Code of Ethics for Registered Nurses and Licensed Practical Nurses

Canadian Nurses Association

www.cna-aiic.ca
Preamble

The Canadian Nurses Association’s Code of Ethics for Registered Nurses and Licensed Practical Nurses (herein called the Code) is a statement of the ethical values of nurses and of nurses’ commitments to persons with whom the nurse has developed a therapeutic relationship. It is intended for nurses in all contexts and domains of nursing practice and at all levels of decision-making. It is developed by nurses for nurses. It provides ethical guidance for nurses working through ethical challenges that arise in their practice with individuals, families, communities and with colleagues in nursing and other fields of health care provision. For licensed practical nurses (or registered practical nurses in Ontario) and for registered nurses and nurse practitioners these commitments are to persons as per their regulatory standards.

The societal context in which nurses work is constantly changing and can be a significant influence on their practice. The Code is revised periodically (see Appendix A) to ensure that it is attuned to the needs of nurses by responding to 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 create greater awareness of and engagement with ethical issues among nurses in Canada.

Purpose of the Code

The Code serves as a foundation for nurses’ ethical practice. The values and ethical responsibilities expected of registered nurses practicing in Canada are set out in part I. Endeavours that nurses should undertake to advocate for social inequities as part of ethical practice are outlined in part II.

The Code provides guidance for ethical relationships, behaviours and decision-making, and it is to be used in conjunction with the professional standards, laws and regulations that guide practice.

Further, this Code serves as a means for self-evaluation and self-reflection for ethical nursing practice and provides a basis for feedback and peer review. The Code also serves as an ethical

In this document, the terms nurse includes licensed practical nurses (registered practical nurses in Ontario), nurses who are registered nurses, and or nurses who are registered or licensed in extended roles, such as nurse practitioners.

2 In this document, the terms moral and ethical are used interchangeably based upon consultation with nurse ethicists and philosophers. We acknowledge that not everyone concurs in this usage.

3 In this document, nursing practice refers to all areas of nursing practice, including direct care (which includes community and public health), education, administration, research and policy development.

4 Words or phrases in bold print are found in the glossary. They are shown in bold only on first appearance.
basis from which nurses can advocate for quality work environments that support the delivery of safe, compassionate, competent and ethical care.

The Code is used by many nursing regulatory bodies in Canada to define ethical nursing standards. Nurses recognize the privilege of being part of a self-regulating profession and have a responsibility to merit this privilege. The Code informs other health-care professionals as well as members of the public, scientific bodies, and governments about the ethical commitments of nurses and the responsibilities nurses accept as being part of a self-regulating profession.5

Foundation of the Code

Ethical nursing practice involves ethical responsibilities that nurses are expected to uphold on the basis of their professional values. Nurses are accountable for these ethical responsibilities in their professional relationships with persons, families, communities with whom the nurse has developed a therapeutic relationship as well as with students and colleagues.

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

5 For licensed practical nurses (or registered practical nurses in Ontario) these commitments are to individuals, families and groups; for registered nurses and nurse practitioners these commitments are to individuals, families and groups and extend to communities and populations.
The Code is organized in two parts:

Part I: Part I, “Nursing Values and Ethical Responsibilities,” describes the ethical responsibilities central to ethical nursing practice. These ethical responsibilities are articulated through seven primary values and accompanying responsibility statements, which are grounded in nurses’ professional relationships with individuals, families, groups, communities, and populations as well as with students, nursing colleagues and other health-care providers. The seven primary values are:

1. Providing safe, compassionate, competent and ethical care
2. Promoting health and well-being
3. Promoting and respecting informed decision-making
4. Preserving dignity
5. Maintaining privacy and confidentiality
6. Promoting justice
7. Being accountable

Part II: Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being. Part II, “Ethical Endeavours,” describes endeavours that nurses can undertake to address social inequities.
Using the Code in Nursing Practice

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--regardless of attributes such as age, race, gender, sexual orientation, disability, or others--in order to uphold the dignity of all. In health-care practice, values may be in conflict. Such value conflicts need to be considered carefully in relation to the practice situation. When such conflicts occur, or when nurses need to 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 C).

