure confirmability, the researchers discussed emerging categories and themes until a consensus was reached. In addition, the findings obtained from the participants' expression were reported by the researchers without comment. To ensure credibility, participants from 13 different institutions were included in the study. This provided very comprehensive information on the moral distress experiences of chief/assistant nurse officers. To ensure dependability, both researchers took part in the analysis and interpretation of the data. In order to ensure transferability, the characteristics of the participants, purposive sampling method, research method and semi-structured interview form were explained in detail.

3 | RESULTS

The characteristics of participants are presented in Table 2. The mean age was 42.61 ± 5.23 years, the professional experience was 21.38 ± 6.71 years and the experience as a nurse manager was 13.76 ± 5.55 years.

3.1 | Be a manager in the pandemic

This theme is about the effects of the pandemic on CNOs. CNOs had to manage the anxiety of their employees and families as well as their own and their families and ensure employee and patient safety and maintain the continuity of care and quality while keeping up with almost daily changes.

3.1.1 | Fast and continuous changes

Participants were put in a position to solve crises and organize arrangements for emergent issues (setting up temporary units, responding to abrupt demands for manpower planning, etc.) during the pandemic. The assumption of new tasks that were not normally listed in the job definition such as entering daily data about cases or supplying and tracking the distribution of personal protective equipment resulted in increased workload, requiring CNOs to be available and work outside of working hours.

> We have lived through a period of unknowns. Treatment and the use of personal protective equipment kept changing. We had to define new road maps for constantly occurring instant demands. At that time, my family life was not even a matter of discussion, but it was only my work life that mattered. (P-10)

