

2017 EDITION

CODE OF **Ethics**

FOR REGISTERED NURSES



CANADIAN
NURSES
ASSOCIATION®

cna-aiic.ca/ethics

CNA is the national professional voice of over 139,000 registered nurses and nurse practitioners across Canada. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.

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2017 Highlights

This edition of the *Code of Ethics for Registered Nurses* contains new and updated content that reflects the contemporary practice needs of registered nurses and nurses licensed in extended roles, such as nurse practitioners. Examples include:

- New content addressing medical assistance in dying
- Updated terminology and definitions such as:
 - advance care planning
 - equity
 - primary health care
 - job action
 - medical assistance in dying
 - workplace bullying
- Updated ethics models including Oberle and Raffin Bouchal
- New content on advocating for quality work environments that support the delivery of safe, compassionate, competent and ethical care
- Updated references

History of the Canadian Nurses Association Code of Ethics

1954

CNA adopts the International Council of Nurses code as its first code of ethics

1980

CNA adopts its own code, called *CNA Code of Ethics: An Ethical Basis for Nursing in Canada*

1985

CNA adopts a new code, called *Code of Ethics for Nursing*

1991

Code of Ethics for Nursing revised

1997

Code of Ethics for Registered Nurses adopted as the updated code of CNA

2002

Code of Ethics for Registered Nurses revised

2008

Code of Ethics for Registered Nurses revised

2017

Code of Ethics for Registered Nurses revised

CNA ethics resources — please visit cna-aiic.ca/ethics

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Purpose of the Code

The Canadian Nurses Association (CNA) Code of Ethics for Registered Nurses (herein called the Code) is a statement of the ethical values of nurses and of nurses' commitments to persons with health-care needs and persons receiving care. The *Code* is both aspirational and regulatory. It is an aspirational document designed to inform everyone about the ethical **values**¹ and subsequent responsibilities and endeavours of **nurses**.² It is also a regulatory tool. Nursing in Canada is a self-regulating profession; thus, nurses are bound to a code of **ethics** as part of a regulatory process that serves and protects the public.

The *Code* provides guidance for ethical relationships, behaviours and decision-making and is used in conjunction with professional standards, best practice, research, laws and regulations that guide practice. It provides guidance for nurses working through ethical challenges that arise in practice with **persons receiving care** and with **colleagues** in nursing and other fields of health-care provision.

The *Code* is intended for nurses in all contexts and domains of nursing practice (clinical practice, education, administration, research and policy; CNA, 2015c) and at all levels of decision-making. It is not based on a particular philosophy or ethical theory but arises from different schools of thought, including relational ethics, an ethic of care, principle-based ethics, feminist ethics, virtue ethics and values. The *Code* is developed by nurses for nurses, and it has a practical orientation supported by theoretical **diversity**. It is a means for self-evaluation, feedback and peer review and is a basis for advocacy. The *Code* also serves as an ethical basis from which nurses can **advocate** for **quality practice environments** that support the delivery of safe, **compassionate**, competent and ethical care.

The societal context in which nurses work is constantly changing and can be a significant influence on their practice. The *Code* is revised periodically to ensure that it is attuned to the needs of nurses by reflecting changes in social values and conditions that affect the public, nurses and other **health-care providers**, and the health-care system. Periodic revisions also promote lively dialogue and debate and create greater awareness of and engagement with ethical issues among nurses in Canada. The *Code* may interest and be useful to all health-care providers.

¹ Words or phrases in bold print are found in the glossary. They are shown in bold only on first appearance.

² In this document, the terms *nurse* and *registered nurse* include registered nurses and/or nurses who are registered or licensed in extended roles, such as nurse practitioners.

Foundation of the Code

Nursing ethics is concerned with how broad societal issues affect health and well-being. This means that nurses endeavour to maintain an awareness of aspects of **social justice** that affect the **social determinants of health** and **well-being** and to advocate for improvements. Although these elements are not part of nurses' regulated responsibilities, they are part of ethical practice and are important educational and motivational tools for all nurses.



The *Code* is organized into two parts:

Part I. Nursing Values and Ethical Responsibilities — describes the ethical responsibilities central to ethical nursing practice articulated through seven primary values and responsibility statements. These statements are grounded in nurses' professional relationships with persons receiving care as well as with students, nursing colleagues and other health-care providers. The seven primary values are:

- A. Providing safe, compassionate, competent and ethical care
- B. Promoting **health** and well-being
- C. Promoting and respecting informed decision-making
- D. Honouring dignity
- E. Maintaining **privacy** and **confidentiality**
- F. Promoting **justice**
- G. Being accountable

Part II. Ethical Endeavours Related to Broad Societal Issues — describes activities nurses can undertake to address social inequities. Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being.

Using the Code in Nursing Practice

The seven primary values are related and overlapping. It is important for all nurses to work toward adhering to the values in the *Code* at all times for persons receiving care — regardless of attributes such as age, race, gender, gender identity, gender expression, sexual orientation, disability, and others — in order to uphold the dignity of all. Nurses recognize the unique history of — and the impact of the social determinants of health on — the Indigenous Peoples of Canada. In health-care practice, values may be in conflict. Such value conflicts need to be considered carefully in relation to each practice situation. When such conflicts occur, or when nurses think through an ethical situation, many find it helpful to use an **ethics model** for guidance in ethical reflection, questioning and decision-making (see Appendix A).

Nurses’ self-reflection and dialogue with other nurses and health-care providers are essential components of ethical nursing practice.

While nursing practice involves both legal and ethical dimensions, the law and ethics remain distinct. Ideally, a system of law would be compatible with the values in the *Code*. However, there may be situations in which nurses **collaborate** with others to change a policy that is incompatible with ethical practice. When this occurs, the *Code* can guide and support nurses in advocating for changes to law, policy or practice. It can be a powerful political instrument for nurses when they are concerned about being able to practise ethically.

Nurses are responsible for the ethics of their practice. Given the complexity of ethical situations, the *Code* can only outline nurses’ ethical responsibilities and guide them in their reflection and decision-making. It cannot ensure ethical practice. For ethical practice, other elements are necessary, such as a commitment to do good, a sensitivity and receptiveness to ethical matters, and a willingness to enter into relationships with persons who have health-care needs and other problems. Practice environments have a significant influence on nurses’ ability to be successful in upholding the ethics of their practice. Nurses’ **self-reflection** and dialogue with other nurses and health-care providers are essential components of ethical nursing practice.

Quality Practice Environments

Nurses and employers have an obligation to advocate for conditions that support ethical nursing practice, including quality practice environments — for the benefit of persons receiving care and for each other. Such environments have the necessary organizational structures and resources to promote safety, support and respect for all persons in the practice setting. Other health-care providers, organizations and policy-makers at local regional, provincial/territorial, national and international levels strongly influence ethical practice.

Advocacy

Advocacy refers to the act of supporting or recommending a cause or course of action, undertaken on behalf of persons or issues. It relates to the need to improve systems and societal structures to create greater **equity** and better health for all. Nurses endeavour, individually and collectively, to advocate for and work toward eliminating social inequities.

Nursing ethics encompasses the breadth of issues involved in health-care ethics, but its primary focus is the ethics of practice known as everyday ethics.

Nurses' Self-Reflection and Dialogue

Nurses need to recognize that they are moral agents in providing care. This means that they have a responsibility to conduct themselves ethically in what they do and how they interact with persons receiving care. This includes self-reflection and dialogue. Nurses in all facets of the profession need to reflect on their practice, on the quality of their interactions with others and on the resources they need to maintain their own health and well-being. In particular, there is a pressing need for nurses to work with others (i.e., other nurses, other health-care providers and the public) to create the **moral communities** that enable the provision of safe, compassionate, competent and ethical care.