Nursing practice involves both legal and ethical dimensions. Still, the law and ethics remain distinct. Ideally, a system of law would be completely compatible with the values in this Code. However, there may be situations in which nurses need to collaborate with others to change 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. The Code 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 nurses 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; sensitivity and receptiveness to ethical matters; and a willingness to enter into relationships with persons that have health-care needs and 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. The importance of nurses’ work environment, advocacy and reflective practice is highlighted below.

Quality Work Environments
Nurses and employers have an obligation to persons, and to each other, to advocate for and contribute to quality practice environments. Such environments have the organizational structures and resources necessary to promote safety, support and respect for all persons in the practice setting. Other health-care providers, organizations and policy-makers at regional, provincial/territorial, national and international levels strongly influence ethical practice.

Advocacy
While advocating for quality practice environments is important, many other matters can be advocated for including ethical nursing practice and social determinants associated with health and well-being. Advocacy is the act of supporting or recommending a cause or course of action, undertaken on behalf of persons on behalf of issues. These other forms of advocacy relate to the need to improve systems and societal structures to create greater equity for all. Nurses should endeavour, individually and collectively to advocate for and work toward eliminating social inequities (see Appendix C).

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. 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 professionals, managers, administrators, 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, and a primary focus is the ethics of the everyday practice. How nurses attend to ethics in carrying out their daily interactions, including how they approach their practice and reflect on their ethical commitment to the people they serve, is the substance of **everyday ethics**.

In their practice, nurses 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. Nurses are challenged in meeting these responsibilities and should embrace the wisdom of nurse colleagues, health professional ethicists, ethics committees and formal nurse leaders to support them in maintaining ethical practice.
Types of Ethical 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. There are a number of terms that can assist nurses in identifying and reflecting on their ethical experiences and discussing them with others: 6

**Ethical (or moral) agent/agency** is the capacity or power of a nurse to direct their motives and actions to some ethical end; essentially, doing what is good and right.

**Ethical (or moral) uncertainty** occurs when a nurse feels indecision or a lack of clarity, or is unable to even know what the moral problem is, while at the same time feeling uneasy or uncomfortable.

**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. True dilemmas are infrequent in health care. More often, there are complex ethical problems with multiple courses of actions from which to choose.

**Moral (or ethical) distress** is what nurses’ experience when they seriously compromise themselves or allow themselves to be compromised as a moral agent when practising in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural contexts of the workplace environment (Pauly, Varcoe, & Storch, 2012). Recent research suggests that moral distress is a form of relational trauma (Musto, Rodney, & Vanderheide, 2015).

**Moral (or ethical) residue** is what nurses experience when they seriously compromise themselves or allow themselves to be compromised. The moral residue that nurses carry forward from these kinds of situations can help them reflect on what they would do differently in similar situations in the future (Webster & Baylis, 2000).

**Moral (or ethical) disengagement** can occur if nurses begin to see the disregard of their ethical commitments as normal. A nurse may then become apathetic or disengage to the point of being unkind, non-compassionate or even cruel to other health-care workers, students, and to persons’ needs and concerns.

**Moral indifference** implies a failure to assume the ethical responsibilities of the profession, leaving one in a passive state that calls into question the integrity of the [nurse] as well as

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6 These situations are derived from CNA, 2004b; Fenton, 1988; Jameton, 1984; and Webster & Baylis, 2000.
imperiling the obligation to protect the vulnerable patient (Falcó-Pegueroles, Lluch-Canut, Roldan-Merino, Goberna-Tricas, & Guardia-Olmos, 2015, p. 604).

**Ethical 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) courage** is exercised when a nurse stands firm on a point of moral principle or a particular decision about something in the face of overwhelming fear or threat to himself or herself.