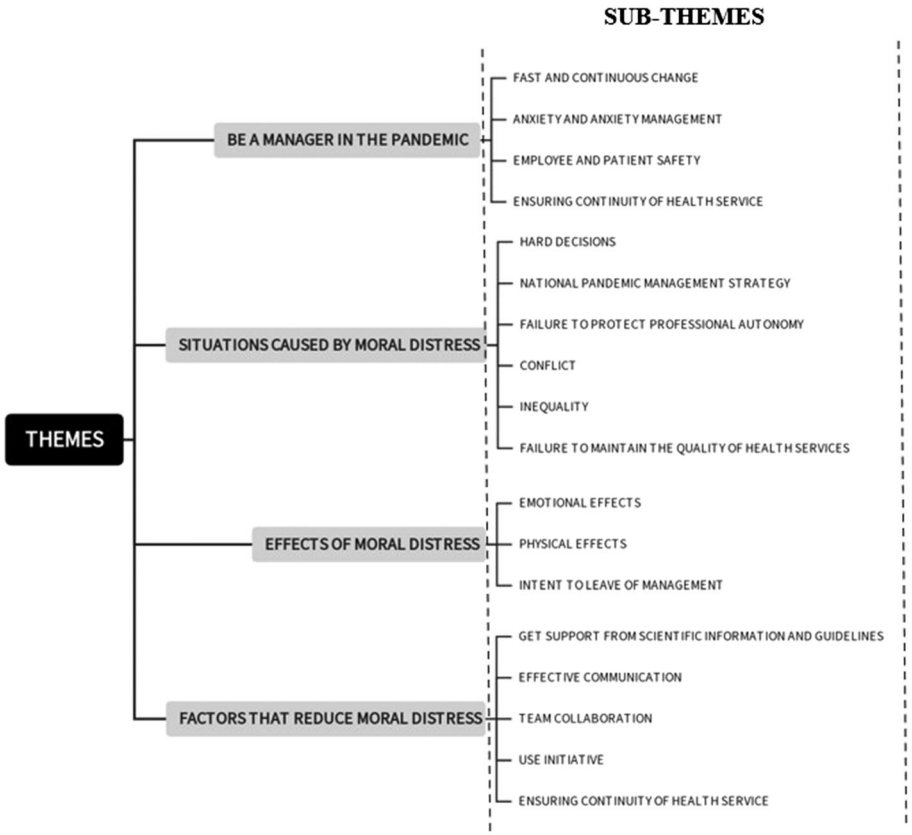

FIGURE 1 Themes and sub-themes

TABLE 2 The characteristics of participants

Participant	Age	Gender	Employment year	Employment year as a nurse executive	Education	Position	Hospital of employment
P-1	40	Woman	21	13	Master's degree	Chief nurse officers	Training and research hospital
P-2	46	Woman	25	18	Bachelor's degree	Chief nurse officers	Private hospital
P-3	36	Woman	13	4	Bachelor's degree	Chief nurse officer assistant	Public hospital
P-4	40	Woman	21	13	Master's degree	Chief nurse officers	University hospital
P-5	42	Woman	25	15	Master's degree	Chief nurse officers	Private hospital
P-6	47	Woman	28	15	Master's degree	Chief nurse officers	University hospital
P-7	49	Woman	30	25	Bachelor's degree	Chief nurse officers	Training and research hospital
P-8	40	Woman	15	9	Master's degree	Chief nurse officer assistant	University hospital
P-9	35	Woman	12	10	Master's degree	Chief nurse officer assistant	Public hospital
P-10	54	Woman	33	20	Master's degree	Chief nurse officers	University hospital
P-11	43	Woman	23	16	Master's degree	Chief nurse officers	Public hospital
P-12	41	Woman	17	14	PhD degree	Chief nurse officer assistant	Public hospital
P-13	41	Woman	15	7	Bachelor's degree	Chief nurse officer assistant	Training and research hospital

3.1.2 | Anxiety and anxiety management

In addition to their concerns about the pandemic, CNOs experienced anxiety in association with their executive roles and had to manage the anxiety of their employees. All participants expressed their worries about whether an employee would be lost due to COVID-19. Stating that they performed follow-up calls with their employees, who were COVID-positive and who were contacts of COVID-positive individuals, CNOs particularly expressed the difficulties in the management of the anxiety in association with uncertainties at the beginning of the pandemic.

> Everyone was trying to avoid looking after patients in COVID clinics. It was necessary to make separate calls with all involved individuals. (P-4)

> Talking to them, allocating more time to them … because their motivation drops considerably in this stressful period …. Their willingness to perform the job diminishes. (P-2)

3.1.3 | Employee and patient safety

Arrangements were made for the supply and tracking of personal protective equipment and employee safety; confined areas were allocated in the clinics as clean and infected areas, the number of nurses per patient was reduced, and the hospitals were reorganized.

> First of all, we ensured the safety of our employees …. We have taken measures to make employees feel safe in every sense …. During this process full of unknowns, we even performed training …. We informed our team after every information we acquired. (P-2)

3.1.4 | Ensuring continuity of health service

CNOs had to respond quickly against acute changes and repeatedly perform nursing workforce planning to ensure the continuity of health care services during the pandemic, and they made decisions on whether to open new clinics. They also had to manage to health care services of these new covid clinics and covid intensive care units and ensure quality and safe health services.

> Suddenly, inpatient clinics became full to capacity; we opened a pandemic-dedicated clinic at three o'clock a.m. We made such decisions with the team …. However, some people criticized these decisions. There were times when dissatisfaction was not limited within the group of nurse colleagues but physicians, other personnel, as well as ourselves, became dissatisfied at times. (P-6)

3.2 | Situations that cause moral distress

This theme includes the factors that emerged in the pandemic conditions and expressed as causes of moral distress (MD) by CNOs. Team conflicts arising or deepening due to pandemic conditions, inability to provide equality among nurses and other health workers, inability to guarantee the quality and continuity of care, unsatisfactory national health policies and ignoring of professional autonomy of CNOs lead to MD.

3.2.1 | Hard decisions

CNOs had to make many decisions that posed moral challenges to them. The leading decisions that challenged fairness included the process of selection of nurses to be assigned to dedicated COVID-19 clinics or to be assigned to other hospitals or contact tracing teams; the allocation of administrative leaves; and deciding whether employees with chronic diseases would work during the peaks of the pandemic.

> During this period, I had to attract employees to COVID clinics to work, those saying that they had an old mother or a child at home, who could stay nowhere else. Otherwise, I would not be able to comply with the principle of equality. Honestly, I went through ethical dilemmas during this period. I communicated with COVID clinics in writing but (crying) … though I did not want to reveal my situation as a manager. (P-10)

3.2.2 | National pandemic management strategy

Participants experienced moral distress because they worked depending on managers (such as chief physician officer, provincial health directors and other authorities who are responsible for the supply of medical materials, and payment of health care workers), who they often considered unqualified. They observed practices by their managers that they considered inappropriate. They also had moral distress because of the inadequacy and unfairness of national regulations on wages and personal rights of health care workers and nurses.

