2017

Embedding Micro-Ethical Dilemmas in High-Fidelity Simulation Scenarios: Preparing Nursing Students for Ethical Practice

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Bachelor of science in nursing (BSN) students have reported feelings of frustration and powerlessness when encountering every day, microethical dilemmas during junior- and senior-level clinical practicum experiences. The authors' nursing curriculum incorporated explicit ethics education recommended by professional nursing organizations, education credentialing agencies, and literature-based strategies, such as microethical and bioethical case studies, didactic ethics courses, group discussions, role-play, clinical practicum experiences, and self-reflection (American Association of Colleges of Nursing, 2008 ; Eby et al., 2013 ; Rushton & Kurtz, 2015). These teaching strategies prepared students to understand and value what should be done to promote quality patient care; however, students verbalized an inability to act on their knowledge due to fear of reprisal, lack of confidence, and feelings of powerlessness (Krautscheid & Brown, 2014 ; Krautscheid, Luebbering, & Krautscheid, 2016 ; Rees, Monrouxe, & McDonald, 2014). These anecdotal- and literature-based findings raised a sense of urgency about improving applied ethics education within the collective curriculum at the author's BSN program at a private, faith-based institution in the Pacific northwestern United States. The goal of this educational innovation was to ensure that each student encountered a microethical dilemma and demonstrated effective patient advocacy while managing ethical dilemmas that commonly arise during practice situations.

Microethical situations (Benner, Sutphen, Leonard, & Day, 2010 ; Worthley, 1997) were first defined by Worthley as every day-, routine-, and individual-level decisions that have the potential to cause harm. Microethical dilemmas, such as substandard infection control practices, unsafe medication administration procedures, and confidentiality breaches, were embedded within existing high-fidelity simulation (HFS) scenarios in the academic laboratory. This educational strategy permitted opportunities to integrate cognitive, psychomotor, and affective domains of learning. In simulation, students applied their knowledge of ethical frameworks while demonstrating effective communication and leadership skills that created the potential to strengthen personally held attitudes about moral agency and advocacy.

High-fidelity simulation closely replicates authentic patient care scenarios, triggering intense feelings, such as those experienced by students during challenging clinical situations (Smith, Witt, Klaassen, Zimmerman, & Cheng, 2012). One benefit of HFS is the ability to rehearse the integration of ethical knowledge and affective attitudes while engaging in psychomotor actions, such as effective conflict communication skills. Purposefully structured HFS ethical dilemmas may be rehearsed, debriefed, and repeated until positive emotions associated with moral courage and ethical practice are inculcated and negative emotions that could thwart moral agency are minimized.

Curricular Assessment

Curricular assessment at the academic agency identified an emphasis on the cognitive construction of professional ethical standards. For example, formal ethics education was evident in a three-credit sophomore-level ethics course emphasizing major theories in classical and

contemporary moral philosophy. Additional cognitive ethics education was evident within junior- and senior-level nursing courses, such as discussions about the American Nurses Association (American Nurses Association, 2015) and National Student Nurses Association (National Student Nurses Association, 2009) Code of Ethics, ethical ways of knowing (Masters, 2014), bioethical and microethical case studies, and postclinical seminar discussions about ethical situations encountered during clinical practicum. The assessment revealed a substantial reliance on cognitive domain teaching strategies focused on knowledge attainment. Knowledge includes a cognitive understanding of what the best action should be within a contextual situation (Bastable & Alt, 2014). For example, students know the procedures that health care providers should implement to protect patients, peers, and populations from the spread of infection. Thus, a nursing student who knows what best practice should be has the foundational knowledge to identify substandard microethical practices. Less evident in the curricular assessment were explicit examples of psychomotor and affective teaching strategies and learning activities supporting congruence between knowing what one should do and taking action on those convictions.

Acting on one's values is associated with higher levels of affective domain learning (e.g., conceptualizing the meaning of the ethical dilemma and acting upon one's internalized values; Baumlein, 2015) and professional ethics. Curricular assessment revealed affective domain activities such as reflective writing and critical reflection on clinical experiences. Both of the aforementioned educational strategies address the lowest levels of affective domain learning, such as listening and responding (Bastable & Alt, 2014). Curricular assessment also revealed psychomotor domain learning strategies such as role-play activities in didactic settings, promoting ethical action through experiential practice, rehearsal, and repetition. In addition to role-play, some students also engaged in psychomotor learning when they experienced ethical dilemmas spontaneously arising during clinical practica. Such random exposure to microethical situations revealed a gap in psychomotor domain teaching strategies and learning activities. Every student would not have an equal opportunity to intentionally rehearse his or her response to ethical dilemmas within real-world contextual nursing practice.