**Ethical (or moral) well-being** is a state associated with very low levels of exposure to ethical conflict explained by experiencing a congruence between thought and action, that is, the [nurse] identifies a situation as being ethically conflictive while having mechanisms and resources at their disposal to optimally resolve the conflict, thereby experiencing congruence between thought and action (Falcó-Pegueroles et al., 2015).

Moral resilience is the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks (Rushton, 2016).
Part I: Nursing Values and Ethical Responsibilities

Nurses in all domains of practice bear the ethical responsibilities identified under each of the seven primary nursing values. These responsibilities apply to nurses’ interactions with all persons who have needs and concerns as well as with students, colleagues and other health-care professionals. 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 professionals and the public. Nurses help their colleagues implement the Code, and they ensure that student nurses are acquainted with the Code.

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 as well as with families, communities, 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 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 and report to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same.

5. Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They learn from near misses and work with others to reduce the potential for future risks and preventable harms.

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.

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7 The value and responsibility statements in the Code are numbered and lettered for ease of use, not to indicate prioritization. The values are related and overlapping.

8 Provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting.
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, families and communities informed about potential and actual plans to delivery of care. They inform employers about potential threats to safety and quality 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 people during the course of the job action.

9. During a natural or human-made disaster, including a communicable disease outbreak, nurses have a duty to provide care using appropriate safety precautions referring to regulations and guidelines provided by government, regulatory bodies, employers, unions and professional associations.

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 research \(^9\) that are in keeping with nursing values.

11. Nurses respect the well-being of persons and groups above all other objectives, including the search for knowledge. \(^11\) They pay attention to the safety of persons, informed consent, the risk-benefit balance, the confidentiality of data and the monitoring of research.

12. All nurses have a joint responsibility to foster a safe and quality work environment, working towards 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 to protect others and themselves (CNA, 2016; Canadian Nursing Students’ Association [CNSA], 2014).

13. 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-centered approach to care.

14. Nurses support each other, including students, in providing person-centered care.

15. **Formal nurse leaders** have a particular responsibility to provide a safe environment with safe staffing levels that support and facilitate appropriate nurse assignment and delegation. This environment includes policies that protect the nurse from inappropriate assignments or inappropriate delegation of nursing responsibilities, activities or tasks (CNA and CFNU, 2015a; CNA 2009).

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\(^9\) (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island [ARNPEI], Prince Edward Island Health Sector Council, 2014, p. 3)


\(^11\) Ibid.
B. Promoting Health and Well-Being

Nurses work with people 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 people in their care, recognizing and using the values and principles of **primary health care**.

2. Nurses work with people to explore the range of health-care choices available to them, recognizing that some people have limited choices because of social, economic, geographic or other factors that lead to inequities (Registered Nurses’ Association of Ontario [RNAO], 2010). Nurses recognize the social determinants of health in their assessment, provision and evaluation of care, collaborating with others to enhance the person’s well-being (RNAO, 2011).

3. When an epidemic or disaster 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, 2012).

4. Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons 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 behavior or professional practice that erodes the safety of persons, the ethical environment and generates moral distress, nurses have an obligation to express and report their concern individually or collectively to the appropriate authority or committee (ANA, 2015).

6. **Formal nurse leaders** must respond to nurses’ concerns about the ethical work environment and strive to resolve them in a way that preserves nurses’ integrity as well as the quality and safety of care. Nurse leaders must seek to change enduring activities or expectations in the practice setting that are ethically objectionable (CNA and CFNU, 2015a; CNA 2009).

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, to the extent possible, provide persons 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 individuals, families, groups, populations and communities in their care in an open, accurate, understandable, and transparent manner and, whenever possible, in a way that allows adequate time for persons to decide.

2. Nurses respect the wishes of capable persons to decline to receive information about their health condition.

3. Nurses recognize that capable persons may place a different weight on individualism and may choose to defer to family, cultural expectations, or community values in decision-making.

4. 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 Licensed Practical Nurses of British Columbia [CLPNBC], 2015b; College of Registered Nurses of British Columbia [CRNBC], 2013a).