> Our nurse colleagues were always on time for their shift work … However, some from other occupational groups did not appear at work but they were shown as if they attended … even though we came to work regularly, we were only got paid for our work in the COVID clinic … but the physicians received the full payment although it was only their names that appeared in the clinic. (P-9)

3.2.3 | Failure to protect professional autonomy

Decisions or assignments made by CNOs were sometimes deemed invalid by senior management, or these decisions and assignments were cancelled through personal networking. This situation caused CNOs to feel that they were not empowered with adequate professional autonomy in their current position, resulting in moral distress.

> We made assignments based on merit. Sometimes, some assignments were canceled by the health directorate, by top-level managers, or some staff members left after being assigned by the ministry suddenly. I feel bad because these situations are not good fits to my personality. So, in the middle of the fight, a nurse is leaving and you cannot do anything in this situation, the instruction comes from top-level managers. (P-1)

3.2.4 | Conflict

Participants experienced conflicts with their colleagues, other professionals or managers because of the decisions made and implemented during the pandemic. The most intense conflict situations were experienced in the case of assignments to COVID clinics, other hospitals and contact tracing teams.

> At times, sudden assignments happened. We say that you are going to that hospital tomorrow or you are going to work in the intensive care from now on. Some reacted to this situation … the person comes with his/her child or family members. S/He asks, where will I leave my child, it is so far, how can I go there? (P-1)

3.2.5 | Inequality

Due to political, administrative and institutional factors, CNOs could not achieve the level of equality they aimed for among nurses and between nurses and other health care professionals. CNOs, who could not intervene effectively in these situations, felt powerless.

> Physicians followed the events from a distance much farther during the process… because they did not enter the room of the patient unless they really had to …. Yet, my colleague has to enter the patient's room and have one-on-one contact with the patient for the provision of care, who knows how many times a day. Their sadness became my sadness and my distress …. I agree with them but there is not much I can do. (P-7)

3.2.6 | Failure to maintain the continuity of health services

Participants felt most distressed as the number of nurses became less adequate compared to the pre-pandemic period. This was because nurses became COVID positive or had close contact with COVID positive individuals, had chronic illnesses and were assigned to non-hospital jobs and COVID-infected hospitalized patient numbers increased. This affected the continuity and quality of the health care service provided.

> Unfortunately, we perform quantitative assessments in the process …. They say that this nurse should be put to work at all sites. However, there are colleagues, who are incompetent professionally or who are not ready psychologically …. I'm not sure whether the individuals we assigned were the right people. I had an inner conflict on this issue. (P-13)

3.3 | Effects of moral distress

This theme includes the effects of moral distress on CNOs. Moral distress effects on CNOs were manifest as emotions such as unhappiness, helplessness, hopelessness, powerlessness, being anxious and anger. They also experienced sleep disturbances, palpitations, headaches and other cardiovascular problems due to this stressful experience, resulting in many CNOs wanting to leave their job.

3.3.1 | Emotional effects

When the participants were asked how they felt in the ethical and moral situations they experienced during the pandemic process, they stated that they felt unhappy, helpless, hopeless, powerless, anxious and angry.

> I was deeply unhappy. There are conflicts and problems everywhere. Negativity pours out every day … It has been more intense in my team because it is mostly nurses, who are in contact with the patient. (P-7)

3.3.2 | Physical effects

CNOs experienced sleep disturbances, palpitations, headaches and cardiovascular problems due to the process full of anxiety and stress.

> During this period, I had some sleep problems. I was thinking over and over again that this and that should be fulfilled tomorrow. Besides, I had intense headaches and hypertension. (P-4)

3.3.3 | Intent to leave

Participants wished to resign due to long working hours, excessive workload, conflicts, weakness and inadequacies.

> Sometimes I wondered if I should quit … it is not right to leave people in a difficult situation … I had a hard time. (P-1)

3.4 | Factors that reduce moral distress

Participants believed that approaches such as getting support from scientific information and guidelines, using effective communication, boosting team collaboration and using initiative in their manager role would help to reduce moral distress.