According to Kalaitzidis and Schmitz (2012), how individuals learn to respond to ethical dilemmas depends on his or her prior opportunities to rehearse decision making, as well as the outcome of previous experiences. The curricular assessment revealed a need to plan and implement learning activities that would ensure each student intentionally rehearsed and received feedback about ethical decision making while managing microethical issues that arise amidst patient care. The best resource-efficient option to achieve this educational goal was to create and embed microethical dilemmas within existing HFS scenarios.

Educational Innovation: HFS Microethical Dilemmas

Microethical dilemmas were developed and embedded within an existing HFS scenario associated with a senior-level medical-surgical course. Dilemmas, such as infection control breaches, violating patient confidentiality, and unsafe medication administration practices, were selected based on findings in the literature (Callister, Luthy, Thompson, & Memmott, 2009 ; Gallagher, 2010 ; Goud, 2005 ; Krautscheid & Brown, 2014 ; Lachman, 2007), as well as anecdotal student reports of microethical dilemmas encountered during clinical practicum. The

duration of each dilemma scenario was 5 to 7 minutes, adding a total of 20 to 26 minutes to the HFS schedule. Learning outcomes for the microethical component of the HFS were developed using Bloom's Taxonomy (Krathwohl, Bloom, & Masia, 1973) and included the following: students will (a) notice and verbally question unsafe and unethical activities, (b) advocate for ethical, evidence-based patient care, (c) demonstrate ethically informed and evidence-based patient-centered care, and (d) discuss professional ethical standards during postsimulation debriefing.

An actor was hired to play the role of a registered nurse (RN-actor) who implemented the microethical dilemmas. Initially, volunteers were scheduled to play the role of the RN; however, volunteers presented commitment and scheduling challenges that weakened the implementation of the educational innovation. Thus, funds were allocated from the school of nursing operating budget and the actor was paid $20.00 per hour. Hiring an actor who is unfamiliar to the students strengthened the reality of the HFS experience, replicating practicum situations in which students do not know the clinical agency nursing staff, and, thus, need to learn how to navigate hierarchical health care cultures while learning how to provide quality patient care. The RN-actor and simulation faculty members rehearsed microethical dilemma scenarios prior to implementation within an existing HFS (i.e., patient [Laerdal SimMan ®] with type 2 diabetes presenting with diabetic ketoacidosis and a foot ulcer). On the basis of positive psychology literature recommendations (Fredrickson, 2001), the RN-actor was scripted to respond favorably when students raised questions about substandard practice, thus stimulating positive emotions, negating prefactual fears, and empowering future ethical actions.

Students prepared for simulation in the same manner they prepared for actual clinical practicum experiences. Students reviewed the patient's health history, plan of care, pathologies, and medications. Students were not notified that an ethical dilemma might arise during HFS, further replicating the authentic nature of routine, every-day ethical dilemmas that arise during nursing practice. Eight students were scheduled for a 4-hour simulation session that was implemented using a progressively unfolding case scenario format. Two students rotated into the scenario approximately every 30 minutes while the remaining six students and a faculty member observed from a closed-circuit viewing room. While in the midst of providing patient care for the simulated patient, each student pair was exposed to a microethical situation presented by the RN-actor. A noted weakness of this simulation structure is that reticent students have a tendency to abdicate to their classmate, permitting their classmate to take the lead during the microethical simulation. In such situations, the RN-actor purposefully engaged the withdrawn student, drawing them into the scenario. For example, after identifying the patient's intracellular dehydration, students notified the unit secretary via an intercom system that they wanted help administering a 1000-mL isotonic intravenous (IV) bolus. The RN-actor entered the HFS patient room and the students delegated IV bolus administration to the RN-actor because the students were involved in other patient care activities, such as calculating IV insulin dosages. The RN-actor was scripted to omit handwashing and was also instructed to omit decontaminating the needleless injection port prior to connecting the bolus IV tubing to the injection port on the existing primary IV tubing. The microethical dilemma arose when the student pair identified unsafe practices and were faced with deciding whether they should speak up and advocate for best practice, protecting the health of the patient. Cognitively, students had previously learned in both the academic skills laboratory and classroom that the RN should wash their hands prior to

patient care and scrub the needleless IV injection port with an alcohol wipe for 15 seconds to minimize the risk of catheter-associated infections (Lockman, Heitmiller, Ascenzi, & Berkowitz, 2011).