Nursing ethics encompasses the breadth of issues involved in health-care ethics, but its primary focus is the ethics of practice known as **everyday ethics**. Nurses in all contexts and domains of nursing practice and at all levels of decision-making experience situations involving ethics. The values and responsibility statements in the *Code* are intended to support nurses in working through these experiences within the context of their unique practice situations.

Ethical Types of Experiences and Situations

When nurses can name the type of ethical concern they are experiencing, they are better able to discuss it with colleagues and supervisors, take steps to address it at an early stage, and receive support and guidance in dealing with it. Identifying an ethical concern can often be a defining moment that allows positive outcomes to emerge from difficult experiences. In the *Code*, the terms moral and ethical are used interchangeably based upon consultation with nurse ethicists and philosophers.³ There are a number of terms that can assist nurses in identifying and reflecting on their ethical experiences and discussing them with others:⁴

ethical (or moral) agent. Someone who has the capacity to direct their actions to some ethical end, for example, good outcomes for patients (Storch, Rodney, & Starzomski, 2013). Exercising that capacity would be ethical (or moral) agency.

ethical (or moral) courage. When nurses stand firm on a point of moral principle or a particular decision about something in the face of overwhelming fear or threat to themselves.

ethical (or moral) dilemmas. Arise when there are equally compelling reasons for and against two or more possible courses of action, and where choosing one course of action means that something else is relinquished or let go. An ethical dilemma is a particular type of ethical problem.

ethical (or moral) disengagement. Can occur when nurses normalize the disregard of their ethical commitments. A nurse may then become apathetic or disengaged to the point of being unkind, non-compassionate or even cruel to other health-care providers and persons receiving care.

ethical (or moral) distress. “Arises when nurses are unable to act according to their moral judgment” (Rodney, 2017, s-7). They feel they know the right thing to do, but system structures or personal limitations make it nearly impossible to pursue the right course of action (Jameton, 1984; Webster & Baylis, 2000; Rodney, 2017). Moral distress can lead to negative consequences such as feelings of anger, frustration and guilt, yet it can also be a catalyst for self-reflection, growth and advocacy (Rodney, 2017).

³ CNA acknowledges that not everyone concurs in this usage.

⁴ These situations are derived from CNA, 2004; Fenton, 1988; Jameton, 1984; and Webster & Baylis, 2000.

ethical (or moral) indifference. “Implies a failure to assume the ethical responsibilities of the profession, leaving one in a passive state that calls into question the moral **integrity** of the [nurse] as well as imperiling the obligation to protect the vulnerable patient” (Falcó-Pegueroles, Lluch-Canut, Roldan-Merino, Goberna-Tricas, & Guardia-Olmos, 2015, p. 604).

ethical (or moral) problem. A situation where there are conflicts between one or more values and uncertainty about the correct course of action. Ethical problems involve questions about what is right or good to do at individual, interpersonal, organizational and societal levels.

ethical (or moral) residue. What each of us carries with us from times in our lives when, in the face of morally distressing situations, we have been seriously compromised. These instances leave lasting and powerful impressions in our thoughts that persist over time; hence the term moral residue (Webster & Baylis, 2000).

ethical (or moral) resilience. The capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress or setbacks (Rushton, 2016).

ethical (or moral) violations. Involve actions or failures to act that breach fundamental duties to the persons receiving care or to colleagues and other health-care providers.

ethical (or moral) well-being. Congruence between thought and action that results from nurses having the necessary mechanisms and resources in place to optimally resolve ethical conflicts (Falcó-Pegueroles et al., 2015).

Identifying an ethical concern can often be a defining moment that allows positive outcomes to emerge from difficult experiences.

Part I. Nursing Values and Ethical Responsibilities

Nurses in all contexts and domains of practice and at all levels of decision-making bear the ethical responsibilities identified under each of the seven primary nursing values.⁵ These responsibilities apply to nurses' interactions with all persons who have health-care needs or are receiving care as well as with students, colleagues and other health-care providers. The responsibilities are intended to guide nurses in applying the *Code* to their practice. They also serve to articulate nursing values to employers, other health-care providers and the public. Nurses help their colleagues implement the *Code*, and they ensure that nursing students are acquainted with it.

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.
2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.
3. Nurses build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a **conscious** effort. Such relationships are critical to understanding people's needs and concerns.
4. Nurses question, intervene, report and address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care; and they support those who do the same (see Appendix B).
5. Nurses are honest⁶ and take all necessary actions to prevent or minimize **patient safety incidents**. They learn from **near misses** and work with others to reduce the potential for future risks and preventable harms (see Appendix B).

⁵ The value and responsibility statements in the *Code* are numbered and lettered for ease of use, not to indicate prioritization.

⁶ Provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting.

6. Nurses practise “within their own level of competence and seek [appropriate] direction and guidance . . . when aspects of the care required are beyond their individual competence” (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island, & Prince Edward Island Health Sector Council, 2014, p. 3).
7. When resources are not available to provide appropriate or safe care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care informed about potential and actual plans regarding the delivery of care. They inform employers about potential threats to the safety and quality of health care.
8. Nurses planning to take **job action** or practising in environments where job action occurs take steps to safeguard the health and safety of persons receiving care during the course of the job action (see Appendix B).
9. During a natural or human-made disaster, including a communicable disease outbreak, nurses provide care using appropriate safety precautions in accordance with legislation, regulations and guidelines provided by government, regulatory bodies, employers, unions and professional associations (see Appendix B).
10. Nurses support, use and engage in research and other activities that promote safe, competent, compassionate and ethical care, and they use guidelines for ethical research⁷ that are in keeping with nursing values.
11. Nurses who are involved in research respect the well-being of persons receiving care above all other objectives, including the search for knowledge.⁸ They pay attention to the safety of persons receiving care and to **informed consent**, the risk-benefit balance, the privacy and confidentiality of data and the monitoring of research.
12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).
13. Nurses work toward preventing and minimizing all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves (CNA, 2016a; CNA & CFNU, 2015; Canadian Nursing Students’ Association, 2014).

⁷ See *Ethical Research Guidelines for Registered Nurses* (CNA, 2002) and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014).

⁸ *Ibid.*

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14. When differences among members of the health-care team affect care, nurses seek constructive and collaborative approaches to resolving them and commit to conflict resolution and a person-centred approach to care.
 15. Nurses support each other in providing person-centred care.

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.
2. Nurses work with persons receiving care to explore the range of health-care choices available to them, recognizing that some have limited choices because of social, economic, geographic or other factors that lead to inequities (Registered Nurses' Association of Ontario [RNAO], 2011). Nurses recognize the social determinants of health in their assessments, diagnoses, outcomes planning, implementations and evaluations with individuals, families and communities, collaborating with others in and outside of the health sector (CNA, 2013).
3. When a community health intervention interferes with the individual rights of persons, nurses use and advocate for the use of the least restrictive measures possible for those in their care (CNA, 2008).
4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.
5. When the integrity of nurses is compromised by patterns of institutional behaviour or professional practice that erode the ethical environment and the safety of persons receiving care (generating moral distress), nurses express and report their concern individually or collectively to the appropriate authority or committee (American Nurses Association [ANA], 2015).

