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A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in the Clinical Setting

Cynthia S. Randall
University of Southern Maine

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A Simulation to Improve the Clinical Nursing Instructor's

Teaching of Ethics to Students in the Clinical Setting

By

Cynthia S. Randall

DNP Capstone Project

Submitted to

University of Southern Maine

School of Nursing

December, 2015

Capstone Chair: Carla E. Randall, Ph.D., RN, CNE

Capstone Committee Member: Julien Murphy, Ph.D.

Capstone Committee Member: Judy Tupper, DHEd, CHES, CPPS

SIGNATURE FINAL APPROVAL FORM

THE UNVERSITY OF SOUTHERN MAINE

DOCTORAL OF NURSING PROGRAM

We hereby recommended that the DNP Capstone project by Cynthia Randall entitled:

A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in the Clinical Setting

Be accepted in partial fulfillment of the requirements for the Degree of Doctoral of Nursing Practice

Committee Members:

Chair
Carla E. Randall, Ph.D., RN, CNE
Associate Professor of Nursing
University of Southern Maine

Julien Murphy, Ph.D.
Professor of Philosophy
University of Southern Maine

Judy Tupper, DHEd, CHES, CPPS
Muskie School of Public Service
University of Southern Maine

Accepted

Committee Chair: _Carla Randall_____ Date: _18 December 2015_

Committee Member: _____ Date: _12-18-2015_

Committee Member: _Judy Tupper_____ Date: _12/18/15_

Department Faculty: _____ Date: _____

Dedication

This DNP capstone project is dedicated to my children, Kelsey and Jacob Randall. Their presence and support on this journey of learning made the completion of this project possible.

Acknowledgements

Abstract

Ethical knowledge and skill is crucial to the discipline of nursing and is considered foundational knowledge for nursing practice (American Nurses Association [ANA], 2008). Nurses who assume roles in clinical teaching may be clinically competent but may have limited nursing education experience or knowledge in clinical instruction. The purpose of this project was to improve the educational experience of clinical instructors in the teaching of ethics to students in the clinical setting. This DNP capstone was a quality improvement project with a mixed method design using simulation as a teaching strategy. Eight clinical instructors from a university based baccalaureate nursing program in the Northeast were recruited to participate in an educational workshop designed to improve teaching of ethical decision making.

Simulation and debriefing methods were utilized to increase the participant's awareness of their own knowledge and skill in ethics, and provide an opportunity for reflection on useful teaching strategies in applied ethics during clinical instruction. Following the educational intervention, participants experienced an increase in knowledge and confidence in ethics and teaching ethics to students in the clinical setting. The results of this project provided insight to specific gaps in the clinical instructor's knowledge of ethics and in teaching ethics in practice, as well as what knowledge was needed to apply ethics in clinical instruction. This project has implications for nursing faculty development and may be replicated by other nursing programs who desire to develop their clinical instructors' teaching of ethics.

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Chapter 1 Nature of the Problem

Introduction

Ethics and ethical decision making are crucial to the profession of nursing. Ethics "includes values, codes, and principles that govern decisions in nursing practice, conduct, and relationships" (American Association of College of Nursing [AACN], 1998, p. 14). Ethics is considered foundational to the profession and the practice of nursing (American Nurses Association [ANA], 2008). The ANA *Code of Ethics* was developed to serve as a guide for those licensed within the nursing profession (2008). "The code reflects our fundamental values and ideals as individual nurses and as a member of a professional group" (ANA, 2008, p. xi).

Nursing is a practice discipline and as such, knowledge is applied in practice. Given the nature of the work, nurses are confronted with ethical issues in their practice every day and therefore need to be knowledgeable and skilled in applying ethics in practice. "Skill and knowledge in resolving conflicts related to role obligations and personal beliefs are necessary" (AACN, 1998, p. 14).

While it is true that ethics is significant to the profession, nurses struggle with applying ethics in practice (Dunphy Suplee et al., 2014; Erdil & Korkmaz, 2009; Epstein & Carlin, 2012; Numminen & Leino-Kilpi, 2007; Park, 2013). Clinical nursing expertise does not equate to ethical expertise (Robichaux, 2014). For several reasons, nurses who become clinical nursing instructors may have limited knowledge of ethics and experience with ethical decision making skills in practice, and therefore, will likely have difficulty teaching these skills to nursing students in clinical situations (Robichaux, 2014).

This project involved an educational workshop for clinical instructors on the teaching of ethics to nursing students in the clinical setting utilizing simulation as a teaching methodology. The workshop was designed to educate clinical faculty on teaching ethics in clinical practice.

Problem Statement

Nurses who become clinical instructors have limited experience and skills to instruct pre-licensure baccalaureate nursing students in the application of ethics in practice (Dunphy Suplee et al., 2014; Epstein & Carlin, 2012; Erdil & Korkmaz, 2009; Numminen & Leino-Kilpi, 2007; Park, 2013; Robichaux, 2014). Scholarly articles report that although nurses may have clinical expertise, they frequently, for various reasons, do not possess sufficient knowledge or experience in ethics of care to be competent in applying ethics in practice. Examples of this include, internalizing ethical knowledge and taking an active part in ethical decision making process (Dunphy Suplee et al., 2014; Epstein & Carlin, 2012; Erdil & Korkmaz, 2009; Numminen & Leino-Kilpi, 2007; Park,2013). With this limited ethical practice in clinical settings, nurses who become clinical instructors will have challenges in teaching ethics in practice.

Inexperience with applying ethics in practice, coupled with the issue that clinical instructors are often hired without any formal background in teaching, complicates the problem. Clinical nursing instructors are often hired based on their experience as clinicians, but may not have formal education in nursing education, and often report being unprepared to assume a nurse educator role (Davidson & Rourke, 2012; Duffy, Stuart & Smith, 2008; Hewitt & Lewallen, 2010; Krautscheid, Kaakinen & Warner, 2008; Poindexter, 2013).

In their report on the success of part-time faculty, Duffy and colleagues (2008) concluded "the clinical proficiency of nursing instructors does not always extend to teaching effectiveness" (p. 53). Davidson and Rourke (2012) surveyed the orientation needs of clinical instructors and found all participants expressed a need to develop further teaching and learning skills. Instructors reported having no general awareness or formal teaching experience and therefore have very little background in teaching to guide their newly acquired role as a nurse educator (Davidson and Rourke, 2012; Duffy et al., 2008).

Nursing faculty members may recognize the need for ethics in nursing education in order to prepare students to make the many moral decisions required in clinical practice however, few studies describe how ethics is actually taught in nursing school (Krawczyk, 1997). Krawczyk (1997) explored teaching strategies to determine the development of moral judgment in nursing students. The author's findings support that a teaching format that includes student involvement in applied ethics was important to stimulate and develop their growth in moral reasoning (Krawczyk, 1997).

Barriers and challenges to ethical practice identified in this project, coupled with a lack of teaching experience and formal teaching education, makes it difficult for the clinical instructor to have the teaching skills to develop a student's ethical formation during clinical practice. Critical ethical reflection on providing and delivering good nursing care must be applied in actual nursing practice in order for students to develop their professional identity in ethics (Goethals et al., 2010; Parks, 2013).

The impetus for this project was based on personal experience as a clinical instructor, and nurse, along with nursing classroom reflection and informal discussions of

ethics in graduate school over the last several years. Due to personal experience, lack of

research on teaching ethics in clinical settings using simulation, and the attention to

improve ethics education in the literature, the topic of ethics was chosen to be explored.

Significance of the Problem

Nurses experience challenges to practice ethically (Rodney, 2004). Challenging

work environments or settings may make it difficult for nurses to practice ethically

(Goethals et al., 2010). Practice settings typically do not support nurses in developing

their application of ethics (Goethals et al., 2010; Robichaux 2014, Rodney et al., 2004).

The stress of unresolved ethical concerns and ethical situations hinders moral practice

(Rodney, 2004)**.** Goethals et al. (2010) reviewed the literature on ethical reasoning and

behavior and found that the challenges nurses encounter in their ethical conduct is linked

to difficult work environments. Nurses and nursing students have reported difficulties an

insufficient confidence in applying ethical knowledge and decision- making in clinical

situations (Goethals, et al., 2010; Park, 2013).

In the last decade, there has been significant attention placed on ethics of nursing

practice, with ethical issues frequently emerging within clinical practice settings

(Robichaux, 2014). Such issues may not always be high stakes ethics but every day

ethical concerns that often involve inter-professional conflicts or organizational and

system problems (Robichaux, 2014). When confronted with these everyday ethical

issues nurses often struggle with reconciling their desire to provide the best possible care

for their patients and families (Robichaux, 2014). Ethical committees tend to address the

extremely challenging issues such as end-of-life decisions while every day ethics remain

unrecognized, underappreciated and unresolved, diminishing the moral environment of

an organization (Robichaux, 2014). Given the climate, limited attention to ethics in

practice and lack of practice with applied ethics, nurses who become clinical instructors

may not have gained experience of ethical decision making in practice. Therefore, are

underprepared to then teach undergraduate nursing students about ethics in clinical

practice.