3.4.1 | Get support from scientific information and guidelines

Keeping up with published studies and practices, the guidelines developed by the ministry, international organizations and associations regarding the pandemic have become a considerable source of support in solving the problems encountered during the management of the process.

> We regularly reviewed the websites of professional associations. So, we spent our best efforts to keep up with studies, guidelines, and handbooks of associations, and guidance from the ministry of health, and implemented arrangements. (P-4)

3.4.2 | Effective communication

They resolved the conflicts on assignments and administrative issues to a large extent with the personnel through one-on-one meetings, where they explained the current conditions.

> What I say to my colleagues is just that we may not solve all problems but we can have tea together, get to know each other, and relax. (P-9)

3.4.3 | Team collaboration

The teams and the regular meetings, which were established and held, respectively, by the hospital management during the pandemic, helped reduce the distress levels of participants in making decisions, and having such teams and meetings allowed the participants to be more confident in their decisions.

> Of course, sometimes we were undecided. However, in such cases, the commission is available for consultations. Let us say that a person has some problems, then, we address the issues at a commission meeting. (P-8)

3.4.4 | Use initiative

During the pandemic process, the participants implemented the decisions they thought were right in order to protect the health and well-being of the personnel, instead of strictly implementing the regulations in some of the decisions they made and took initiative as a CNO. The use of initiative helped them to experience less distress in decision-making.

> As for workforce planning, before legal regulations, I did not put employees with lung disease and bronchitis in COVID units. I did not assign breastfeeding or pregnant women too. Some colleagues disagreed about this. I said, these are my decisions, it is my initiative as the CNOs. (P-10)

3.4.5 | Ensuring the continuity of health care

Experiencing the positive result of their decisions, such as ensuring that health services were not disrupted and quality is preserved, helped CNOs deal with moral distress.

> We collaborated with our teammates when we assigned them to a job. We actively performed vaccination jobs, we worked together with our colleagues on the weekends and after work. (P-9)

4 | DISCUSSION

The first theme of the study includes the difficulties that CNOs have experienced under pandemic conditions. CNOs described being a manager in the pandemic as a highly anxious experience. Sudden and unpredictable changes were occurring constantly, which required the need to adapt constantly in order to ensure patients', employees' and their own safety. Furthermore, CNOs assumed the responsibility to manage the anxiety of their staff. The workload of nurse managers increased considerably, and they experienced high levels of anxiety during the pandemic (Middleton et al., 2021). Nurse managers had to manage the psychological responses of their employees as well (Bookey-Bassett et al., 2020; Mollahadi et al., 2021). In the study, manager nurses spent more time in the field managing the anxiety and psychological reactions of employees, organizing daily or weekly staff schedules and attempting to listen to the problems of each of the nurses under their supervision. However, any sources of support nurse managers used to manage their own concerns are not mentioned. Participant statements clearly reveal that CNOs also have difficulties in managing their own distress and need support.

The pandemic is associated with various factors that would cause nurse managers moral distress (Cacchione, 2020; Laventhal et al., 2020; Roshanzadeh et al., 2020). Therefore, the second theme of the study is 'the conditions causing moral distress'. The only study examining the experience of moral distress in a similar sample was conducted before the pandemic and moral distress in nurse managers was associated with lacking psychological safety, feeling powerlessness, maintaining moral integrity, getting strength from networking and having moral residue in this study (Prestia et al., 2017). Uncertainty and abrupt changes that have occurred during the pandemic have created some conditions specific to moral distress. Being responsible for the implementation of national regulations and requirements in the field as brought in by rapidly changing directives, CNOs had to make instant and important decisions (Mollahadi et al., 2021). CNOs have faced challenges in decision making, particularly in the resource allocation and workforce planning. Nurse managers described workforce planning as a challenge (Wu et al., 2020). The annulment of their decisions by higher level managers has damaged their professional autonomy and moral integrity. Moreover, the requirement to maintain the balance between the demands of senior managers and the unmet needs of both the institution and employees has been challenging for CNOs. Failure to maintain professional autonomy and the need to maintain the balance between stakeholders have been reported as sources of moral distress in the literature (Holge-Hazelton et al., 2021; Sarkoohijabalbarezi et al., 2017). Roshanzadeh's study, which examines the ethical decision-making process of executive nurses, in parallel with our study found that holding authority in the decision making is perceived by CNOs as independence and autonomy. A manager's competency in taking decisions independently is reflected in ethical decision-making process (Roshanzadeh et al., 2020).