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical responsibilities:

1. Nurses provide persons receiving care with the information they need to make informed and autonomous decisions related to their health and well-being. They also work to ensure that health information is given to those persons in an open, accurate, understandable and transparent manner.
2. Nurses respect the wishes of **capable** persons receiving care to decline to receive information about their health condition.
3. Nurses ensure that nursing care is provided with the person's informed consent. Nurses recognize and support a capable person's right to refuse or withdraw **consent** for care or treatment at any time (College of Registered Nurses of British Columbia [CRNBC], 2017a). Nurses recognize that capable persons receiving care may place a different weight on individualism and may choose to defer to **family**, cultural expectations or community values in decision-making while complying with the law of consent.
4. Nurses are sensitive to the inherent power differentials between care providers and persons receiving care. They do not misuse that power to influence decision-making.
5. Nurses advocate for persons receiving care if they believe the health of those persons is being compromised by factors beyond their control, including the decision-making of others.
6. Nurses provide education to support the informed decision-making of capable persons. They respect the decisions a person makes, including choice of lifestyles or treatment that are not conducive to good health, and continue to provide care in a non-judgmental manner.

Nurses are sensitive to the inherent power differentials between care providers and persons receiving care. They do not misuse that power to influence decision-making.

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7. When family members disagree with the decisions made by a person receiving care, nurses assist families in gaining an understanding of the person's decisions.
 8. If a person receiving care is clearly **incapable** of consent, the nurse respects the law on capacity assessment and substitute decision-making in the nurse's jurisdiction (Canadian Nurses Protective Society [CNPS], 2009).
 9. For any person that is considered incapable of consenting to care, nurses promote that person's participation in discussions and decisions regarding their care in a manner that is adapted to the person's capabilities.
 10. Nurses, along with other health-care providers and **substitute decision-makers**, consider and respect the best interests of the person receiving care and any previously known wishes or **advance care planning** that applies in the situation (CNPS, 2009).

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.
2. Nurses support persons receiving care in maintaining their dignity and integrity.
3. In health-care decision-making, in treatment and in care, nurses work with persons receiving care to take into account their values, customs and spiritual beliefs, as well as their social and economic circumstances without judgment or bias.
4. Nurses intervene, and report when necessary,⁹ when others fail to respect the dignity of a person they are caring for or a colleague (including students), recognizing that to be silent and passive is to condone the behaviour. They speak up, facilitate conversation and adjudicate disputes, as appropriate/required.
5. Nurses respect the privacy of persons receiving care by providing care in a discreet manner and by minimizing intrusions.
6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

⁹ See footnote 6.

7. Nurses maintain appropriate professional **boundaries** and ensure their relationships are always for the benefit of the person. They recognize the potential vulnerability of persons receiving care and do not exploit their trust and dependency in a way that might compromise the **therapeutic relationship**. They do not abuse their relationship for personal or financial gain and do not enter into personal relationships (romantic, sexual or other) with persons receiving care.
8. In all practice settings where nurses are present, they work to relieve pain and suffering, including appropriate and effective symptom management, to allow persons receiving care to live and die with dignity.
9. Nurses encourage persons receiving care at the end of their life to be clear about what they want. They listen to a person's stories to gain greater clarity about their goals and wishes.
10. Nurses document a person's wishes regarding end-of-life care in order to make their wishes and decisions clear and known to other caregivers (College of Registered Nurses of Manitoba [CRNM], College of Licensed Practical Nurses of Manitoba [CLPNM], & College of Registered Psychiatric Nurses of Manitoba [CRPNM], 2016; College of Registered Nurses of Nova Scotia [CRNNS] & College of Licensed Practical Nurses of Nova Scotia [CLPNNS], 2016).
11. When a person receiving care is terminally ill or dying, nurses foster comfort, alleviate suffering, advocate for adequate relief of discomfort and pain, and assist people in meeting their goals of culturally and spiritually appropriate care. This includes providing a palliative approach to care for the people they interact with across the lifespan and the continuum of care, support for the family during and following the death, and care of the person's body after death.
12. Nurses understand the law so as to consider how they will respond to **medical assistance in dying** and their particular beliefs and values about such assistance. If they believe they would conscientiously object to being involved with persons receiving care who have requested such assistance, they discuss this with their supervisors in advance (see Appendix B; Canada, Parliament, 2016; College of Nurses of Ontario [CNO], 2017b; CRNM et al., 2016; CNA, 2015a).
13. Nurses treat each other, colleagues, students and other health-care providers in a respectful manner, recognizing the power differentials among formal leaders, colleagues and students. They work with others to honour dignity and resolve differences in a constructive way.
14. Nurses foster a moral community in which ethical values and challenges can be openly discussed and supported.

E. Maintaining Privacy and Confidentiality

Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

Ethical responsibilities:

1. Nurses respect the interests of persons receiving care in the lawful collection, use, access and disclosure of personal information.
2. When nurses are conversing with persons receiving care, they take reasonable measures to prevent confidential information in the conversation from being overheard.
3. Nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with privacy laws.
4. When nurses are required to disclose information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm to the persons receiving care or colleagues.
5. When nurses engage in any form of communication, including verbal or electronic, involving a discussion of clinical cases, they ensure that their discussion of persons receiving care is respectful and does not identify those persons unless necessary and appropriate (CNA, 2012).
6. Nurses advocate for persons receiving care to have access to their own health-care records through a timely and affordable process when such access is requested.
7. Nurses respect policies that protect and preserve the privacy of persons receiving care, including security safeguards in information technology.
8. Nurses do not abuse their access to information by accessing health-care records, including those of a family member or any other person, for purposes inconsistent with their professional obligations. When using photo, video or other technology for assessment, diagnosis, planning, implementation and evaluation of persons receiving care, nurses obtain their consent and do not intrude into their privacy. They handle photos or videos with care to maintain the confidentiality of the persons involved, including colleagues and students.

9. Nurses intervene if others inappropriately access or disclose the personal or health information of persons who are receiving or have previously received care.
10. In the use of **social media**, nurses safeguard the privacy and confidentiality of persons and other colleagues (CNA, 2012).
11. In all areas of practice, nurses safeguard the impact new and emerging technologies can have on patient privacy and confidentiality, **professional boundaries**, and the professional image of individual nurses and the organizations in which they work (CNA, 2012). They are also sensitive to ethical conduct in their use of electronic records, ensuring accurate data entry and avoiding the falsification or alteration of documentation.

F. Promoting Justice

Nurses uphold principles of justice by safeguarding **human rights**, equity and **fairness** and by promoting the **public good**.

Ethical responsibilities:

1. Nurses do not discriminate on the basis of a person's race, ethnicity, **culture**, political and spiritual beliefs, social or marital status, gender, gender identity, gender expression, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability, socio-economic status, or any other attribute.
2. Nurses respect the special history and interests of Indigenous Peoples as articulated in the Truth and Reconciliation Commission of Canada's (TRC) *Calls to Action* (2012).
3. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other.
4. Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours if observed or if reasonable grounds exist to suspect their occurrence.
5. Nurses provide care for all persons including those seen as victims and/or abusers and refrain from any form of **workplace bullying** (CNA, 2016a).
6. Nurses make fair decisions about the allocation of resources under their control based on the needs of persons receiving care. They advocate for fair treatment and fair distribution of resources.