Clinical instructors have the added responsibility to focus on and nurture the

student-teacher learning relationship by addressing the developmental level of a student's

knowledge and morals during learning. Students will often raise questions about the

same ethical conflicts that nurses have experienced in their practice (Goethals et al.,

2010). With little or no support from the work environment and with their past and

personal values informing the process, clinical instructors must assist the students to

work through the ethical dilemma that emerges in the clinical setting.

Clinical instructors may do this by "utilizing a step-wise approach, identifying

salient points of the ethical issues, bringing students into relation with their own capacity

for ethical knowledge and providing the students the opportunity to analyze the conflict

and apply ethics" (Brown & Street, 2007, p 154). Often the instructor must act as a coach

or role model for students to identify their source of moral distress, the ethical principles

involved and the approach used for ethical analysis and decision-making. Since students

have general knowledge and limited to no clinical experience, they need role modeling

and guidance from the clinical instructor to understand the ethical behaviors involved,

challenge the 'status quo' and to analyze the potential outcomes of alternate decisions to

ethical problems. The leadership skill of the clinical instructor is significant to create

meaningful interactions with students and these ethical lessons often easier to learn in

context (Adelman-Mullally et al., 2013). The instructor works to build on a foundation

of ethical problem solving and preventive approach to ethics by tapping into ongoing

ethical inquiry that will serve students throughout their education and nursing careers

(Adelman-Mullally et al., 2013; Brown & Street, 2007; Hamric & Delgado, 2009;

Rodney, 2004).

If clinical instructors are struggling with the very essence of their teaching role,

then including application of ethics in clinical nursing education with little to no guidance

results in an impossible task to take on for clinical instructors during teaching. AACN

supports the following position on nursing faculty:

Excellent nurses are not necessarily expert teachers. Clinical proficiency alone is

not sufficient to convey nursing knowledge and practice to others in a meaningful,

useful and appropriate way (AACN, 2005). "Faculty require professional

development, mentoring and institutional encouragement to master the faculty

role and continue in it" (AACN, 2005, p. 12).

Nursing programs, particularly baccalaureate education programs, have an

important task of teaching ethical values of the profession to nursing students. The

American Association of Colleges of Nursing (AACN) states in the *Essentials of

Baccalaureate Education for Professional Nursing Practice* (1998) that "graduates must

be able to identify potential and actual ethical issues arising from practice and assist

patients in addressing such issues; therefore, knowledge of ethics and ethical decision

making is critical" (p. 14). This strongly suggests that applied ethics need to be included

as part of the education of nurses. In order to do this, programs educating those who teach

need to include teaching strategies for students to be involved more actively in ethical

discussions. Additionally, the AACN (1998) notes that coursework and clinical practice

should prepare students to apply ethical concepts, provide an ethical framework for

decision-making in practice and "take action to prevent or limit unsafe or unethical health

and nursing care practices by others" (p 14).

There are barriers to fostering clinical instructor's development as teacher.

Baccalaureate nursing programs may not support or have the resources to support or

mentor clinical instructors. They may have low full-time faculty numbers, insufficient

time and increased teaching load assignments as well as the aging workforce, faculty

shortage, and the lingering belief that anyone who is a clinical nurse can teach. These

factors place a significant amount of stress on nursing faculty members and educational

programs (AACN, 2009; Baker, 2010; Cangelosi, Crocker & Sorrell, 2009). Given these

barriers and challenges, hiring clinical instructors with limited or no preparation for

teaching then becomes the norm for SON programs.

In 2010, a 2-year, comprehensive Carnegie study of nursing education was

released (Benner, Sutphen, Leonard, & Day, 2010). The study concluded, "the current

system of nursing education is not adequate to prepare today's nurses for the immediate

future" (Benner et al., 2010, p. 32). The authors contend that, "many teachers and

students are dissatisfied with the teaching preparation of current nursing faculty".

(Benner et al., 2010, p. 32). This important study made strong recommendations for

transforming nursing education. Best practices in nursing education include integrating

components of what Benner and colleagues call the three apprenticeships: knowledge,

skilled-knowhow and ethical comportment of the profession (Benner et al., 2010).

Additionally, the study calls for an imperative to "better prepare future nursing faculty for

teaching" (Benner et al., 2010, p. 224).

The DNP as a Leader in Clinical Nursing Education

The Doctoral of Nursing Practice (DNP) degree is a practice-focused

doctorate that provides the graduate with the skills required for effective leadership,

quality improvement and policy changes (AACN, 2006). The DNP graduate, with

advanced education and practice, is considered an expert in practice and a change agent

for practice (AACN, 2006). While the DNP program is "rigorous with demanding

expectations" and includes a "scholarly approach to the discipline and a commitment to

the advancement of the profession" (AACN, 2006, p. 3) it is not a direct solution to the

nursing faculty shortage as "…the basic DNP curriculum does not prepare the graduate

for a faculty teaching role…" (AACN, 2006, p.5).

While "there is a critical need for more doctorally prepared nurse educators to

advance the science of nursing education" (NLN, 2013, p. 2), the DNP Essentials

document clearly spells out the need for additional education for those receiving a DNP

degree to enter a teaching role. "… as an educator, whether that role is operationalized in

a practice environment or the academy, should have additional preparation in the science

of pedagogy to augment their ability to transmit the science of the profession they

practice and teach" (AACN, 2006, p. 7). Benner, Sutphen, Leonard and Day (2010) also

support the need for those graduating from nursing programs to have additional education

courses.

"To be responsible stewards of the nursing profession and to address emerging

needs of educational systems, the Carnegie Foundation for the Advancement of

Teaching issued a report calling for all graduate nursing programs to support the

study of pedagogies specifically designed and evaluated for nursing education.

The need for doctoral programs to include teacher education courses and

experiential learning that better prepares future nursing faculty is integral to the

report's recommendation to transform nursing education to meet the needs of

today's health care system." (NLN, 2013, p. 2).

By being prepared to take a leadership role within an academic setting and

addressing the concerns of not being prepared to teach, the new DNP graduate can

become an integral part of any school of nursing. When schools of nursing are able to

shift away from the current pattern of hiring with the assumption that any nurse can

teach, there will be a dramatic paradigm shift and an end to the current practice of hiring

nurses who are underprepared for clinical teaching. This shift has far reaching

implications for DNP nursing curricula and posts DNP course offerings that would

facilitate a change in hiring practices within schools of nursing. The DNP nurse

educator, who becomes formally educated in nursing education and practice, is then well

positioned to affect a transformational change in nursing education that bridges ethical

theory to clinical practice and grows the moral development for nursing students in the

clinical practice environment.

Background and Context

The setting for this project was a university based undergraduate baccalaureate

nursing program located in the Northeast of the United States. Currently, 19 clinical

instructors provide clinical instruction to 160 pre-licensure students. Of these

individuals, five have an advanced degree in nursing or are enrolled in a master's

program. The other 14 clinical instructors have baccalaureate degrees in nursing and

have clinical experience in their field. Only 4 of these 19 hired instructors have had some

formal education in nursing education, either have taken a nursing education course or

post graduate certificate. (E. Elliott, personal communication, September 23, 2014).

Similar to other university nursing programs state-wide, nursing faculty members

who are hired for clinical practice instruction at this institution are primarily selected

based on their clinical expertise and availability. Typically, they have an interest or

desire in teaching students and have clinical experience in nursing. Many nursing

programs have limited choices in hiring individuals and have challenges hiring qualified

faculty with nursing education background or advanced degrees as is required by

accrediting agencies and state boards of nursing (SBON) (ANA Maine Nursing Summit,

March, 2014; NCSBN 2013, ACEN 2013). As recommended by accredited bodies,

nursing programs may hire clinical faculty who are credentialed with a minimum of a

master's degree with a major in nursing. However, this is not always feasible due to the

limited number of individuals with advanced degrees or pursuing advanced degree who

apply for these part-time positions; low compensation for educator professions as

compared to nursing professions and no incentives by the workplace to pursue advanced

education (ANA Maine Nursing Summit, March, 2014). The SBON in which the project

takes place requires an instructor to have a master's degree to teach however, given the

constraints, nursing programs can obtain exceptions to this rule.

The education and orientation for clinical instructors typically does not include

nursing education classes or reflect any specific preparation on how to teach ethics in

practice (AACN, 2005). In the setting where the project takes place, at best there is a brief orientation, lasting a few hours, on the process of clinical teaching, policies, and procedure for clinical faculty. (E. Elliott personal communication September 23, 2014). A four hour education workshop for clinical instructors at the SON setting revealed that nursing instructors felt at times unsure of their teaching ability and also report being left to navigate how to do clinical instruction on their own with limited guidance and mentoring (USM Teaching Workshop, August, 2014).