5. Nurses are sensitive to the inherent actual or potential power differentials between care providers and those receiving care. They do not misuse that power to influence decision-making.

6. Nurses advocate for persons if they believe that the health of those persons is being compromised by factors beyond their control, including the decision-making of others.

7. When family members disagree with the decisions made by a person with health-care needs, nurses assist families in gaining an understanding of the person’s decisions.

8. Nurses respect the informed decision-making of capable persons, including choice of lifestyles or treatment not conducive to good health. In such instances nurses, in a non-judgmental manner, nurses provide education about choices that would negatively impact the person’s health.

9. When illness or other factors reduce a person’s capacity for making choices, nurses assist or support that person’s participation in making choices appropriate to their capability. Nurses also seek to determine the wishes of children and youth who have not yet met the age of consent.

10. 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], 2004).

11. Nurses, along with other health-care professionals and with 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, 2004).
D. Preserving Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons with respect.

2. Nurses support persons in maintaining their dignity and integrity.

3. In health-care decision-making, in treatment and in care, nurses work with persons to take into account their unique values, customs and spiritual beliefs, as well as their social and economic circumstances without judgement or bias.

4. Nurses intervene, and report when necessary, 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 physical privacy of persons by providing care in a discreet manner and by minimizing intrusions as much as possible.

6. When providing care, nurses utilize practice standards, best practice guidelines and policies concerning restraint usage to minimize loss of safety, well-being and/or dignity for persons.

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 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.

8. In all practice settings where they are present, nurses work to relieve pain and suffering, including appropriate and effective symptom and pain management, to allow persons to live and die with dignity. They listen attentively to understand the person’s wishes, and support the person’s family/community.

9. Nurses ought to encourage persons 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 goals and wishes, and work to support the family as well as the person.

10. Nurses document a person’s wishes regarding end-of-life care to make their wishes and decisions clear and known to other care-givers (CRNM, College of Licensed Practical Nurses of Manitoba, & College of Registered Psychiatric Nurses of Manitoba, 2016a; College of Registered Nurses of Nova Scotia [CRNNS], 2015a).

12 See footnote 7.
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 support a dignified and peaceful death. This includes providing a palliative approach to care for the people they interact with, across the lifespan and across the continuum of care and support for the family during and following the death, and care of the person’s body after death.

12. Nurses have an obligation to understand the law and subsequent regulations to consider how it affects their practice and their particular beliefs and values. For example, with medical assistance in dying, if nurses believe they would conscientiously object to being involved with persons who have requested such assistance, they should discuss this with their supervisors in advance (Canada, Parliament, 2016; CNO, 2016; CRNM, CLPNM, & CRPNM, 2016b, CNA, 2015a). For detailed guidance about nurse practitioners’ and nurses’ roles and responsibilities in medical assistance in dying, please consult CNAs National Nursing Framework on Medical Assistance in Dying in Canada (2016).

13. Nurses treat each other, colleagues, students and other health-care workers in a respectful manner, recognizing opportunities for sharing governance with those in formal leadership positions, staff and students. They work with others to preserve dignity and resolve differences in a constructive way.

14. Nurses work to foster a 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 right of persons to have control over the collection, use, access and disclosure of their 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 required 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, family, community 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 is respectful and does not identify those persons unless necessary and appropriate (CNA, 2012).

6. Nurses advocate for persons to receive 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 persons’ privacy, including security safeguards in information technology.

8. Nurses do not abuse their access to information by accessing health-care records, including a family member’s or any other person’s, for purposes inconsistent with their professional obligations.

9. When using photo, video or other technology for assessment and evaluation of a person’s care, nurses obtain their consent and do not intrude into the privacy of a person. They handle photos or videos with care to maintain the confidentiality of the persons involved, including staff.

10. Nurses intervene if others inappropriately access or disclose personal or health information of persons receiving care.

11. In the use of social media, nurses safeguard the privacy of persons in their care, their families and other staff (CNA, 2012).