At the end of each 30-minute simulation session, the student teams returned to the closed-circuit viewing room and participated in approximately 20 minutes of group debriefing with their classmates and a faculty member. Debriefing questions stimulated discussion about the scenario, student actions, ethical decision-making frameworks, and ethical codes of conduct.

Evaluation of Innovation

The simulation was the most notable education yet. It definitely made me start thinking...I'm in a real hospital, I'm not going to let someone come in and infect my patient. It definitely helped me think through that and do something about it.

Ethics education is a hard thing because until people are in situations or experiences, they may not know how to handle the situation. I mean, you can get a lot from watching someone, but until you're doing it yourself, you're not getting the full experience.

Students also made comments that contrasted HFS against including role-play scenarios in the didactic classroom, Role-play is pretty relaxed, you know, usually you go up there, you volunteer with your friends and sometimes you have a script or you don't. Simulation is a real-life situation. I was actually doing something rather than pretending.

Another student said, "Role-play has less stress. For me, simulation is much more stressful because it feels real. In role-play, it is more like, well, this is what you would say." Role-play offers a strategy to introduce a topic, such as identifying microethical dilemmas; however, role-play lacks the requisite authenticity to promote adequate somatic experiences that strengthen learning through engaging emotions and kinesthetic movements.

I felt confidence in my ability to be an advocate. Because I stuck my neck out on the line and stood up for what I felt was right, regardless of what I thought the repercussions were, it has given me the strength to do it again.

I think speaking up in simulation was one of those situations that was like, yeah, that was the right thing to do! I felt really confident about it and it made me feel better about doing it again in the future.

Even though it's a simulation, there was still that on-the-spot thinking and nervousness that grips you. It was a confidence thing for me. It felt really good, calling out the unethical behavior. That's legitimately powerful!

For me, it opens the next door to being able to say something again. I think the more you take those opportunities to say something, it instills more confidence.

According to Gentile (2010), rehearsing ethical dilemmas helps dispel myths and fears, instilling confidence in one's capability to speak up and voice his or her values.

At first, I was like, "uh, uh, uh, uh," because you have to get over the first barrier of saying something. Then I was like, I really need to say something. So I said, "well, she is not your patient and that would be a [Health Insurance Portability and Accountability Act] violation." Even though it was just a simulation, it was still hard for me.

Another student wrote, "Now that I've experienced it in simulation lab, I feel like I'll have those tools. I can use those same words that I used in simulation lab and be less afraid to speak out." Finally, another student stated, "We need more opportunities to practice and rehearse these situations because, when you do, it'll be more natural." These comments suggest how the learning experience provided space for the students to practice their message and develop key phrases for future situations.

Discussion

Through simulation, students gained confidence in their ability to effectively communicate concerns, overcame prefactual fears associated with speaking up in health care settings, and felt empowered to advocate. Embedding microethical dilemmas within simulation and scripting the dilemma to promote positive student emotions is recommended to help students exercise their voice, develop a sense of moral agency, and optimally prepare students for ethical dilemmas they will encounter in both prelicensure and postlicensure clinical practice. The integration of ethical dilemmas within HFS provided a resource-efficient and contextually authentic opportunity to experience speaking up, optimally preparing students for the current complex and chaotic practice environments. Students recommended embedding microethical dilemmas within junior-level HFS scenarios, providing timely opportunities to rehearse and receive feedback on ethical actions and communication strategies prior to the senior year. Further qualitative and quantitative investigations are recommended to understand the effect of this educational innovation on students' ability to transfer learning to clinical practice settings.

References

American Association of Colleges of Nursing. (2008). The essentials of baccalaureate nursing education for professional nursing practice. Washington, DC : Author.