Scope of the Problem

Frequently, clinical instructors are hired as part-time faculty who may have an interest in teaching but have little preparation for the role, responsibilities and challenges. This limited preparation and experience has been previously identified in the literature and reasons for this have been cited. Expert authors such as Diekelman, Ironside and Harlow (2003) contend that "...teachers continue to teach as they were taught. This is in large part because faculty skills and pedagogical literacy are at a critically low level."

A recent study by Dunphy-Suplee and colleagues (2014) supports this continued problem to indicate that gaps exist in the preparation of clinical faculty teaching undergraduate nursing students. Many part-time faculty members are relatively new to teaching, do not have the teaching knowledge or expertise, may lack effective preparation, and may uphold their personal views on the clinical teaching role based on, experiences as a clinician or student in implementing the role (Dunphy-Suplee et al., 2014). Unfortunately, educational settings do not have sufficient mentoring or faculty support to provide effective teaching strategies to bridge theory to practice for students in

the clinical setting and do not require the clinical instructor to be formally educated in

nursing education (Dahlke et al.; 2012; Dunphy-Suplee et al., 2014).

Additionally, schools of nursing are increasingly using Bachelor of Science (BS)

prepared registered nurses as clinical instructors, although the SBON and accrediting

agencies require Masters of Science (MS) prepared faculty (AACN,2005). Given that

most clinical instructors are hired due to their clinical expertise alone, one can conclude

that individuals hired for clinical teaching most likely do not have adequate preparation,

practice, or sufficient knowledge to teach ethical decision making skills to students.

Consequences of the Problem If Not Addressed

Nurses play a critical role in patient safety and quality care. The Institute of

Medicine [IOM] report, *Keeping Patients Safe: Transforming the Work Environment of*

Nurses (2003) found evidence that the work environment significantly influences the

ability of a health professional to keep patients safe from harm and errors. There is

limited support for nurses in the workforce to develop the ability to consciously reflect

and act on everyday ethics and build moral environments in their practice setting

(Robichaux, 2014).

A lack of attention to educational preparation of the professional nurse in

particular, ethical formation will continue to propagate and further erode the existing

healthcare environment. For a change to be realized, there also needs to be higher

expectation towards formal nursing education of those hired to teach undergraduate

nursing students otherwise, clinical nurses will continue to "teach as they were taught"

(Diekelman et al., 2003). By transforming the practice of educating nurses, the nurse

educator can have an impact on the development of high performing and effective care giving nurses, through moral development, that in turn improves safety and quality of care.

The Implications for Practice

Numminen and Leino-Kilpi (2007) found in their review of the literature that "research focusing on nurse educators and clinical instructors related to education of ethical decision making in nursing students was non-existent" (p. 805). Implementing a quality improvement project to improve the quality of nursing education and implications for nursing practice in the clinical setting can inform the profession, schools of nursing and contribute to improving safety and quality of care. Without improving the education of the nurse who becomes a clinical instructor, the inaccurate assumptions that any nurse can teach will be maintained. Further, without improving the ability of clinical nursing faculty to include ethics in clinical practice, the 'status quo' will be maintained and everyday ethics for nursing will continue to be minimized, overlooked and underappreciated.

Purpose

The purpose of this project was to improve the knowledge and skill in ethics and teaching of ethics of clinical instructors working within undergraduate educational setting. Developing the clinical instructors' abilities to teach and apply ethics in practice will facilitate nursing students' learning of applied ethics and eventually have an impact on their practice.

The project questions explored during implementation of this project were:

- What knowledge or experience (ethical or teaching) is needed by clinical instructors to teach ethics in practice settings?

- What current ethical expertise is used in clinical teaching practice in an undergraduate education setting?

- What barriers or challenges exist for clinical instructors to teach ethics in clinical practice?

- How will an educational workshop on ethics using simulation methods for clinical instructors, influence or impact their ability to teach ethics in clinical education?

Specific Objectives and Aims:

In order to improve the clinical instructor's knowledge and skill in ethics and teaching of ethics to nursing students in the clinical setting, a specific objective of the project was to provide an educational workshop for clinical instructors using simulation methods. The workshop was provided as an intervention that educated clinical faculty on teaching ethics in clinical practice. A project aim through an educational workshop was to provide teaching strategies and reflection for clinical faculty on how to teach ethics to undergraduate nursing students in a clinical setting.

Enhancing a student's ethical comportment and formation through improving the education of clinical instructors demonstrates a commitment to improve clinical nursing education as outlined by Benner et al., (2010). Given the magnitude of the problem and time constraints within the Doctoral of Nursing Practice (DNP) project guidelines, the project focused on the application of ethics in practice by small sample of clinical

instructors (n=8) in an undergraduate nursing education program. Given the enormous

changes in and complexity of current nursing practice and practice settings, it served to

provide future nurses entering practice knowledge and skills for today's ethical practice.

Clinical instructors are in a unique position to assist nursing students obtain a

good grasp of everyday ethical comportment, develop moral reasoning, demonstrate

appropriate skill at responding ethically and demonstrate the skill of ethical reflection to

discern moral dilemmas (Benner et al., 2010, p. 28). When a nurse is able to act ethically

and cultivate ethical environments to work in, a positive impact will be made on patient

safety and quality care. As nursing student learns to act from a state of understanding

and ethical action in practice they will begin to model a preferred moral environment in

the organizations in which they work.

The timeline was set forth and works well within the guidelines of the DNP

handbook (2013) for the University of Southern Maine, School of Nursing. Changes in

knowledge and skills in ethics and teaching of ethics were demonstrated in a small

sample of clinical instructors at the end of the project.

The next chapter will review the literature for current research, education and

practice on ethics and teaching of ethics to nursing students in the clinical setting.

Additionally, a theoretical and conceptual model will be described and applied to this

project in the following pages.

Chapter 2

Literature Review

Nursing ethics is considered foundational to the profession and the practice of nursing (ANA, 2008). In every day nursing practice, all nurses are confronted with ethical challenges. Nurses must deal with specific moral questions along with everyday problems that arise, such as questions of confidentiality, inter-professional conflict, system issues, patient rights, and life and death. The ANA *Code of Ethics* (2008,) was developed to serve as a guide for professional practice. "As health care has become increasingly complex driven by health information technology, the aging of the population and health reform, among other factors, the need for direction in nursing ethics has become more apparent" (Larson, 2014, para 4).

An understanding of ethics and how to apply an ethical decision making framework will assist nurses with a clearer view of the issues, possible courses of action, and the principles underlying the right actions in practice (Dahnke & Dreher, 2006). Therefore, it is vital for clinical instructors to have ethical knowledge and skills to provide opportunities for nursing students to learn and apply ethics in practice. This review of the literature will explore current research and knowledge about challenges and barriers for nurses to gain ethical experience in practice and the difficulties faced by clinical instructors to facilitate learning for nursing students in practice.

Moral responsibility. All nurses have a moral responsibility to work towards achieving a climate in health care that is ethical (Doane, 2002). Moral responsibility in nursing practice means being guided by "one's inner compass" (Lindhl et al., 2007, p. 133). In a phenomenological study by Lindh et al., (2007), this theme related to moral

responsibility was explored with fourteen nursing student participants. Ideals, values, and knowledge were continually brought together and how these values were acquired and embedded in situations were studied (Lindh et al., 2007). Doane (2002) discusses the development of teaching and learning ethics in nursing and describes an individual's moral identity as the best predictor of the commitment towards moral action. It is in the moral identity of an individual, what a person considers to be the right decision or action and rationale, which leads to following through with a particular course of action (Doane, 2002). "More attention should be given to fostering one's moral responsibility in nursing practice in order for creative ethical actions to be realized" (Doane, 2002, p. 523). Doane (2002), urged nurses "to see ethics as something they are, not merely as something they follow, and to develop the knowledge and ability to live in, and navigate their way through the complex, ambiguous, and shifting terrain of ethical nursing practice" (p. 523).

These thought leaders maintained that ethical formation should integrate components of moral identity such as courage, including finding and navigating one's voice and inner strength, to develop one's identity and capacity as moral agents and embracing moral community (Doane, 2002; Lindh et al., 2007). These particular components should be considered as part of the foundational knowledge and skills of nurse educators and used to convey to students how to achieve ethical action in every day practice.

Nurse educators have an obligation to prepare nursing students for ethical practice, even in light of current organizational climate and potential challenges in the clinical settings. Nurses must be prepared to recognize ethical situations, act to resolve

ethical issues and challenge unethical practices. While students, nurses, and nurse

educators may recognize and engage in ethical issues in the clinical environment, they

often experience difficulties in addressing them (Epstein & Carlin, 2012; Levett –Jones et

al., 2009). It is a struggle to teach nursing in challenging environments that lacks

attention to ethical practice (Epstein & Carlin, 2012; Levett –Jones et al., 2009).