12. In all areas of practice, nurses safeguard the impact new 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. When providing care, nurses do not discriminate on the basis of a person’s race, ethnicity, **culture**, political and spiritual beliefs, social or marital status, gender identity, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability or socio-economic status or any other attribute.
2. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care, toward other health-care professionals or students and toward each other.

3. 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. Nurses provide care for all persons including those seen as victims and/or abusers and refrain from any form of workplace bullying (CNA, 2016).

4. Nurses make fair decisions about the allocation of resources under their control based on the needs of persons. They advocate for fair treatment and for fair distribution of resources.

5. 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.

6. 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). Formal nurse leaders must protect whistle-blowers who have provided reasonable grounds for their concerns.

7. Nurses work collaboratively to develop a moral community. As part of the moral community, all nurses acknowledge their responsibility to contribute to positive and healthy work environments.

8. Formal nurse leaders have a particular responsibility to assure that employees are treated fairly and justly, and that nurses’ concerns are heard and they are involved in decisions related to their practice and working conditions (CNA and CFNU, 2015a).

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 and student nurses represent themselves clearly with respect to name, title and role.

3. Nurses practise within the limits of their competence, formal education qualifications, and regulatory framework. 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 their role within the care team. When the acuity, complexity or variability of a person’s health condition increases, nurses assist each other where necessary (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 that someone else 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.

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. The nurse has a duty to take all reasonable steps to ensure that the quality and continuity of care for the person is not compromised. If nurses can anticipate a conflict with their conscience, they have an obligation to notify their employers or, if the nurse is self-employed, persons receiving care, in advance so that alternative arrangements can be made.

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 public.

9. Nurses share their knowledge and provide feedback, mentorship and guidance for the professional development of nursing students, novice nurses, nurses new to their practice area, and other health-care team members.
Part II: Ethical Endeavours / Nurses as Advocates

The Code’s section on Nursing Values and Ethical Responsibilities has several responsibilities related to health care advocacy to better serve persons with needs or concerns. There are broad aspects of social justice that are associated with health and well-being and that ethical nursing practice addresses. These aspects are focused on the need for improvements in systems and societal structures in order to create greater equity for all (McTeer, 2012). Individually and collectively, nurses should keep abreast of current issues and concerns and be strong advocates for fair policies and practices. They can do so by:

i. Advocating for health-care systems that ensure accessibility, universality, portability, publicly administered and comprehensiveness of necessary health-care services.

ii. Utilizing the principles of primary health care for the benefit of the public and persons receiving care.

iii. Recognizing and working to address organizational, social, economic and political factors that influence health and well-being within the context of nurses’ role in the delivery of care.

iv. Advocating for a full continuum of accessible health-care services provided at the right time and 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.

v. Recognizing the significance of social determinants of health and advocating for policies and programs that address them (e.g. safe housing, safe injection sites).

vi. While maintaining awareness of major health concerns such as poverty, inadequate shelter, food insecurity and violence, working individually and with others for social justice and advocating for laws, policies and procedures that bring about equity.

vii. Working with individuals, families, and communities and advocating for a full range of health-care choices.

viii. Collaborating with other health-care team members and professional organizations to advocate for changes to unethical health and social policies, legislation and regulations.

ix. Recognizing that some groups in society are systemically disadvantaged or are part of disadvantaged and/or vulnerable groups and communities (which leads to diminished health and well-being), working and advocating to improve their quality of life and taking action to overcome barriers to health care.
x. 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).

xi. Advocating for initiatives that reduce environmentally harmful practices in order to promote health and well-being.

xii. Advocating for the discussion of ethical issues among health-care team members, persons in their care, families and students, encouraging ethical reflection and working to develop their own and others’ heightened awareness of ethics in practice.

xiii. While maintaining awareness of broader global health concerns, such as violations of human rights, war, world hunger, gender inequities and environmental pollution, working and advocating individually and with others to bring about social change locally and globally.