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7. Nurses advocate for evidence-informed decision-making in their practice including, for example, evidence for best practices in staffing and assignment, best care for particular health conditions and best approaches to **health promotion**.
 8. Nurses work collaboratively to develop a moral community. As part of this community, all nurses acknowledge their responsibility to contribute to positive and healthy practice environments. Nurses support a climate of trust that sponsors openness, encourages the act of questioning the status quo and supports those who speak out in good faith to address concerns (e.g., **whistle-blowing**). Nurses protect whistle-blowers who have provided reasonable grounds for their concerns.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice.
2. Nurses are honest and practise with integrity in all of their professional interactions. Nurses represent themselves clearly with respect to name, title and role.
3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.
4. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

5. Nurses maintain their **fitness to practise**. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer. If they are self-employed, they arrange for someone else to attend to their clients' health-care needs. Nurses then take the necessary steps to regain their fitness to practise, in consultation with appropriate professional resources.
6. Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform their duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care (see Appendix B).
7. If nursing care is requested that is in conflict with the nurse's moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person's needs or desires. But nothing in the Criminal Code compels an individual to provide or assist in providing medical assistance in dying. If nurses can anticipate a conflict with their conscience, they notify their employers or persons receiving care (if the nurse is self-employed) in advance so alternative arrangements can be made (see Appendix B).
8. Nurses identify and address **conflicts of interest**. They disclose actual or potential conflicts of interest that arise in their professional roles and relationships and resolve them in the interest of the needs and concerns of persons receiving care.
9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, other nurses and other health-care providers (see Appendix B).
10. Nurses advocate for more comprehensive and **equitable** mental health care services across age groups, socio-cultural backgrounds and geographic regions.

Part II. Ethical Endeavours Related to Broad Societal Issues

Ethical nursing practice addresses broad aspects of social justice that are associated with health and well-being. These aspects are focused on improving systems and societal structures to create greater equity for all. Individually and collectively, nurses keep abreast of current issues and concerns and are strong advocates for fair policies and practices. They can do so by:

1. Advocating for publicly administered health systems that ensure accessibility, universality, portability and comprehensiveness in necessary health-care services.
2. Utilizing the principles of primary health care for the benefit of the public and persons receiving care.
3. Recognizing and working to address organizational, social, economic and political factors that influence health and well-being within the context of nurses' roles in the delivery of care.
4. Advocating for a full continuum of accessible health-care services at the right time, in the right place, by the right provider. This continuum includes health promotion, disease prevention and diagnostic, restorative, rehabilitative and palliative care services in hospitals, nursing homes, home care and the community.
5. Recognizing the significance of social determinants of health and advocating for policies and programs that address them (e.g., safe housing, supervised consumption sites).
6. Maintaining an awareness of major health concerns, such as poverty, inadequate shelter, food insecurity and violence, while working for social justice (individually and with others) and advocating for laws, policies and procedures that bring about equity.
7. Working with people and advocating for expanding the range of available health-care choices.
8. Collaborating with other health-care team members and professional organizations to advocate for changes to unethical health and social policies, legislation and regulations.

9. Recognizing that **vulnerable groups** in society are systemically disadvantaged (which leads to diminished health and well-being), and advocating to improve their quality of life while taking action to overcome barriers to health care.
10. Promoting the participation of persons considered incapable in consenting to care in the health-related discussions and decisions that affect them (e.g., minors, persons with impaired mental function).
11. Calling on all levels of government to acknowledge the current state of Indigenous health in Canada and to implement health-care rights and take actions with Indigenous people to improve their health services (TRC, 2015).
12. Supporting environmental preservation and restoration while advocating for initiatives that reduce environmentally harmful practices in order to promote health and well-being.
13. Advocating for the discussion of ethical issues among health-care team members, persons receiving care and students, encouraging ethical reflection and working to develop their own and others' awareness of ethics in practice.
14. Maintaining awareness of broader **global health** concerns, such as violations of human rights, war, world hunger, gender inequities and environmental changes, and working and advocating (individually and with others) to bring about change locally and globally.
15. Advocating for excellence in palliative and end-of-life care and for palliative care options that are available to all — at home, in long-term care, acute care and hospice care.
16. Becoming well-informed about laws (e.g., safe contraception, medical assistance in dying) and advocating for and working with others to create policies and processes that provide ethical guidance to all nurses.

Glossary

The glossary is intended to provide nurses with a common language for their reflections, discussions and actions related to nursing ethics. While not necessarily providing formal definitions, the glossary presents information in a manner and language that is meant to be helpful and accessible.

Advance care planning: an ongoing process of reflection, communication and documentation regarding a person's values and wishes for future health and personal care in the event they become incapable of consenting to or refusing treatment or other care. Conversations to inform health-care providers, family and friends — and especially a substitute decision-maker — are regularly reviewed and updated. Such conversations often clarify their wishes for future care and options for their end of life. Attention must also be paid to provincial/territorial legal and health guidelines (CNA, Canadian Hospice Palliative Care Association [CHPCA], & Canadian Hospice Palliative Care Nurses Group [CHPC-NG], 2015).

Advocate: actively supporting a right and good cause; supporting others in speaking for themselves or speaking on behalf of those who cannot speak for themselves.

Boundaries: a boundary in the nurse-person relationship is the point at which the relationship changes from professional and therapeutic to unprofessional and personal (College and Association of Registered Nurses of Alberta [CARN], 2011; see *professional boundaries*).

Bullying: (see *workplace bullying*)

Capable: being able to understand and appreciate the consequences of various options and make informed decisions about one's own life, care and treatment.

Collaborate: to build consensus and work together on common goals, processes and outcomes (RNAO, 2006).

Colleagues: all health-care providers and nurses working in all domains of practice.

Compassionate: the ability to recognize and be aware of the suffering and vulnerability of another, coupled with a commitment to respond with competence, knowledge and skill.

Competency: the integrated knowledge, skills, judgment and attributes required of a nurse to practise safely and ethically in a designated role and setting. (Attributes include, but are not limited to, attitudes, values and beliefs.)

Confidentiality: the ethical obligation to keep someone’s personal and private information secret or private (Fry & Johnstone, 2008).

Conflicts of interest: occur when the nurse either makes or is in a position to make a decision based upon what is good for the nurse’s own best interests, not the best interest of others who might be affected (Oberle & Raffin Bouchel, 2009; CNO, 2017a).

Conscientious objection: a situation in which a nurse informs their employer about a conflict of conscience and the need to refrain from providing care because a practice or procedure conflicts with the nurse’s moral beliefs (CRNBC, 2017b).

Conscious: the state of being aware of and attaching importance to a behaviour or action.

Consent: the voluntary agreement to some act or purpose made by a capable individual. Criteria for consent include the person or substitute decision-maker being adequately informed and being capable of giving (or refusing) consent without coercion, fraud or misrepresentation (CRNBC, 2017a).

Culture: “the learned values, beliefs, norms and way of life that influence an individual’s thinking, decisions and actions in certain ways” (CNO, 2009a, p. 3).

Diversity: the variation between people in terms of a range of factors such as ethnicity, national origin, race, gender, gender identify, gender expression, ability, age, physical characteristics, religion, values, beliefs, sexual orientation, socio-economic class or life experiences (RNAO, 2007).

Duty to provide care: nurses have a professional duty and a legal obligation to provide persons receiving care with safe, competent, compassionate and ethical care. There may be some circumstances in which it is acceptable for a nurse to withdraw from care provisions or to refuse to provide care (see Appendix B; CRNBC, 2017b; CRNNS, 2014).

Equitable: determining fairness on the basis of people’s needs. This means that those who are less fortunate would receive more resources than those who are well off.