Parker Palmer, an educator and author, (2007) suggests the community of

educators possess the power to alter these challenges to practice ethically, or in other

words alter the "currents" within ethical environments. The author contends that "we

must help our students uncover, examine, and debunk the myth that institutions are

external to and constrain us, as if they possessed powers that render us helpless – an

assumption that is largely unconscious and wholly untrue, institutions are us" (Palmer,

2007, p. 3).

While many studies focus on skill competence for nurses, few studies focus on

ethical competence in practice or the knowledge and skill needed for clinical instructors

to address those competencies when teaching in clinical practice (Epstein & Carlin,

2012). Preparing nursing students for ethical challenges in the clinical environment and

understanding how to foster ethical development is an important area that nurse educators

and clinical instructors must attend to.

Nurses and ethical decision-making in practice. There is great complexity and

challenges within the ethical-decision making process that nurses encounter in practice.

Traditionally, nurses have been marginalized for attempting action or excluded from

ethical decision making and have faced losing their job when speaking out (Epstein &

Carlin, 2012). "Understanding ethical decision-making is an important part of being a professional nurse, a moral agent, and ensuring the ability to act on moral agency" (Rodney et al., 2002, p. 76). However, researchers collected data from studying students in clinical practice and found that nurses are not supported in their direction to address these concerns (Epstein & Carlin, 2012; Erdil & Korkmaz, 2009; Levett & Jones et al., 2009).

Ethical decision making in health care is a complex issue that requires nurses to critically think about day to day ethical situations, effectively communicate, navigate the uncertainty, apply decision-making models to each situation, and ethically act. Professional decisions on the ethics of care influence not only the quality of patient care and ethical problem solving but also the learning experience and professional development of student nurses (Park, 2013 p. 590). The ANA *Code of Ethics* for Nurses (2008), states that "the nurse is responsible for contributing to a moral environment that encourages respectful interactions with colleagues, support peers, and identification of issues that need to be addressed" (p. 6). Nurses are mandated to provide safe and ethically competent care, but how they respond to ethical dilemmas and or problems varies depending on the situational context as well as individual, organizational, and cultural factors (Park, 2013).

Due to the continuous presence with patients and families, nurses are the obvious people to act as central individuals in the ethical decision making process (Cerit & Dinc, 2012). Goethals et al. (2010) reports in a literature review of nurses' ethical reasoning and behavior that nurses are involved very little, if at all, in the process. Goethals et al., (2010) concludes it becomes difficult for nurses if not involved, to advocate and learn the

role of ethics in practice. The authors contend that "often nurses have difficulty addressing their own moral distress and acting on their own personal values and norms" (p. 646-647).   Goethals et al., (2010) also found that many factors can hinder nurses from applying ethics to practice and acting ethically such as stressful working environment, poor leadership in health care organizations, limited time and resources, lack of participation in ethical decision making, and willingness to conform to norms and expectations of others.

Often nursing students in the clinical setting see and experience challenges to providing ethical care (Erdil & Korkmaz, 2009). A striking conclusion by Erdil and Korkmaz (2009) in a descriptive study of nursing students' observations of ethical problems during their clinical education found that staff nurses did not take an active part in ethical decision-making. In Numminen and Leino-Kilpi's, (2007) review of literature of nursing students and ethical decision-making found that students felt confused about nurses responsibility in ethical issues. Further, the authors found that "students' immediate cultural environment, their clinical experiences, their perception of their role as nurses, and recent education were factors influencing students' ethical decision-making ability" (Numminen & Leino-Kilpi's, 2007, p. 804). Constraints to the moral agency of the nurse make it difficult for students to utilize ethical knowledge and navigate its application to every day nursing practice (Epstein & Carlin, 2012; Erdil & Korkmaz, 2009; Levett-Jones et al., 2009; Numminen & Leino-Kilpi, 2007).

Managing ethical dilemmas are part of professional practice of a nurse (Epstein & Carlin, 2012). Epstein and Carlin (2012) contend that "…despite students being taught to think critically and to solve problems, they seem to be left on their own when it comes to

taking action, at least when ethical elements are involved" (p. 900). Nurse educators are responsible to ensure that both the clinical and academic environments bridge any knowledge gaps, foster ethical development and prepare future nurses to recognize and address various ethical issues. The clinical instructor is in a unique position to use the many ethical situations that arise during clinical rotations to help the students develop and improve their own ethical decision making skills (Smith, 2001).

While there are many didactic topics within nursing ethics, there is limited information available to guide the practical application of ethics in the clinical learning environment as concluded by Erdil and Korkmaz (2009) in their observations of student nurses. In order to prepare nursing students for ethical decision making, clinical instructors must possess a strong understanding of ethics and practical skills in ethical decision making. In addition, opportunities to further understand and examine every day ethical situations and practical knowledge is paramount as the clinical instructor gains experience in the teaching role. As Benner (1991) notes, procedural ethics (ethical decision making process) is dependent on "everyday skillful ethical comportment and practical moral reasoning that is formed by the particular knowledge of the embodied knower" (p. 1). Thus, providing opportunities to enrich and foster ethical development in practice for nursing students is paramount to the clinical educator's role. Clinical instructors must navigate the delicate political climate and culture of the organizations and relationships with staff when acting on ethical points in clinical settings that creates additional barriers for teaching applied ethics to students (Epstein & Carlin, 2012; Levett-Jones & Lathlean, 2008).

Nurses, ethics and the workplace. Health care settings present a dynamic moral climate where students are often immersed in a complex network of competing demands, priorities, and relationships (Levett-Jones & Lathlean, 2008). In these complex environments, nurses must manage ethical care of patients while attending to several competing demands simultaneously (Corley 2002). "Nurses are challenged with increased workloads, under-resourced or severely strained organizations, institutional constraints and demands, increasingly complex patient and family health needs, and poorly managed health care systems" (Rodney & Street, 2004, p. 217). Authors such as Rodney (2002; 2004), Epstein and Delgado (2010), and Corley (2002) have extensively explored the literature on the effects of the moral climate of nursing practice and the phenomenon of moral distress in nursing. The pressure within an increasingly demanding health care system is a frequent cause for emotional stress and anxiety among nursing staff. Nurses attempt to maintain their moral integrity in environments that are frequently met with conflict and disagreement (Corley, 2002). These issues of stress can lead to a range of ethical situations in which constraints to quality care is pervasive and nursing staff, students, and clinical instructors experience profound distress (Corley, 2002).

When nurses are forced to negotiate professional values or standards of care and act unethically, they experience moral distress (Epstein & Delgado, 2010). For nurses these moral values have been violated due to constraints beyond their control (Epstein & Delgado, 2010). This distress can occur over and over again for nurses, with an increase in intensity occurring with each instance (Epstein & Delgado, 2010). After each distressing situation, "the moral wound of having had to act against one's values remains"

(Epstein & Delgado, 2010, p. 1). This lingering "moral wound" is known as moral residue which nurses carry with them (Epstein & Delgado, 2010). It is powerful and affects the nurses' thoughts and views of self (Epstein & Delgado, 2010). According to Epstein and Delgado (2010), moral wound is critical because "nurses find it difficult to rise above the moral distress in ethical climate in which they work and this residue eats away at self" (p. 1). "There is extensive documentation on the level of moral distress in nursing, the problems in the moral climate of nursing practice and constraints to practice ethically; however, there is not much research for how to deal with these problems" (Rodney & Street, 2004, p. 217).

In a qualitative multi-site study of ethical practice in nursing, Rodney and colleagues (2002) reported that nurses often experience a great deal of difficulty navigating the moral culture towards ethical action in their practice sites. Nurses stated they were "hardly in control of ethical decision making in practice" (Rodney et al., 2002, p. 89). Additionally, nurses in focus groups as part of the study reported their "voices were seldom heard as they confronted everyday ethical problems and to some extent, they were not heard because they tended not to explicitly note a problem as ethical" (Rodney, et al., 2002, p. 90). The nurses spoke about good practice, but did not consciously speak of it in terms of ethics (Rodney et al., 2002). Although the study found that nurses were almost always aware of their ethical practice, they were not necessarily following an ethical philosophy in their practice (Rodney et al., 2002).

Similarly, more recently Pavlish and colleagues (2011), collected information from nurses on ethically difficult situations, nurse actions and situational outcomes through questionnaires. In several cases nurses stated they chose not to pursue their

ethical concerns beyond providing standard nursing care (Pavlish et al., 2011).

Additionally, several nurses "expressed significant regret" in their written narratives that

included "most regrettably unnecessary pain and suffering, and some claimed that they

did not do enough for the patient" (Pavlish et al., 2011, p. 385). Thus concluding from

both studies that even a decade later, nurses are still challenged to apply ethics in

practice. Beyond practice of ethical knowledge and skill, an ethical decision framework

that emphasizes context and action is warranted in nursing practice.

Jameton (1990) linked ethics to culture; "Morality is best viewed as part of

culture; it addresses the conduct of the group and its members and identifies the most

central or important commitments or values of the group" (p. 446). Complex moral

situations are shaped by the cultural context in which it occurs (Jameton, 1990). Nurses'

moral concern regarding the ethical climate of the workplace is significant to their

practice and should not merely be perceived as a personal concern (Jameton, 1990).