xiv. Advocating for excellence in palliative and end-of-life care and options for a palliative care approach that is available to all whether at home, in long-term care, in acute care or in special (hospice) units

xv. Becoming well-informed about laws (e.g., abortion, medical assistance in dying) and advocating for working with others to create policies and processes that provide ethical guidance to all nurses

xvi. Advocating for access to medically assisted death for all Canadians who request it and meet the criteria
Glossary

The glossary is intended to provide nurses with a common language for their reflections and discussions about nursing ethics. It may also be instructive, since nurses who read the glossary terms are more likely to investigate these concepts further, especially if they are unfamiliar. The glossary does not necessarily provide formal definitions of terms, but rather it presents information in a manner and language that is meant to be helpful and accessible. Some terms in the glossary are not included in the main body of the Code but are in the appendices, others may not appear exactly as noted in the text, and others may not be included in the text but may be useful to nurses in their ethical reflection and practice. Some terms may also have legal or regulatory definitions specific to certain provincial/territorial jurisdictions.

**Abandonment:** A situation where the nurse has engaged with the persons in their care or has accepted an assignment and then discontinues care without negotiating a mutually acceptable withdrawal of service with the person in care, or without arranging for suitable alternative or replacement services, or without allowing the employer a reasonable opportunity for alternative or replacement services to be provided (CRNBC, 2015).

**Advance care planning:** An ongoing process of reflection, communication and documentation of a person’s values and wishes for future health and personal care in the event that 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 — should be 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], 2015a, p. 7).

**Advance directive:** a person’s written wishes about how and what decisions should be made if they become incapable of making decisions for themselves. In decisions about life-sustaining treatment, advance directives are meant to assist with decisions about withholding or withdrawing treatment. Also called living wills or personal directives.

**Adverse effect:** An unethical or unsafe situation raising concerns about the practice or behavior of another heath professional or individual in the workplace (CRNNS, 2015b).

**Adverse events:** unexpected, undesirable incidents resulting in injury or death that are directly associated with the process of providing health care or health services to a person receiving care (Hebert, Hoffman & Davies, 2003). **Near misses** are incidents in which an adverse event is caught before it happens, and such incidents can be instructive in preventing future adverse events.

**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 [CARNA], 2005a). See professional boundaries below.

**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)

**Compassion:** the ability to convey in speech and body language the hope and intent to relieve the suffering of another. Compassion must coexist with competence. “Compassion is a relational process that involves noticing another person’s pain, experiencing an emotional reaction to their pain, and acting in some way to help ease or alleviate the pain” (Dutton, Lilius & Kanov, 2007).

**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, 2002).

**Conflict of interest:** occurs when the nurse 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, 2009a).

**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, being capable of giving or refusing consent and with no coercion, fraud or misrepresentation (CRNBC, 2013a; CLPNBC, 2015b). **Conscious:** The state of being aware of and attaching importance to a behaviour or action.

**Conscientious objection:** a situation in which a nurse informs the nurses’ 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, 2007).

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

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

**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 (CRNBC, 2007; College of Registered Nurses of Nova Scotia [CRNNS], 2006a).

**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:** features of 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 one’s practice and providing steps in ethical decision-making. Normally, this model includes critical questions to consider in reflecting 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 and those 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 to be those people identified by the person receiving care or in need of care as providing 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 practise 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. Nurses restrict or accommodate practice if they cannot safely perform essential functions of the nursing role due to mental or physical disabilities (CARNA, 2011b, p.5).

**Formal nurse leaders:** all nurses in institutional or community-health agency leadership positions such as charge nurses, supervisors, managers, administrators and executives (Schick-Makaroff, Storch, Pauly, & Newton, 2014).
**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 by all (CNA, 2003).

**Health:** a state of complete physical, mental (spiritual) and social well-being, not merely the absence of disease (CNA, 2007; 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 or communities.

**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 and Human Rights* (CNA, 2004a).

**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.

**Inequity:** an instance of unjust or unfair treatment of each individual’s needs; health inequity means a lack of equitable access and opportunity for all people to meet their health needs and potential (CNA, 2006).