Equity: in health care, the fulfillment of each individual’s needs as well as the individual’s opportunity to reach full potential as a human being. Health equity occurs when everyone has an opportunity to reach their full potential, and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances (CNA, 2013).

Ethical work environment: an environment with the potential to promote moral integrity and moral agency (Fry, Veatch, & Taylor, 2011).

Ethics: a branch of philosophy that deals with questions of right and wrong and of ought and ought not in our interactions with others.

Ethics model: a scheme showing areas for reflection on an individual’s practice and providing steps in ethical decision-making. Normally, this model includes critical questions to consider in reflecting on or in dealing with an ethical situation.

Everyday ethics: how nurses pay attention to ethics in carrying out their common daily interactions, including how they approach their practice and reflect on their ethical commitments to persons receiving care or with health-care needs.

Fairness: equalizing people’s opportunities to participate in and enjoy life, given their circumstances (Caplan, Light, & Daniels, 1999), and society’s equitable distribution of resources (in health care this means an expectation of equitable treatment).

Family/families: in matters of caregiving, family is recognized as those people identified by the person receiving or in need of care who provide familial support, whether or not there is a biologic relationship. However, in matters of legal decision-making it must be noted that provincial legislation is not uniform across Canada and may include an obligation to recognize family members in priority according to their biologic relationship (CNA, 1994).

Fitness to practise: all the qualities and capabilities of an individual relevant to their practice as a nurse, including but not limited to freedom from any cognitive, physical, psychological or emotional condition and dependence on alcohol or drugs that impairs their ability to practise nursing (CRNBC, 2008; CRNNS, 2017).

Global health: the “optimal well-being of all humans from the individual and the collective perspective.” Health is considered “a fundamental right and should be equally accessible to all” (CNA, 2009a, p. 2).

Health: a state of complete physical, mental (spiritual) and social well-being, not merely the absence of disease (CNA, 2015c; World Health Organization [WHO], 2006).

Health-care providers: all those who are involved in providing care; they may include professionals, personal care attendants, home support workers and others (CNA, 1994).

Health-care team: a number of health-care providers from different disciplines (often including both regulated professionals and unregulated workers) working together to provide care for and with persons, families, groups, communities or populations.

Health promotion: a continuing process of enabling people to increase their control over and improve their health and well-being.

Human rights: the rights of people as expressed in the Canadian Charter of Rights and Freedoms (1982) and the United Nations *Universal Declaration of Human Rights* (1948), and as recorded in the CNA position statement, *Registered Nurses, Health and Human Rights* (2011).

Incapable/incapacity: failing to understand the nature of the treatment decisions to be made, as well as the consequences of consenting to treatment or declining treatment.

Informed consent: the process of giving permission or making choices about care. It is based on both a legal doctrine and an ethical principle of respect for an individual’s right to sufficient information to make decisions about care, treatment and involvement in research. In the *Code* the term *informed decision-making* is primarily used to emphasize the choice involved.

Integrity: adherence to moral norms that is sustained over time. Implicit in integrity is soundness, trustworthiness and the consistency of convictions, actions and emotions (Burkhart, Nathaniel, & Walton, 2015).

Job action: activities undertaken by union members to express disagreement with their employer's or government's policies or laws. Such activities could include going on strike, work slowdowns, work-to-rule, picketing and other protest actions.

Justice: includes respecting the rights of others, distributing resources fairly, and preserving and promoting the common good (the good of the community).

Medical assistance in dying: "(a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death" ("*An Act to Amend the Criminal Code*," s. 241.1[a][b]).

Moral climate: in health care, the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered (Rodney, Hartrick Doane, Storch, & Varcoe, 2006).

Moral community: a workplace where values are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard (adapted from Rodney, Buckley, Street, Serrano, & Martin, 2013). Coherence between publicly professed values and the lived reality is necessary for there to be a genuine moral community (Webster & Baylis, 2000).

Near miss: "a patient safety incident that did not reach the patient" (Incident Analysis Collaborating Parties [IACP], 2012, p. 8).

Nurse(s): in this code, the terms *nurse* and *registered nurse* include registered nurses and/or nurses who are registered or licensed in extended roles, such as nurse practitioners.

Patient safety incident: "an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient." It may be a harmful incident, a no-harm incident or a near miss (IACP, 2012, p. 8).

Persons receiving care: an individual, family, group, community, population or system that accesses the services of the nurse; may also be referred to as a client(s), resident(s) or patient(s).

Primary health care: “a philosophy and approach that is integral to improving the health of all people living in Canada and the effectiveness of health service delivery in all care settings. PHC focuses on the way services are delivered and puts the people who receive those services at the centre of care. [Essential principles include] accessibility; active public participation; health promotion and chronic disease prevention and management; use of appropriate technology and innovation; and intersectoral cooperation and collaboration” (CNA, 2015b, p. 1).

Privacy: (1) physical privacy is the right or interest in controlling or limiting the access of others to oneself; (2) informational privacy is the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared. A person has a reasonable expectation of privacy in the health-care system so that health-care providers who need their information will share it only with those who require specific information.

Professional boundaries: “the spaces between the nurse’s power and the client’s vulnerability. They separate the therapeutic behavior of the nurse from any behavior which well-intentioned or not could lessen the benefit of care to [persons]. Boundary crossings are brief excursions across boundaries that may be inadvertent, thoughtless or even purposeful if done to meet a specific therapeutic need. . . . A boundary violation is an act of abuse in the nurse-person relationship” (CARNA, 2011, pp. 6-8).

Public good: the good of society or the community, often called the common good.

Quality practice environments: practice environments that have the organizational and human support allocations necessary for safe, competent and ethical nursing care (CNA & CFNU 2015).

Self-reflection: the ability to evaluate one’s own thoughts, plans and actions in relation to ethical responsibilities and ethical guidelines.

Social determinants of health: “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices” (WHO, 2017, para. 1).

Social justice: the fair distribution of society's benefits and responsibilities and their consequences. It focuses on the relative position of one social group in relation to others in society as well as on the root causes of disparities and what can be done to eliminate them (CNA, 2009b).

Social media: a group of Internet-based applications and technologies that facilitate the creation and sharing of information, ideas, career interests and other forms of expression via virtual communities and networks. Social media includes social networking, online forums, chat rooms, texting/instant messaging, blogs, wikis, file sharing (video and audio) and virtual worlds (CNA, 2012).

Substitute decision-maker: a capable person with the legal authority to make health-care treatment or withdrawal of treatment decisions on behalf of an incapable person. Each jurisdiction has its own guidelines related to substitute decision-making and instructional directives for treatment and care. Terms also differ across provinces and territories. Nurses need to become familiar with the terms used in their own jurisdictions (CNA, CHPCA et al., 2015; CNA, 2015a).

Therapeutic relationship: a relationship the nurse establishes and maintains with a client, through the use of professional knowledge, skills and attitudes, in order to provide nursing care that is expected to contribute to the client's well-being (CARNA, 2011).

Unregulated care providers: paid providers who are neither licensed nor registered by a regulatory body (CRNBC, 2017c).

Values: "a rational conception of the desirable; a standard or quality that is esteemed, desired, and considered important. Values are expressed by behaviors or standards that a person endorses or tries to maintain. Values are typically organized into a hierarchic system of importance to the individual" (Fry, Veatch, & Taylor, 2011, p. 485).