Similarly, Rodney et al. (2002), asserted that "strengthening nurses' moral agency means

attending to nurses' personal needs, while at the same time improving the moral climate

of the workplace" (p. 89).

In 2004, the American Association of Critical Care Nurses (AACCN) began a

movement to address ethical concerns in their specialty by developing the *4A's to Rise*

Above Moral Distress, an ethical resource for critical care nurse. This framework assists

the nurse to identify and address moral distress in their practices. "AACCN believes that

moral distress is one of the key issues affecting the work-place environment. Addressing

moral distress is part of the organization's strategic initiatives to create a healthy

workplace environment" (AACCN, 2004, p. 1). To support ethical practice for patient

and families, the organization has taken a stance on what constitutes a healthy work

environment. Nursing organizations like AACCN have collaborated with other thought

leaders in nursing to develop key elements for a healthy work environment for nurses and

have disseminated these standards across the discipline of nursing. AACN's *The*

Standards for Establishing and Sustaining Healthy Work Environments (2005) was

developed and disseminated for health care individuals and organizations to help

empower the nursing work environments.

Similarly, the Veterans Health Administration (VA) National Center for Ethics in

Health Care has developed an *Integrated Ethics* (2008) program to improve ethics quality

in health care. The VA has become a leader in quality and organizational change in the

American Health Care System. They have prepared an integrated ethics model and

toolkit for facilities. The main impetus for this program was a desire to focus on ethics

quality in health care and improve gaps in ethic quality within the VA system (VA,

2008). The VA purports that ethics quality means "that practice throughout and

organization are consistent with widely accepted ethical standards, norms, or expectations

for a health care organization and its staff" (VA, 2008, p. 1.2).

Shaping the future of nursing ethics has been a high priority for many experts

concerned with barriers to ethical practice in health care organizations. Recently, experts

and colleagues from the Berman Institute of Bioethics and Johns Hopkins University

School of Nursing convened leaders from a number of nursing organizations for the

National Nursing Ethics Summit, where they discussed creating a blueprint for nursing

ethics for the future (Larson, 2014). Individual nurses must be able to speak up if

something ethical worries them and the blueprint will address the supportive nature of

infrastructure and organization in health care ethical environments (Larson, 2014). If

nurses have confidence that their professional judgment and their concerns will be heard

and respected then their ability and skill in ethics and ethical decision making actions will

be experienced.   The point emphasized by these summit experts, is that it is simply not

enough for nurses to have these skills if the environment does not support them (Larson,

2014).

Rodney et al., (2002) describes a moral horizon in nursing as "the good" towards

which nurses must steer their professional and ethical practice (p. 81). The authors

contend that 'currents' within the moral climate of the health care setting in which nurses

work have a significant influence on this process (Rodney, et al., p. 81). "These

'currents', such as unsupportive or hierarchical relationships and demanding workloads,

to name a few, can create difficult working situations and ultimately affect the nurses'

ability to practice ethically" (Rodney, et al., p. 81). All these factors come into play

when nurses are confronted with ethical issues in their work environment.

These issues must receive further attention from all nurses within health care

organizations, including nurse educators in academia, who have a moral responsibility to

address the "currents" embedded in practice as identified in the *Code of Ethics for

Nurses*. Ethical knowledge for all nurses, including clinical nursing instructors, must be

grounded in strategies that use knowledge and skills to act on these moral issues within

practice.

Clinical expertise does not equate to ethical competence. Clinical instructors

need to help nursing students experience ethics in practice and are in the best position to

do this. The clinical instructors should have a clear vision and understanding of

professional nursing, in particular the *Code of Ethics,* and how it is enacted in the practice

setting. Excellent clinical skills alone are not sufficient enough to convey nursing

knowledge and practice of ethics to others in a meaningful and useful way.

Nursing programs, particularly baccalaureate preparation, have an important

charge of educating the student on ethical values of the profession. The *Essentials of

Baccalaureate Education for Professional Nursing Practice* (AACN, 1998) states that

"graduates must be able to identify potential and actual ethical issues arising from

practice and assist patients in addressing such issues; therefore, knowledge of ethics and

ethical decision making is critical" (p. 14). This mandates that knowledge of ethics be

included as part of the education process of baccalaureate nursing education. In order to

fulfill this obligation, programs of study educating those who teach need to include

knowledge of ethics and ethical decision making frameworks to assist the students

learning in practice. Additionally, the AACN (1998) notes that coursework and clinical

practice should prepare students to apply ethical concepts, an ethical framework for

decision-making in practice, and "take action to prevent or limit unsafe or unethical

health, and nursing care practices by others" (p. 14).

Clearly, clinical instructors have an important role in students' learning process.

They are frequently responsible with the enormous task of bridging the educational

curricula with clinical practice and in many cases with little guidance (Roberts,

Christman & Flowers, 2013). Individual nurses are hired for clinical teaching

specifically for their clinical expertise without any formal education in nursing education

or curriculum (Duffy, Stuart & Smith, 2008; Hewitt & Lewallen, 2010; Krautscheid,

Kaakinen & Warner, 2008; Poindexter, 2013). Therefore, it is difficult to assume clinical

instructors are competent in nursing education practices and may need professional

development once hired as clinical instructors.

       Emphasis on experiential ethical learning. Models of ethical behavior and

action that demonstrate how nurses should respond to issues in the clinical setting, are

often easier for nursing students to learn in context of real situations rather than in the

classroom or from assigned readings. Benner (1991); emphasizes the importance of the

development of skillful moral comportment that is fostered in practice. Ethical

comportment refers to more than just words, intents, beliefs or values; it also integrates a

stance, direction, courage, and action (Benner, 1991). "Ethical dimensions of care must

be learned experientially because it is dependent on recognition of salient ethical

comportment in specific situations located in concrete specific communities, practices,

and habits" (Benner, 1991, p. 2). Experience is gained when an individual actively learns

to recognize salient ethical features in practice (Benner, 1991). Benner (1991) contends

that "ethical principles of formal nursing education are of no significance if practical

situations relevant to these principles go unnoticed or if the nurse does not have the skill

to act ethically" (p. 2). Benner and colleagues (2010) have examined the practice

knowledge of nurses using narratives and discover that ethical comportment and ethical

expertise of practice resides in this practice knowledge.

       In *Educating Nurses* (2010), Benner and colleagues focused their teaching of

ethics on formation. Knowing that nursing students will need to act ethically in situations

burdened with conflict and confusion, they make the analogy of a sailboat (Benner et al.,

2010). The authors contend that instructors must help students find the keel of their boat

(Benner et al., 2010). "They [students] come with pretty flat-bottom boats and the trouble with a flat-bottom boat is, when the wind blows, you just scatter across the water. And the wind blows this way; you scatter back across the water" (Benner et al., 2010, p. 169). Therefore, clinical instructors have a significant role to convey ethical learning with nursing students during clinical practice.

Nursing education has an impact on the development of students' moral reasoning and moral behaviors (Numminen & Leino-Kilpi, 2007). Beckett et al. (2007) in a descriptive study of nursing students and relational practice using reflective essays found that students who were taught ethical principles and theories in the classroom, often found it difficult to apply the concepts in the clinical setting. Students will struggle with what the right thing to do is in a nurse-patient relationship, how to demonstrate an ethical caring response and whether they should adhere to formal and informal policies (Beckett et al., 2007, p. 32).

Using an ethical decision-making model as a medium of moral thinking and moral behavior is an important element of nursing ethics education (Numminen & Leino-Kilpi, 2007). Numminen & Leino-Kilpi (2007) found in a literature review that the use of an ethical framework or model produced the greatest growth in ethical decision-making. Similarly, Krawczyk (1997) studied the development of moral judgment in nursing students. This developmental cross-sectional study found that an ethics course with group participation, use of case studies, and a decision making element combined with clinical experiences in dealing with ethical issues largely facilitated nursing students learning of ethics (Krawczyk, 1997). Student's level of moral reasoning was related to the type of curriculum, level of education and their experiences of ethical issues in

clinical practice. Students experiencing an integrated curriculum had higher levels of

moral development (Krawczyk, 1997). Moreover, all three authors found that multiple

factors, such as, the immediate cultural environment, clinical experiences, perception of

their role as nurses, and recent education highly influence students' ethical decision

making in practice (Beckett et al., 2007; Krawczk, 1997; Numminen & Leino-Kilpi,

2007).