Another source of moral distress is that CNOs are enforcers of decisions they are not involved in making. Nurses have not been included in pandemic scientific committees of Turkey where national regulations for health care services are developed (Senol Celik et al., 2021). Exclusion from the decision making that they could contribute with their knowledge and experience is among other sources of moral distress (Mollahadi et al., 2021; Whitehead et al., 2021). Although CNOs do not agree with the national regulations regarding nurses' wages and personal rights, they have felt to have to defend these regulations to resolve respective conflicts. CNOs suffer from moral distress because of these issues and perceived inequality among health care professionals. Prestia et al. (2017) found that moral distress was described with issues of salary and compensation for staff, financial constraints by CNOs.

Study data revealed that CNOs received support from scientific sources during their efforts for coping with moral distress. It is known that the scientific competencies and communication skills of a nurse manager are important to cope with difficulties (Mollahadi

et al., 2021). The importance of the effective communication skills of nurse managers was also pointed out in the study conducted by Lord et al. (2021). Nurses emphasized that the only motivation for them to volunteer to work in COVID units was the effective communication of their managers (Lord et al., 2021). CNOs also stated that team collaboration was an important factor in coping with moral distress. Gab Allah (2021) found that nurse managers experienced a lower level of distress when they felt institutional support. In particular, working in collaboration with senior management makes CNOs feel stronger. Prestia et al. (2017) found that when CNOs not felt the support of the senior managers, they do not feel psychologically safe, felt powerless and have difficulties maintaining their moral integrity during efforts to fulfil demands from the senior management.

5 | CONCLUSION

Extraordinary situations are extremely challenging for CNOs, who are in a key position in maintaining the quality of health care services. Facing several expectations such as the management of an unfamiliar and uncertain process and the management of the psychological responses of both employees and themselves, CNOs may have difficulties in maintaining their moral integrity and may experience moral distress. Based on the lessons learned from the COVID-19 pandemic, team conflicts arising or deepening due to pandemic conditions, inability to provide equality among nurses and other health workers, inability to guarantee the quality and continuity of care, national health policies that deepen or fail to eliminate these negativities and ignoring of professional autonomy of CNOs were determined as factors leading to MD in the study. CNOs who suffer several emotional and psychical symptoms because of moral distress intend to leave their manager position. It is suggested that CNOs should be included in decision making processes, their professional autonomy should be respected and they should be supported for improving their communication and conflict resolution skills.

5.1 | Implications for nursing management

Although partially overlooked in the literature, CNOs experience moral distress. Especially, extraordinary situations such as pandemics have several factors that led to moral distress. Health care systems, where CNOs are excluded from decision making processes, where a traditional hierarchical structure is established and where their professional autonomy is interfered with. Although factors leading to moral distress mostly seem to be associated with pandemic-specific conditions and systems, some characteristics of CNOs are effective in coping with moral distress. Such characteristics may include coping skills, communication skills, team collaboration skills, the use of scientific knowledge and taking initiative.

5.2 | Limitations

Because the literature with CNOs in the field is very limited, the findings of the study discussed in the light of studies including middle-level nurse managers as well.

ACKNOWLEDGEMENTS

We would like to thank our manager nurses who participated in the study.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest. They also declare that they agree with the content of this manuscript.

ETHICS STATEMENT

This study was conducted according to the Declaration of Helsinki. Ethical approval from the University's Ethics Committee (GO21/1079) and written permission from the nursing manager association and verbal consent from participants was obtained.

AUTHOR CONTRIBUTIONS

Azize Atli Özbaş was responsible for conceptualization, formal analysis, methodology, writing – review and editing, software, and writing – original draft. Mustafa Sabri Kovancı was responsible for conceptualization, data curation, formal analysis, methodology, writing – review and editing, software, and writing – original draft.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to privacy or ethical restrictions.

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