Violence: includes any abuse of power, manipulation or control by one person over another that could result in mental, emotional, social or physical harm. Two descriptors of types of violence are interpersonal violence and structural violence. The former is a matter of person-to-person or person-group violence, while the latter is about systematic ways that social structures, organizations and institutions harm or marginalize people (CNA, 2016a).

Vulnerable groups: groups in society who are systematically disadvantaged in a way that leads to a risk of emotional or physical harm; in health care, harms are related to diminished health and well-being (Oberle & Raffin Bouchal, 2009).

Well-being: a person's state of being well, content and able to make the most of their abilities.

Whistle-blowing: reporting the unethical or unsafe practice of a nursing colleague or other health-care professional for such things as errors, incompetence, negligence or patient abuse (Oberle & Raffin Bouchal, 2009). This action would be resorted to only after a person has unsuccessfully used all appropriate organizational channels to right a wrong and has a sound moral justification for taking this action (Burkhardt, Nathaniel, & Walton, 2015).

Workplace bullying: includes behaviours such as verbal abuse or threats of harm, continual criticism, demeaning remarks, intimidation and undermining, as well as more subtle behaviours such as refusing to cooperate, being unavailable to give assistance, hampering another's performance and making their work difficult. Workplace bullying is the term now used for what was previously described as horizontal or lateral violence, which placed responsibility only on individuals and excluded the responsibility of organizations (CNA, 2016a).

Appendix A. Ethical Models

An Ethical Model for Reflection: Questions to Consider

The *Code* points to the need for nurses to engage in ethical reflection and discussion. Frameworks or models can help people order their approach to an ethical problem or concern, and they can be a useful tool to guide nurses in their thinking about a particular issue or question.

When it is appropriate, colleagues in nursing and other disciplines, ethics committees, ethicists, professional nurses associations and colleges of nurses and other experts will be included in discussions of ethical problems. Legislation, standards of practice, policies and guidelines of nurses' unions and professional associations and colleges may also be useful in ethical reflection and decision-making.

Ethical reflection (which begins with a review of one's own ethics and judgment) is required to determine how a particular value or responsibility applies in a particular nursing context. There is room within the profession for disagreement among nurses about the relative weight of different ethical values and principles. More than one proposed intervention may be ethical and reflective of good ethical practice. Discussion and questioning are extremely helpful in the resolution of ethical problems and issues.

Ethical models can facilitate discussion among team members by opening up a moral space for everyone to participate in the conversation about ethics. There are many models for ethical reflection and for ethical decision-making in the health-care ethics literature, and some of these are noted in this section. The model provided here¹⁰ was selected because it promotes reflection, offers a nursing model for considering ethics issues in practice and is applicable to all types of ethical situations.

¹⁰This model is adapted from Oberle and Raffin Bouchal (2009).

Oberle and Raffin Model

Questions for Ethical Reflection

1. Assessing the ethics of the situation, relationships, goals, beliefs and values

- What relationships are inherent in the situation?
- Who is significant in this care situation, and how could they be involved?
- Are my relationships with others in this care situation supportive and nurturing?
- What are the goals of care in this situation?
- Are these goals shared by the person in care, the nurse and others?
- What are my beliefs and values?
- What values in the *Code* are inherent in this situation?
- What values are important for others in the situation, including other health-care providers?
- Do the individuals involved in the situation have different values? Do the differences create conflict?

2. Reflecting on and reviewing potential actions: Recognizing available choices and how these choices are valued

- What expectation does the person/family/community have for care? What actions do the person/family/community think will do the most good? Have I helped this person/family/community become clear about what they value and the actions they think will be taken?
- What action(s) do I think will do the most good? What do other health-care providers think?
- What action(s) will cause the least amount of value conflict and/or moral distress? What are the potential consequences of the actions? How will key persons be affected?
- What values does society view as important in this situation? What are societal expectations of care?
- What economic and political factors play a role in the person's care? What actions are possible given the existing resources and constraints?

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- What legislation applies to this situation in terms of my obligations, the institution's obligations and the obligations of other health-care providers? Are there legal implications for different actions?

3. Selecting an ethical action: Maximizing the good

- What do I believe is the best action?
- Can I support the patient's/family's/community's choice? The choice of other care providers? If not, what actions do I need to take?
- Are there constraints that might prevent me from taking ethical action?
- Do I have the kind of virtues required to take ethical action? Do I have the necessary knowledge and skill?
- Do I have the moral courage to carry out the action I believe is best? Will I be supported in my decision?

4. Engaging in ethical action

- Am I acting according to the *Code*?
- Am I practising the way a reasonably prudent nurse would practise in this situation?
- Am I acting with care and compassion in my relationships with others in this situation?
- Am I meeting professional and institutional expectations in this action?

5. Reflecting on and reviewing this ethical action

- Did I report it through the appropriate channels?
- Were the outcomes of this action acceptable?
- Was the process of decision-making and action acceptable? Did all involved feel respected and valued?
- How was the person/family/community affected? How were the care providers affected?
- Were harms minimized and was good maximized?
- What did I do well?
- What might have been done differently?

Other Models and Guides for Ethical Reflection and Decision-Making: Resources and Applications

Several other models for ethical reflection and decision-making are in common use. Nurses find that some models are helpful in particular areas of practice (e.g., in acute care practice, long-term care, public health) and that some models are more meaningful to them than others.

Many models include the four principles of biomedical ethics — respect for autonomy, beneficence, non-maleficence and justice — which some nurses find practical because these models may bridge biomedical and nursing ethics in acute care. Some nurses prefer a model that offers a diagram rather than text; for example diagram models by Bergum and Storch (CARNA, 2010). Others prefer a more philosophically based model, such as that offered by Yeo, Moorhouse, Khan and Rodney (2010).

A few key sources are listed below.

CNA's Learning Modules: Bringing the Code of Ethics to Life¹¹ provides a convenient way to become familiar with the values and responsibilities at the heart of ethical nursing practice and how to apply them in everyday working scenarios. There are eight learning modules: one for each of the seven primary values of the *Code*, plus an additional module on social justice.

- Providing safe, compassionate, competent and ethical care
- Promoting health and well-being
- Promoting and respecting informed decision-making
- Honouring dignity
- Maintaining privacy and confidentiality
- Promoting justice
- Being accountable
- Social justice

¹¹ See cna-aiic.ca/ethics

Framework for Ethical Decision-Making (developed by Michael McDonald with additions provided by Patricia Rodney and Rosalie Starzomski in 2001) provides detailed questions to consider in ethical decision-making. This framework uses ethical principles to develop questions similar to those in Oberle and Raffin Bouchal (2009), but the principles may give deeper meaning to the nature of the questions.

Concepts and Cases in Nursing Ethics (first developed in 1996 by M. Yeo and A. Moorhouse) provides a way to think through ethical problems using three types of analysis (descriptive, conceptual and normative; see Yeo et al., 2010).

Using ethical resources to evaluate alternatives: Principles/concepts

- **Autonomy:** What does the person want? How well has the person been informed and/or supported? What explicit or implicit promises have been made to the person?
- **Non-maleficence:** Will this harm the person? Others?
- **Beneficence:** Will this benefit the person? Others?
- **Justice:** Consider the interests of all those involved who have to be taken into account (including the person). Are biases about the person or family affecting your decision-making? Treat like decisions alike.
- **Fidelity:** Are you fostering trust in the person/family/team relationships?
- **Care:** Will the person and family be supported as they deal with loss, grief and uncertainty? What about any moral distress of team members? What principles of the palliative care approach can be incorporated into the alternatives?
- **Relational autonomy:** What relationships and structures are affecting the various individuals involved in the situation? How can these relationships and social structures be used to enable support of the person, family members and health-care providers?