   Purtillo and Doherty (2011) report that if students gain the opportunity to apply

ethical knowledge and skill in real-life situations their level of confidence and experience

regarding ethics will deepen. Further, these authors assert that "it is the mutual task of

students, classroom learning and clinical faculty working together to ensure that students

trust their developing competencies and abilities to understand their role as moral agents"

and act appropriately with a caring response consistent with the responsibility of the

professional role (Purtillo & Doherty, 2011, p. 130-131).   According to Purtillo and

Doherty (2011) "a caring response is fundamental to both the art and science of effective

health care delivery and is the ethical goal of every health professional and patient

relationship" (p. 27). In challenging uncertainty and environments of current nursing

practice, clinical instructors in the clinical setting must find ways to nurture the formation

of ethical practice in nursing students to impact their learning.

   Clinical instructors preparation for teaching. Nurse educators in the clinical

settings have an important leadership role in students' learning process. Dahlke and

colleagues (2012) in a literature review of the clinical instructors' role in nursing

education concluded that the clinical instructor guides the student while learning in a

highly complex environment and plays an important role in bridging clinical situations

and classroom theory (Dahlke, Baumbusch, Affleck & Kwon, 2012). Clinical instructors

must use clinical practice settings and simulation to create experiential learning

opportunities for students. In these settings, students gain skills in clinical reasoning,

which is especially important in the formation of ethical skills (Dahlke et al., 2012).

Students' clinical practice and their experiences with clinical instructors play an

important role in shaping their professional ethics and values (Dahlke et al., 2012).

Faculty requires professional development, mentoring and encouragement to

develop into the educator role and continue in it (AACN, 2005, Roberts et al., 2013).

However, sources such as the literature review by Dahlke et al. (2012) and Dunphy-

Suplee et al. (2013), survey of seventy-four clinical instructors concluded that instructors

can be expert clinicians but may be inadequately prepared to manage the variety of

clinical teaching challenges. The instructors in these studies often lacked the formal

preparation in nursing education, held various views on the clinical teaching role, and had

a tendency to use their personal values and experiences a clinicians in implementing their

roles (Dahlke et al., 2012; Dunphy Suplee et al., 2014).

With the nursing faculty shortage looming, nursing baccalaureate programs and

clinical agencies are charged with increasing the supply of nurse educators, who can

deliver effective clinical instruction (AACN, 2005).   Cangelosi et al. (2009) concluded

that, "there is limited research on the process of educating clinicians specifically to

assume clinical instructor roles" (p. 367). Their data obtained through 135 narratives

from 45 nurse participants in these descriptive phenomenological study, supported the

idea that a nurse who is proficient in clinical practice is not necessarily proficient in

teaching clinical skills to others. The nurse participants in the study were new to clinical

education and describe a lack of mentoring for their role as educator. The authors

contend that "teaching is not a natural byproduct of clinical expertise, but requires a skill

set of its own" (Cangelosi et al., 2009, p. 371). Therefore, the authors make a strong case

that education and mentoring are essential for nurses who are in the process of learning to

teach (Cangelosi et al., 2009). Further, in a study by Roberts and colleagues (2013)

using semi-structured interviews of 21 clinical instructor participants, the authors found

that [their] "transition from a nurse clinician into the role of adjunct clinical faculty is one

that should be intentionally guided and supported by a mentor, with a focus on the

acquisition of educational skills needed for that role" (p. 295).

Clinical instructors are put into complex and challenging instructional situations

without satisfactory orientation programs, professional developmental opportunities and

ongoing faculty support or mentoring related to the role (Dahlke et al., 2012). Similar

findings were suggested by Davidson and Rourke (2012) in their survey of the orientation

needs of clinical nursing instructors. Minimal support is provided by nursing programs to

develop teaching skills and new clinical instructors often do not use higher levels of

questioning that would stimulate critical thinking among students (Dahlke et al., 2012).

Clinical instructors frequently do not have any formal education in teaching and so they

must draw on their individual personal and professional experiences to guide their

teaching (Dahlke et al., 2012). The authors conclude that the impact of underprepared

clinical instructors with limited formal education to draw from can lead to nursing

students being unprepared for handling complex critical thinking situations. This notion

of clinical instructors will "teach the way they were taught" is also supported by authors

such as Diekelmann and colleagues (2003). Clearly, this informal experience with

teaching is inadequate for nursing students being able to learn ethics in practice, especially if the instructor's experiences and involvement in applied ethics is limited by their previous learning (Epstein & Carlin, 2012).

The need for well-prepared educators in clinical instruction should be a top priority of baccalaureate programs; however, research findings suggest otherwise (Dunphey -Suplee et al., 2013). Dunphey-Suplee et al.,(2013) surveyed nursing faculty preparedness for clinical teaching and identified gaps in the preparation of clinical faculty. Dunphey-Suplee and colleagues (2013) learned that 31% of clinical teachers reported having no preparation for clinical teaching (p. S38).

Although the mandate is for nursing faculty to be prepared at the Masters of Science in Nursing (MS or MSN) level to teach, State Boards of Nursing (SBON) give exemptions for school of nursing (SON) to use Bachelors of Science in Nursing (BS or BSN) prepared nurses to teach a majority of clinical instruction. Most states require MSN prepared educators to teach however, because of the shortage, limited monetary incentive and lack of MSN prepared nurses to teach there is inconsistency across states in meeting this mandate (NLN, 2008; AACN 2005; NCSBN 2012). Thus, it becomes the norm for SON programs include the SON program for this project setting to apply exemptions to hiring clinical instructors with limited or no preparation for teaching.

Research focusing on nurse educators and clinical instructors related to education of ethical decision making is non-existent and has not been sufficiently acknowledged (Nummenin & Leino-Kilpi, 2009). The majority of studies dealing with ethical decision making have focused on practicing nurses or nursing students' perspectives; the role of

clinical instructors in ethics has not been a focus. Anderson (2009) described findings of

an analysis of qualitative data from semi-structured interviews of clinical experts who

become novice nurse educators in the clinical setting. The authors found that without

adequate support for work-role transition as an educator along with a dedication to

changing the way nursing education is delivered and how well educators are prepared;

instructors may become dissatisfied and leave their positions (Anderson, 2009).

Nursing education and simulation. Currently, in nursing, simulation is a widely

recognized teaching methodology and a popular and well integrated strategy in many

nursing programs (Hunt et al., 2015; Jeffries, 2012). Simulation has been an effective

method to teach nursing in a controlled setting resembling a practice situation (Jeffries,

2012). It is a widely recognized and supported teaching methodology for effective

clinical learning & is supported student learning outcomes that are well documented in

the literature (Hunt et al., 2015 & Krautsfield, Kaakinen and Warner. 2008). Similarly,

simulation can be equally applicable to the needs of teachers as they develop and

progress in their educator role. "Using simulation to help clinical faculty practice

teaching with immediate feedback from an expert educator is a viable method for

developing teaching strategies" (Krautscheld et al., 2008, p. 431).

Simulation techniques using high fidelity manikins as well as low fidelity

techniques encompassing standardized patients and role-playing are being used today in a

variety of programs designed to enhance a range of basic to complex skills for healthcare

providers (Jeffries, 2012). However, there is a paucity of evidence that reports on the use

of simulation to improve or develop the skills of the clinical nurse educator or for

education in ethical decision making (Krautschield, et al., 2008; Shellenbarger & Edwards, 2011 & Hunt et al., 2015).

Shellenbarger and Edwards (2011) designed a simulation for graduate nurse educator students that exposed them to clinical teaching issues. The authors provide ideas for planning, implementation, and suggestions for simulation technology uses in the education of nurse educators for their role in clinical teaching. Narrative data obtained from this study using simulation indicated that the participants had a "better understanding of the clinical teaching role and how difficult it is to manage student actions while also safeguarding the patient and addressing patient concerns" (Shellenbarger & Edwards, 2011, p. e5).

In a related research, Krautschield et al., (2008) reported on the use of simulation for faculty development. The authors developed a program with pre-recorded clinical teaching situations to help faculty analyze and reflect on clinical teaching strategies (Krautschield et al., 2008). Data was collected using a descriptive method and reflective themes were collated. The reflective findings of faculty by Krautschield et al., (2008) in a qualitative study described simulation as a "powerful strategy to enhance the teaching ability of the faculty members to effectively facilitate learning in a clinical setting" (p. 433).

Most recently, Hunt and colleagues (2015) reported a descriptive study findings that included simulation to promote professional development of twenty-six clinical instructors. The study utilized role played situations that required instructors to intervene for patient safety. The findings noted that "clinical instructors thought the simulation

prepared them for clinical teaching, increased their confidence, and assisted them to provide student feedback" (p. 468).

Debriefing is where meaningful learning occurs during simulation and was captured in this project via audiotapes (Dreifuerst, 2012). The process of debriefing guides the learner to understand and work through teaching ethics to the nursing student in clinical practice setting. It offers an opportunity for reflection and verbalization of the learning that occur during simulation. Debriefing is an essential component of simulation that promotes student learning (Dreifuerst, 2012; Jeffries, 2012). Debriefing can be defined as an activity that follows a simulated experience that is led by a facilitator where feedback is provided on the participants' level of thinking and performance (National League of Nursing [NLN], 2008). Additionally, specific outcomes of the simulation activities are discussed, and reflective thinking is encouraged (NLN, 2008). Debriefing assists in connecting theory to practice and research which allows participants to think critically and discuss interventions in very complex situations (Jeffries, 2012).