**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, 2008).

**Interprofessional teams:** different professions working together to reach a common goal and share decision making to achieve the goal. The goal in health care is to work in a common effort with individuals, families and communities to enhance their goals and values (RNAO, 2013, p. 64).

**Intersectoral:** all sectors of society (government, community and health). In health care refers to sectors of nursing practice. In public health the sectors mean different government jurisdictions as sectors.
Job action: activities undertaken by union members to express disagreement with their employer/government’s policies or rules. Such activities could include going on strike, work slowdowns, picketing, work to rule, 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: means (a) the administrating 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 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 (Parliament of Canada, Bill C.14, June 17, 2016) (Canada, Parliament, 2016).

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 & Street, 2004). Coherence between publicly professed values and the lived reality is necessary for there to be a genuine moral community (Webster & Baylis, 2000).

Nurse(s): in this Code, the term nurse includes nurses licensed or registered including licensed practical nurses (registered practical nurses in Ontario), registered nurses, and nurses who are registered or licensed in extended roles, such as nurse practitioners.

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

Person-centred care: an approach in which persons are involved in planning and assessing their needs along with the health care team. It involves empowerment, respect for autonomy, voice, self-determination and participation in decision-making (RNAO, 2011b).

Primary health care: a philosophy and approach that is integral to improving the health of all Canadians 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).

Professional boundaries: the spaces between the nurse’s power and the client’s vulnerability. They separate the therapeutic behaviour 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, 2011a, pp. 3-4).
**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 should have a reasonable expectation of their privacy in the health care system so that only staff that need to know their information will share it with only those who need specific information.

**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, 2001).

**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, 2013, 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, 2009).

**Social media:** confidentiality as it applies to social media includes, but is not limited to social networking, online forums, chat rooms, texting/instant messaging, blogs, wikis, file sharing (video and audio), and virtual worlds. (ANBLPN, n.d.).

**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/territories. Nurses need to become familiar with the terms used in their own jurisdictions (CNA, CHPCA, CHPC-NG, 2015; CNA, 2015a).

**Therapeutic relationship:** a relationship established and maintained with a client by the nurse through the use of professional knowledge, skills and attitudes in order to provide nursing care expected to contribute to the client’s well-being (CARNA, 2011a).

**Unregulated care provider:** paid providers who are neither licensed nor registered by a regulatory body (CRNBC, 2006b).

**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 of 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 personal or person-group violence, while the latter is about systematic ways that social structures, organizations and institutions harm or marginalize people (Varcoe, in press).

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 professional for such things as errors, incompetence, negligence or patient abuse (Oberle & Raffin Bouchal, 2009). This action should 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, 2002).

Workplace bullying: this type of bullying includes tolerance for behaviours such as verbal abuse or threat 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 rather than also on organizations (CNA, 2016).
Appendix A: The History of the Canadian Nurses Association Code of Ethics and Codes of Ethics for Licensed Practical Nurses

1954  CNA adopts the International Council of Nurses’ code as its first code of ethics

1980  CNA adopts its own code, entitled *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 and Licensed Practical Nurses*

The Code 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. It has been developed over time by nurses for nurses, and it therefore continues to have a practical orientation supported by theoretical diversity.

Licensed Practical Nurses and Nursing in Canada

At the end of WWII, licensed practical nurses\(^\text{13}\) established their titles.

1914  Practical nurses become respected members of the Canadian Nurses Association.

1945  The first licensure laws in Canada for practical nurses enacted in Manitoba. By 1966 eight of the ten provinces have licensure laws in place for practical nurses/nursing assistants.

\(^{13}\) The licensed practical nurse (LPN) title is used everywhere in Canada except Ontario, which uses registered practical nurse (RPN).
1972  Canadian Association of Practical Nurses and Nursing Assistants founded, together with eight other practical nurse/nursing assistant associations. Communications established that help provide commonality to increase mobility and improve education. CNA Code of ethics adopted.

1995  Colleges of licensed practical nurses individually begin to develop and adopt provincial Codes of ethics as they become regulated.