Appendix B. Applying the Code in Selected Circumstances

Responding Ethically to Incompetent, Non-Compassionate, Unsafe or Unethical Care

Nurses question, intervene, report and address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care; and they support those who do the same. (A4)

Nurses are honest and take all necessary actions to prevent or minimize patient safety incidents. They learn from near misses and work with others to reduce the potential for future risks and preventable harms. (A5)

Nurses intervene, and report when necessary,¹² when others fail to respect the dignity of a person they are caring for or a colleague (including students), recognizing that to be silent and passive is to condone the behaviour. They speak up, facilitate conversation and adjudicate disputes, as appropriate/required. (D4)

Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice. (G1)

Nurses are attentive to signs that a colleague is unable, for whatever reason, to perform their duties. In such a case, nurses will take the necessary steps to protect the safety of persons receiving care. (G6)

If a nurse encounters a situation where harm is underway or there is a clear risk of imminent harm, the nurse takes immediate steps to protect the safety and dignity of the persons receiving care. Some examples of appropriate immediate steps in cases of actual or imminent harm could include, but are not limited to, speaking up if a potential error in drug calculations is detected, questioning an unclear order, intervening to prevent unsafe restraint practices, protecting patients when a colleague's performance appears to be impaired for any reason (see CRNNS, 2017) or intervening in a serious breach of confidentiality involving people with sexually transmitted infections. Nurses are aware of provincial and territorial legislation and nursing practice standards that may include direction regarding disclosure and reporting and provide further clarity on whether there is a clear risk of imminent harm.

¹² See footnote 6.

When nurses encounter situations where harm is not imminent but there is potential for harm, they work to resolve the problem as directly as possible in ways that are consistent with the good of all parties. As they work through these situations, nurses review relevant statements in the *Code* and other relevant standards, legislation, ethical guidelines, policies and procedures for reporting incidents or suspected incompetent or unethical care, including any legally reportable offence, to management.

Additional actions for nurses to consider, if they do not contravene requirements under professional standards or provincial or territorial legislation, include:

- Maintain a high level of confidentiality about the situation and actions at all times.
- Review all information available about the current situation. Separate personal from professional issues. Concentrate on the situation at hand.
- Where appropriate and feasible, seek information directly from the colleague(s) whose behaviour or practice has raised concerns.
- Pay attention to the moral distress nurses are experiencing in trying to find an ethical course of action. Consider the risks of not taking action to persons receiving care, colleagues, self, and the organization and reflect on the potential harms and breaches in trust that could result if no action is taken. Nurses also consider the consequences that may occur for them and for others in taking various courses of action.
- If possible, speak with an impartial and trusted colleague outside the situation who can preserve appropriate confidential information and help validate or rule out the conclusions being drawn.
- Seek information from relevant authorities (e.g., supervisor or manager) on expected roles and responsibilities for all of the parties who share responsibility for maintaining safe, competent, compassionate and ethical care.
- Consult, as appropriate, with colleagues, other members of the team, professional nursing associations or colleges, unions or others who are able to assist in addressing and resolving the problem.

- Advise the appropriate parties regarding unresolved concerns and, when feasible, inform the colleague(s) in question of the reasons for your action. Know what immediate help is available to your colleague(s) and be ready to help the colleague(s) find these resources.
- Nurses who engage in responsible reporting of incompetent, unsafe or unethical care are supported by their colleagues, professional association and/or professional college.

Ethical Considerations in Addressing Expectations That Are in Conflict with One’s Conscience

Nurses may not abandon those in need of nursing care. However, nurses may sometimes be opposed to certain procedures and practices in health care and find it difficult to willingly participate in providing care that others have judged to be morally acceptable. Such situations include, but are not limited to, blood transfusions, abortion, suicide attempts, refusal of treatment and medical assistance in dying. The nurse’s right to follow their conscience in such situations is recognized in the *Code’s* provision for **conscientious objection**.

If nurses can anticipate a conflict with their conscience, they notify their employers or persons receiving care (if the nurse is self-employed) in advance so alternative arrangements can be made.

If nursing care is requested that is in conflict with the nurse’s moral beliefs and values but in keeping with professional practice, the nurse provides safe, compassionate, competent and ethical care until alternative care arrangements are in place to meet the person’s needs or desires. But nothing in the Criminal Code compels an individual to provide or assist in providing medical assistance in dying. If nurses can anticipate a conflict with their conscience, they notify their employers or persons receiving care (if the nurse is self-employed) in advance so alternative arrangements can be made. (G7)

Specifically, with respect to medical assistance in dying, nurses consult CNA’s *National Nursing Framework on Medical Assistance in Dying in Canada* (2016b). This framework includes details about the changes in Canadian law (the Criminal Code of Canada), which now permits medical assistance in dying, and detailed guidance for nurses.

Steps in Declaring a Conflict with Conscience¹³

1. Before employment

Nurses have a moral responsibility to advise their prospective employers if they are conscientiously opposed to certain practices and procedures that are likely to occur in their prospective workplace, particularly if the expression of conflict of conscience “would significantly interfere with the provision of services offered by the employing agency” (RCNA, 2000, p. 1). Similarly, employers advise prospective employees about services provided by the organization that may be sensitive for some employees.

2. Anticipating and planning to declare a conflict with conscience

Ideally, the nurse would be able to anticipate practices and procedures that would create a conflict with their conscience (beliefs and values) in advance. In this case, the nurse discusses with supervisors, employers or persons receiving care (if the nurse is self-employed) what types of care the nurse finds contrary to their own beliefs and values (e.g., caring for individuals having an abortion, male circumcision, blood transfusion, organ transplantation, medical assistance in dying) and requests that their objections be accommodated, unless it is an emergency situation.

3. Finding oneself caught in providing care that is in conflict with one’s conscience

When one finds oneself involved in nursing care that creates a conflict with conscience, the nurse notifies the supervisor, employer or persons receiving care (if self-employed). Declaring a conflict with conscience (or conscientious objection) and requesting accommodation is a serious matter that is not to be taken lightly. The nurse remains until another nurse or health-care provider is able to provide appropriate care to meet the person’s needs.

¹³ (ANA, 2006; Royal College of Nursing, Australia [RCNA], 2000)

Key guidelines for declaring a conflict with conscience include the following:

- Nurses who decide not to take part in providing care on the grounds of moral objection communicate their desires in appropriate ways.
- Whenever possible such refusal is made known in advance and in time for alternative arrangements to be made for persons receiving care.
- Moral objections by the nurse are motivated by moral concerns and an informed, reflective choice and are not based on prejudice, fear or convenience.
- When a moral objection is made, the nurse provides for the safety of the person receiving care until there is assurance that other sources of nursing care are available. In the specific case of medical assistance in dying, nurse practitioners who object to participation may have a professional duty to make an effective referral.
- Employers and co-workers are responsible for ensuring that nurses and other co-workers who declare a conflict of conscience receive fair treatment and do not experience discrimination (RCNA, 2000).
- Nurses need to be aware that declaring a conflict of conscience may not protect them against formal or informal penalty.