There is evidence to suggest that simulation accompanied by high-quality debriefings facilitates the transfer of new knowledge, skills, and attitudes to the clinical domain, primarily through the enactment of the reflection stage of experiential learning and by providing the opportunity for the experimentation aspect of adult learning (Brett-Fleegler et al., 2012 p. 292).

Dreifuerst's (2012) exploratory, quasi-experimental, pretest–posttest design studied the "relationship of DML on the development of clinical reasoning skills in pre-licensure nursing students when compared with customary debriefing strategies and on

students' perception of quality of the debriefing experience" (p.326). The study by Driefuerst (2012) demonstrated a "greater change in clinical reasoning skills and identification of higher-quality debriefing and a positive correlation between clinical reasoning and perception of quality" (p. 326). The findings demonstrate that DML is an effective debriefing method. Further, the author concludes that DML "contributes to the body of knowledge supporting the use of debriefing in simulation learning and supports the development of best teaching practices" (Dreifuerst, 2012, p. 326).

Nursing Conceptual Framework.

The theoretical nursing framework for this project was grounded in Benner's (1984) Novice to Expert theory and ideally stated for this project. Benner (1984) proposes that novice nurses learn best in structured formats while proficient and expert nurses learn best with experiential learning experiences in situations that are flexible but complex. Knowledge is embedded in expert practice and this knowledge can be "captured through interpretive descriptions of actual practice" (p. 4). It has been assumed that clinicians can move easily into the role of an educator but this assumption may be unrealistic without some form of additional education (Cangelosi et al., 2009). Through narrative learning, this project will explore the process of "expert nurses to novice teacher".

Benner (1984) purports when nurses move into a new role they become novices again. Since attention is given to learning this new skill of teaching by the novice, there must be some format for learning in a situated context such as using simulation or case studies. Therefore, narrative experiences of these "novice" teachers yet "experienced"

clinicians was used to improve the clinical instructor's ability to teach applied ethics to

nursing students in practical settings.

Conceptual Framework for Change

This project incorporated Lewin's (1951) linear three step change theory as a

framework with consideration given to Albert Bandura's (1977) Social Learning Theory

(SLT). SLT is used to connect cognitive forces of behavior change with consideration to

how an individual moves through change. An important characteristic of SLT is that it

considers an individual's confidence in their own ability to take action towards change

(Bandura, 1977). This confidence must be present and applied in order for a successful

change to occur. Utilizing Lewin's model (1951) of change is a linear look at the change

process, one that is rationale, goal, and plan oriented. Combining this linear movement

towards change with factors that interplay this movement such as personal, past

experiences and environment is ideally stated for this project. Given this project is

dealing with individuals, using a combined model of change that looks at the way a

learner can exercise control over the teaching of ethics to take action and overcome

barriers is significant.

According to Lewin's field theory of change (1951), all changes are due to certain

directional forces. These forces bring about changes in cognitive structure (Lewin, 1951,

p 83). Lewin (1951) explains that in any change, behavior results from forces that have a

particular direction. This direction depends on the cognitive structure of a given situation.

In any new situation, Lewin (1951) proposes that an individual may feel insecure because

the direction is not well defined, "in other words the person does not know what action

will lead to what result" (p. 74). Lewin (1951) concludes "that all behavior depends to a large degree on the cognitive structure in any given space" (p. 74). The author speaks of "learning as a change in cognitive structure and whenever there is change in meaning there is change in cognitive structure" (Lewin, 1951, p. 74).

Additionally, Lewin's theory addresses that the behavior of an individual does not depend entirely on their perception of the present cognitive situation but notes that the mood of an individual will also play a role in behavior changes. Mood is affected by hopes, needs, motivations and past experiences. To bring about change there must be a change in needs and meaning for the individual (Lewin, 1951, p.75-79). Lewin (1951) describes:

> …there are two principal ways to bring about a desired change, one implies a change of the person's own needs or interests; the other leaves needs or interests more or less untouched, and compels the individual to do the undesired action either by direct force by setting up a constellation where other stronger needs overbalance the effect of the first need.   Therefore, mere forces play a considerable role in all education. Learning by force might take place when an individual is pushed into the situation then adapts himself to the situation (p. 77).

Lewin's model as described by Kritsonis (2005), requires the first step in the process of changing behavior is to unfreeze the existing behavior or model. This step was done by motivating participants through education that prepared them for change and recognized the need to change. By using simulation to propel change forward, the clinical instructors actively participated in recognizing problems and brainstorming

solutions within a group. The participants explored the driving force towards change, the

desire to be proficient teachers in teaching ethics, and the restraining factors like an

unsupportive clinical environment. The second step is movement. Through the use of

simulation clinical instructors were persuaded to agree that their existing method has not

been beneficial to students learning about ethics in practice and were encouraged to view

the problem from a fresh perspective. The third step is refreezing which occurred in the

debriefing stage of simulation. This third step needs to take place after the change has

been implemented in order for it to be sustained or "stick" over time and according to

Lewin, as interpreted by Kritsonis (2005) is necessary. Without the debriefing, the

change could be short lived and the instructors may revert back to their old behaviors. It

is the actual integration of the new values into the existing clinical situations that will

serve to "refreeze" the change in behavior and allow instructors to adapt to the change.

The purpose of refreezing is to stabilize the new behavior by reinforcing new patterns.

Bandura's SLT (1977) emphasizes that learning occurs in an observational or

modeling environment and is co-effected by emotions and individual perceptions.

Behavior change is affected by environmental influences, personal factors such as

experience and the interaction between the two (Bandura, 1977). Bandura's (1977)

theory postulates:

> …that psychological procedures, whatever their format, serve as a way of creating
>
> and strengthening expectations of personal effectiveness. Perceived self-efficacy
>
> affects people's choice of activities and behavior settings, how much effort they
>
> expend and how long they will persist in the face of obstacles and aversive
>
> experiences. The stronger the perceived self-efficacy, the greater the desire will

be to accomplish the performance and the efforts to gain personal mastery of the

experience. The congruence between self-efficacy and performance reveal that

behavioral changes correspond closely to the level of self-efficacy whether

instated inactively, by observation or vicariously (p. 287-288).

The SLT was considered for this project because clinical instructors may not be

educated as nurse educators or do not have expertise in ethics and ethical decision

making in practice. Many may have considerable anxiety and fear to explore ethics and

ethical decision making with students in a challenging clinical learning environment.

Clinical instructors have attained a level of perceived self-efficacy and have past

experiences as influencing their abilities and behaviors as clinicians and teachers.

Therefore, these character traits must be given due consideration during this project. The

participants will in part believe in their ability to learn and behave through direct

experiences of observation and modeling using simulation methods. This will increase

their capacity for self-efficacy and behavior to then perform teaching of ethical skills

with students in practice. Self-efficacy of the clinical instructor can be increased in

several ways, such as providing clear instructions, opportunities for skill development or

education, and modeling the desired behavior.

This change project implemented the Deming's (1993) Plan-Do-Study-Act

(PDSA) cycle Model of Improvement. Deming's (1993) cycled as described by Langely

et al., (2009), proposes that while all improvement requires change, not all change will

produce improvement. The ability to develop, test and implement cycles of change is

essential in sustaining improvement. This project can be viewed as the first "try" or cycle

within this model and may be replicated repeatedly to sustain efforts towards change.

Multiple cycles is meant to increase the probability that the proposed change will actually result in sustained improvement from the viewpoint of those affected by change. This cycle forms part of an improvement guide that provides a main framework for developing, implementing, and testing changes leading to improvements in practice (Langley et al., 2009). The model is based in scientific method and results impact an individual's ability to take immediate action which is important when studying practice change (Langley et al., 2009).

The PDSA cycle consists of four stages:

- Plan: the change to be tested or implemented is planned

- Do: the test or change is implemented

- Study: analysis of the data both before and after the change is studies and what was learned is reflected on.

- Act: plan the next change cycle or full implementation (p. 5)

Quality improvement is a form of experimental learning that involves deliberate action to improve care (Lynn et al., 2007, p. 667). Therefore, the PDSA cycle was used as the formal process of this QI change project to initate the cycle of change that can be tested in other further studies related to this topic. The change in this project was planned and implemented in one, rapid cycle and can be studied further in subsequent cycles to impart wisdom to sustain the change in nursing programs.

Gaps in the Literature

It may be assumed by baccalaureate nursing programs and clinical agencies that clinical expertise equates to ethical competence and given this expertise all instructors have an ability to teach all skills effectively. However, there are significant questions and concerns as to whether this is an unreasonable expectation for clinical instructors with no or minimal teaching education. There is little evidence in the literature on standards or best teaching practice for clinical instructors to be prepared to teach ethics in clinical practice (Numminen & Leino-Kilpi, 2007; Robichaux, 2014). The preparation needed for clinical instructors to include ethics in practice is a gap in the literature. Additionally, questions persist related to the programs responsibilities and process for ongoing education and mentoring of clinical instructors once hired especially in light of their limited background in nursing education. Research on the use of simulation to educate instructors in clinical teaching is limited as well.