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. Silver Spring, MD : Nursebooks.

Bastable S. Alt M. (2014). Behavioral objectives. In Bastable S. (Ed.), Nurse as educator. Principles of teaching and learning for nursing practice. (pp. 424 - 468). Burlington, MA : Jones and Bartlett.

Baumlein G. (2015). Use of assessment and evaluation strategies. In Caputi L. (Ed.), Certified nurse educator review book (pp. 49 - 67). Philadelphia, PA : Wolters Kluwer.

Benner P. Sutphen M. Leonard V. Day L. (2010). Educating nurses: A call for radical transformation. Stanford, CA : Jossey-Bass.

Callister L. Luthy K. Thompson P. Memmott R. (2009). Ethical reasoning in baccalaureate nursing students. Nursing Ethics, 16, 499 - 510. 10.1177/0969733009104612

Eby R. Hartley P. Hodges P. Hoffpauir R. Newbanks S. Kelley J. (2013). Moral integrity and moral courage: Can you teach it? Journal of Nursing Education, 52, 229 - 233. 10.3928/01484834-20130311-01

Fredrickson B.L. (2001). The role of positive emotions in positive psychology: The Broaden-and-Build Theory of positive emotions. The American Psychologist, 56, 218 - 226. 10.1037/0003-066X.56.3.218

Gallagher A. (2010). Moral distress and moral courage in everyday nursing practice. The Online Journal of Issues in Nursing, 16, 8. 10.3912/OJIN.Vol16No02PPT03

Gentile M. (2010). Giving voice to values. How to speak your mind when you know what's right. Ann Arbor, MI : Sheridan Books.

Goud N. (2005). Courage: Its nature and development. The Journal of Humanistic Counseling, Education, and Development, 44, 102 - 116. 10.1002/j.2164-490X.2005.tb00060.x

Kalaitzidis E. Schmitz K. (2012). A study of an ethics education topic for undergraduate nursing students. Nurse Education Today, 32, 111 - 115. 10.1016/j.nedt.2011.02.006

Krathwohl D.R. Bloom B.S. Masia B.B. (1973). Taxonomy of educational objectives: The classification of educational goals. Handbook II: Affective Domain. New York, NY : David McKay.

Krautscheid L. Brown M. (2014). Microethical decision making among baccalaureate nursing students: A qualitative investigation. Journal of Nursing Education, 53 (Suppl.), S19 - S25. 10.3928/01484834-20140211-05

Krautscheid L. Luebbering C. Krautscheid B. (2016). Conflict handling styles demonstrated by nursing students in response to microethical dilemmas. Nursing Education Perspectives. Manuscript in press.

Lachman V.D. (2007). Moral Courage: A virtue in need of development? Medsurg Nursing, 16, 131 - 133.

Lockman J. Heitmiller E. Ascenzi J. Berkowitz I. (2011). Scrub the hub! Catheter needleless port decontamination. The Journal of the American Society of Anesthesiologists, 114, 958. 10.1097/ALN.0b013e3182054bd1

Masters K. (2014). Role development in professional nursing practice (3rd ed.). Sudbury, MA : Jones & Bartlett Learning.

National Student Nurses Association. (2009). Code of ethics: Part II. Code of academic and clinical conduct and interpretive statements. Retrieved from http://www.nsna.org/Portals/0/Skins/NSNA/pdf/NSNA_CoC_Academic_Clinical_Interp_Statem ents.pdf

Rees C. Monrouxe L. McDonald L. (2014). 'My mentor kicked a dying woman's bed...' analysing UK nursing students' 'most memorable' professional dilemmas. Journal of Advanced Nursing, 71, 169 - 180. 10.1111/jan.12457

Rushton C. Kurtz M. (2015). Moral distress and you: Supporting ethical practice and moral resilience in nursing. Silver Spring, MD : Nursebooks.

Smith K. Witt J. Klaassen J. Zimmerman C. Cheng A. (2012). High-fidelity simulation and legal/ethical concepts: A transformational learning experience. Nursing Ethics, 19, 390 - 398. 10.1177/0969733011423559

Worthley J.A. (1997). The ethics of the ordinary in healthcare: Concepts and cases. Chicago, IL : Health Administration Press.