Ethical Considerations for Nurses in a Natural or Human-Made Disaster, Communicable Disease Outbreak or Pandemic

Historically and currently, nurses provide care to those in need, even when providing care puts their own health and life at risk (for example, when they work in war-torn areas, places of poverty, places with poor sanitation, etc.). Nurses also encounter personal risk when providing care for those with a known or unknown communicable or infectious disease. However, disasters and communicable disease outbreaks call for extraordinary effort from all health-care personnel, including nurses. The *Code* states:

During a natural or human-made disaster, including a communicable disease outbreak, nurses provide care using appropriate safety precautions in accordance with legislation, regulations and guidelines provided by government, regulatory bodies, employers, unions and professional associations. (A9)

A **duty to provide care** refers to a nurse's professional obligation to provide persons receiving care with safe, competent, compassionate and ethical care. However, there may be some circumstances in which it is acceptable for a nurse to withdraw from providing care or to refuse to provide care (CRNBC, 2017b; CRNNS, 2014). *Unreasonable burden* is a concept raised in relation to the duty to provide care and withdrawing from or refusing to provide care. An unreasonable burden may exist when a nurse's ability to provide safe care and meet professional standards of practice is compromised by unreasonable expectations, lack of resources or ongoing threats to personal and family well-being (CRNBC, 2017b).

The following criteria could be useful for nurses to consider when contemplating providing care in a disaster or communicable disease outbreak:

- the significance of the risk to the person in care if the nurse does not assist;
- whether the nurse’s intervention is directly relevant to preventing harm;
- whether the nurse’s care will probably prevent harm; and
- whether the benefit of the nurse’s intervention outweighs harms the nurse might incur and does not present more than an acceptable risk to the nurse (ANA, 2006).

When demands on the health-care system are excessive, material resources may be in short supply and nurses and other health-care providers may be at risk. Nurses have a right to receive truthful and complete information so they can fulfil their duty to provide care. They have a clear understanding about the obligations and expectations around their role. They must also be supported in meeting their own health needs. Nurses’ employers have a reciprocal duty to protect and support them as well as to provide necessary and sufficient protective equipment and supplies that will “maximally minimize risk” to nurses and other health-care providers. At the same time, nurses use their professional judgment to select and use the appropriate prevention measures; select, in collaboration with the health-care team, the appropriate agency, manufacturer and government guidelines concerning use and fit of personal protective equipment; and advocate for a change when agency, manufacturer or government guidelines do not meet the infection control requirements regarding appropriate use and fit of personal protective equipment (CNO, 2009b).

Nurses carefully consider their professional role, their duty to provide care and other competing obligations to their own health, to family and to friends

Nurses carefully consider their professional role, their duty to provide care and other competing obligations to their own health, to family and to friends. In doing so, they understand the steps they might take both in advance of and during an emergency or pandemic situation so that they are prepared for making ethical decisions (CNA, 2008; Thompson, Faith, Gibson, & Upshur, 2006). Value and responsibility statements in the *Code* support nurses’ reflection and actions.

A. In anticipation of the need for nursing care in a disaster or disease outbreak, nurses:

- work together with nurse colleagues, unions and joint occupational health and safety committees, and others in positions of leadership to develop emergency response practice guidelines using available resources and guidelines from governments, professional associations and regulatory bodies;
- learn about and provide input into the guidelines the region, province or country has established regarding which persons are to receive priority in care (e.g., priority based on greatest need, priority based on the probability of a good outcome, etc.);
- learn how support will be provided for those providing care and carrying the physical and moral burden of care;
- request and receive regular updates about appropriate safety measures nurses might take to protect and prevent themselves from becoming the victim of a disaster or disease;
- assist in developing a fair way to settle conflicts or disputes regarding work exemptions or exemptions from the prophylaxis or vaccination of health-care providers; and
- help develop ways in which appeals or complaints can be handled within the occupational health and safety framework.

B. When in the midst of a disaster or disease outbreak, nurses:

- refer to regulations and guidelines provided by government, regulatory bodies, employers and professional associations;
- help make the fairest decisions possible about the allocation of resources;
- help set priorities in as transparent a manner as possible;
- provide safe, compassionate, competent and ethical care (in disasters, as much as circumstances permit);
- help determine if, when and how nurses may have to decline or withdraw from care; and
- advocate for the least restrictive measures possible when a person's individual rights must be restricted.

Ethical Considerations in Relationships with Nursing Students

Nurses in all roles share the responsibility of supporting nursing students in providing safe, competent, compassionate and ethical care. Several statements in the *Code* include specific references to student nurses and their relationships with others in providing nursing care:

Nurses treat each other, colleagues, students and other health-care providers in a respectful manner, recognizing the power differentials among formal leaders, colleagues and students. They work with others to honour dignity and resolve differences in a constructive way. (D13)

Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, other nurses and other health-care providers. (G9)

On the basis of these statements in the *Code*, the following guidelines are suggested:

- All teacher-nursing student interactions are to be in keeping with ethical nursing practice.
- All nurses and nursing students treat each other with respect and honesty.
- All nurses endeavour to provide nursing students with appropriate guidance for the development of nursing competence.
- The primary responsibility for the assignment and care of the person remains that of the primary nurse to whom the person has been assigned.
- Persons receiving care are informed of the nursing student's status as a learner. Ideally, the preceptor would advise persons in care about the nursing student's status and seek permission for that student to provide care. When the preceptor is not able to speak to all of the nursing student's assigned persons, the student informs the person and requests permission to provide care. The person's right to refuse care or assistance provided by a nursing student is to be treated with respect.
- Nursing faculty, preceptors and nursing students "place the safety and well-being of the [persons in care] above all other objectives, including fulfilling educational obligations" (CNO, 2017c, p. 3).

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- Nursing faculty and their administrators honour the ethical imperative on the well-being of the persons in care, which supersedes the responsibility of providing the student with learning opportunities.
 - Nursing students are expected to meet the standards of care for their level of learning. They advise their faculty clinical instructor and their clinical unit nurse supervisors if they do not believe they are able to meet this expectation.

If nursing students experience difficulties with disrespectful actions from a nurse(s) in practice that they are not able to overcome through conversation with the nurse(s) involved, they discuss these incidents with their faculty clinical instructor and, failing helpful outcomes from that discussion within an appropriate period, they enlist the assistance of the appropriate nursing education administrator in their nursing program.

Acting Ethically in Situations That Involve Job Action

Job action by nurses is often directed toward securing conditions of employment that enable the safe and ethical care of persons receiving care, now or in the future. However, action directed toward such improvements could hinder persons receiving care in the short term. Nurses advocate for their involvement in workplace planning for the safety of those receiving care before and during job action. Members of the public are also entitled to information about the steps taken to ensure the safety of persons during any job action.

Nurses planning to take job action or practising in environments where job action occurs take steps to safeguard the health and safety of persons receiving care during the course of the job action. (A8)

On the basis of this statement in the *Code*, the following guidelines are suggested:

- Each nurse is accountable for decisions made about their practice at all times in all circumstances, including during a legal or an illegal strike (Nurses Association of New Brunswick [NANB], 2004).
- Individual nurses and groups of nurses safeguard persons receiving care when planning and implementing any job action.
- Individuals and groups of nurses participating in or affected by job action share the ethical commitment to the safety of persons in their care. Their particular responsibilities may lead them to express this commitment in different but equally appropriate ways.
- Persons receiving care whose safety requires ongoing or emergency nursing care are entitled to have those needs satisfied throughout any job action.
- During job action, if nurses have any concern about their ability to maintain practice and ethical standards or their ability to ensure the safety of persons in their care, they are responsible for communicating this concern in accordance with identified lines of accountability so that corrective action can be taken as quickly as possible (NANB, 2004).

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