2009  College of Nurses of Ontario adopt a Practice Standards: Ethics for both RNs and RPNs

2013  Canadian Council for Practical Nurse Regulators develops a national code of ethics, which is adopted by Alberta, Saskatchewan, Nova Scotia, New Brunswick, Newfoundland and Labrador and Prince Edward Island.

2014  College of LPNs in Manitoba updates code of ethics; College of LPNs in British Columbia incorporates code of ethics as professional standards.

**Appendix B: 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 should 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 are 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 here\textsuperscript{14} was selected because it offers a nursing model for considering ethics issues in practice, promotes reflection and is applicable to all types of ethical situations.

\textit{Oberle & Raffin Model}\textsuperscript{15}

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 should 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 should 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?

\textsuperscript{15} This model is adapted from Oberle & Raffin Bouchal (2009).
• What legislation applies to this situation in terms of my obligations, the institution’s obligations and the obligations of other health professionals? Are there legal implications of 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 as a reasonably prudent nurse would 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
• Were the outcomes of this action acceptable?
• Was the process of decision-making and action acceptable? Did all involved feel respected and valued?
• How were 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, nonmaleficence 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: examples of diagram models are the Bergum and the Storch models (CARRA, 2005b). Others prefer a more philosophically based model, such as that offered by Yeo, Moorhouse, Kahn and Rodney (2010).

A few key sources are listed below. The first source is likely the most comprehensive, since it analyzes cases using three models.

- **CNA’s *Everyday Ethics: Putting the Code into Practice* (2nd ed.) (2004b) is a study guide to help nurses use the Code and reflect on ethical practice. It offers three models: “A Guide for Moral Decision-Making” (developed by Chris McDonald), “The Four Topics Method” and “The Circle Method for Ethical Decision-Making” (by Jan Storch), with examples of their application to practice (Jonsen, Siegler, & Winslade, 2006). Numerous other models are listed and briefly described in the appendix to this study guide.

- CARRA published *Ethical Decision-Making for Registered Nurses in Alberta: Guidelines and Recommendations* in 2005. Included in CARRA’s paper is the Bergum model for questioning (in the image of a flower) and a full case analysis using the Bergum model.

- The *Framework for Ethical Decision-Making*, (developed by Michael McDonald with additions provided by Patricia Rodney and Rosalie Starzomski), 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. That section of the McDonald model is included below.

- **Nursing Ethics: Cases and Concepts**, (1996) by M. Yeo & A. Moorhouse. These authors provide a way to think through ethical problems using three types of analysis (descriptive, conceptual and normative) (Yeo et al., 2010).

- CNA’s *National Nursing Framework on Medical Assistance in Dying in Canada* (2016), guides nurses in reflecting on ethical issues that may occur as they care for persons considering MAID in various practice settings.

**Use 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?
- **Nonmaleficence**: Will this harm the person? Others?
- **Beneficience**: 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 palliative care 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?

  * (Note: A new WEB address will be supplied here)
References


Association of Registered Nurses of Newfoundland and Labrador ARNNL. (2008a). The role of psychiatric-mental health nurse working in the community. St. John’s NFLD: Authors.


Saskatchewan Registered Nurses Association, Saskatchewan Association of Licensed Practical Nurses & Registered Psychiatric Nurses Association of Saskatchewan. (2012). *Guidelines for determining the appropriate nursing care personnel.* Regina Sask,: Authors


**Ethics Resources**

In addition to the resources listed in the references, there is a wide range of ethics resources available from the websites of CNA and the provincial and territorial registered nurses’ associations and colleges, as well as from the websites of other national organizations such as the Public Health Agency of Canada, Health Canada, other health profession associations, and ethics or bioethics centres across Canada and internationally.

Nurses should also consult with members of their health-care team, ethics consultants in their agency, ethics committees in their facilities or region, practice consultants at nursing associations and colleges, and others with ethics knowledge and skill in its application to health-care practice.

To visit CNA’s ethics resources, go to [www.cna-aiic.ca](http://www.cna-aiic.ca).