Summary

The key points uncovered from this review include:

- Ethical decision making is an important skill for nurses to use in practice

- Nurses are uncomfortable and have limited experience and reflection in the application of ethics in practice due to organizational and workplace barriers.

- Many nurses who become clinical instructors are not well prepared, mentored or supported to improve or develop their teaching practice.

- Simulation as a teaching methodology is one way to contextualize learning and promote active learning to help clinical instructors move from novice to expert.

The findings of this literature review support the assumption that clinical nursing instructors have limited experience and skills for instruction of pre-licensure baccalaureate nursing students in the application of ethics in practice. Given multiple factors, such as minimal teaching experience, limited formal education, support and mentoring, coupled with minimal ethical competence in applying ethics in practice, there is motivation to improve the clinical instructor's ability to teach ethical formation in clinical settings with nursing students.

Benner's (1984) Novice to Expert theoretical framework was ideal to explore in this project given that the clinical instructors role and limited education in nursing education are factors within the nature of the problem. Conceptual models of change that underpins Lewin's linear model to motivate change forward and SLT provide support that perceived self-efficacy and behavior affects an individual's motivation to change. The combined theories are suitable to describe this change given the intervention is focused on a formal linear educational process using human interaction to move and improve change. Deming's (1993) PDSA cycle supports a useful model to improve change in subsequent cycles within this quality improvement project.

The next chapter will focus on the methods used for inquiry into this project and exploring the project questions. A mixed methodology was utilized to describe the results and the following pages will report the methods and intervention used.

Chapter 3 Project Methodology

The purpose of this quality improvement project with a mixed method framework was to improve the teaching of ethics in the practice setting for clinical nursing instructors using simulation as a methodology. This chapter will give an overview of the project design, setting and sample of participants, and recruitment and protection of said participants. All project variables, including demographic information and data collection instruments will be presented. Finally, the data collection and analysis procedures will be described in the following pages.

Project Design

This was a quality improvement project using mixed method design with interpretative features. An educational intervention using simulation was implemented to explore this process. This project explores human experience; therefore a qualitative approach was used to collect data and discuss the findings. Additionally, quantitative methods were used in conjunction to analyze the results. The knowledge generated by this project will promote a better understanding of teaching ethics to nursing students in clinical practice and assist clinical nursing educators to improve their teaching ability of ethics. The change in knowledge and comfort in teaching ethics by the participants was measured and analyzed. The intention of the design and intervention was to create evidence that is practice based. This project sought to generate new insights from qualitative evidence and apply it to teaching practice (Leeman & Sandelowski, 2012; Polit & Beck, 2012). Participants were asked to participate in a one-time, 4 hour, educational workshop that consisted of three parts: an ethics primer, a critical incident

video and role-playing. They were asked to observe, discuss, and role-play with each other to address ethics in clinical practice. The design follows a typical teaching model which includes learner objectives, pre-assessment, implementation using simulation as a teaching method, debriefing and evaluation.

This project involved an educational workshop as an intervention for clinical instructors on the teaching of ethics to nursing students in the clinical setting utilizing simulation as a teaching methodology. The workshop educated clinical faculty on teaching ethics in clinical practice.

Setting

The setting for this project was a pre-licensure baccalaureate nursing program of a state university located in northeastern United States. The university nursing program graduates approximately 160 undergraduate students per year and is one of the largest nursing programs in the state. The mandated state ratio for clinical instruction deemed appropriate by the Maine State Board of Nursing is eight students to one clinical instructor.   Therefore yearly, the nursing program needs approximately 20 clinical instructors at various clinical settings during specific times each semester. The university hires a large number of part-time clinical instructors to fill this need. Approximately 50% of the part-time instructors hired each semester either hold an advanced degree in nursing or are enrolled in a master's program. Some of these hires have had some formal education in nursing education although most have not. (E. Elliott, personal communication, September 23, 2014).

In recent years, nursing programs have had to increase the number of part-time clinical instructors with BS degrees to fill clinical faculty vacancies (AACN, 2005). Additionally, although some with BS degrees are enrolled in a MS program, the majority do not have any formal education in nursing education. These facts are consistent with the trends previously report in the literature review.

While the nursing program for this project setting would prefer to hire clinical faculty who hold a MS degree this is not always possible due to the limited number of individuals with advanced degrees living in the state who apply for these part-time positions and the low compensation that the university offers for this work. In addition, the education and orientation curriculum for clinical instructors does not include nursing education classes or reflect any specific preparation on how to teach ethics in practice. At best, the education for clinical faculty in this setting includes a brief orientation, over a few hours, to the process of clinical teaching along with an overview of the policies and procedure for the nursing program. (E. Elliott personal communication September 23, 2014). A four hour education workshop for clinical instructors at this setting revealed that nursing instructors felt at times unsure of their teaching ability and also reported being left to navigate how to do clinical instruction on their own with limited guidance and mentoring (USM Teaching Workshop, August, 2014).

Nursing faculty who are chosen for clinical practice instruction are selected primarily based on their clinical expertise and availability to teach in certain clinical areas or on certain days and times. They may be considered by their peers and unit managers as an experienced clinician in nursing, and may also have an interest in teaching undergraduate nursing students. These selection techniques for clinical instructors hold

true in the pre-licensure baccalaureate nursing program, where the project was

implemented.

Sample Description

The participants were selected from a purposeful and convenient sampling of

clinical instructors recruited from the University of Southern Maine, School of Nursing.

Prospective subjects were identified from a clinical instructor list that includes

individuals currently teaching clinical in the spring 2015 semester. A recruitment email

was sent to all instructors on the list to introduce the PI and request their voluntary

participation. The recruitment email summarized the research project, the purpose,

activities, benefits, risks, confidentiality and results. The email clearly stated that their

participation was voluntary with no risk to employment. Ten participants were enrolled to

be participants in this project however only eight were able to attend the educational

workshop and continue with the data collection. Therefore, eight clinical instructors was

the final number of participants for this project.

The project was approved by the Institutional Review Board (IRB) and

recruitment was done via email communication to all clinical instructors teaching clinical

in the Spring of 2015 using a secure server. Individuals teaching clinical in the semester

that the project was undertaken were sent an email letter. Inclusion criteria included

clinical instructors in a pre-licensure baccalaureate nursing program teaching within this

university. Exclusion criteria were instructors who were not teaching in a clinical

environment this particular semester. Once participants met the inclusion criteria and

were recruited, a 30 to 45 day timeframe was used to complete the implementation of this

project. Those who indicated an interest to participate in the project read, agreed to, and

signed an informed consent with the principal investigator (PI).

The total length of time for the project from implementation to evaluation was

approximately 6 months. The amount of time each participant was involved in the

project was approximately four to five hours beginning with consent. This time frame

included: explanation of project and signing of consent form, participating in an

individual needs assessment and a 10 minute self-study voiceover power point, a four

hour face-to -face faculty development program and a follow up written survey.

Project Methods

The participants took part in a simulation intervention experience in the clinical

instructor role. Utilizing a plan-do-study-act framework, the educational workshop for the

project provided clinical instructors with the ability to reflect on a critical incident video

of an ethical dilemma on a clinical unit and describe their current teaching of ethics in

practice. The clinical instructor viewed the ethical situation on video and was asked to

respond using his/her existing teaching approach. Debriefing was used to discuss and

evaluate each response. During the workshop, there was an opportunity where gaps exist

to educate clinical instructors on effective methods to respond using an ethical

framework.

The simulation, in two parts, increased their ability to utilize the knowledge and

tools for ethical decision making during clinical instruction and with this new knowledge

gain future opportunities to develop the ethical formation of their students in a clinical

practice setting.

The knowledge of the clinical instructor was measured using mixed methods with a pre- and post-assessments and open-ended questions. It took several weeks to plan, implement the educational module and collate the data. A final semester was used for evaluation and final manuscript write-up.

Following informed consent, the project consisted of the following planned activities with participants following informed consent:

- Each participant was sent a pre-learning assessment that was completed and returned to the PI prior to educational module.   The pre-assessment was given to obtain a baseline of current ethical knowledge, skill and comfort in teaching ethics in a clinical setting. Demographic data such as gender, age, level of formal education, other formal or informal education in nursing education or ethics, number of years teaching and number of years teaching clinical was gathered during this initial pre-learning assessment. The question format included a numerical rating scale. See Appendix B.

- Participants were asked to view a 10 minute self-study voice over PowerPoint that consisted of an ethics primer prior to the educational session. This was created by the PI. See Appendix G.

- A face-to-face four hour educational module was developed by the PI and implemented with the participants.   The time-frame allowed for interactive learning with adequate personal breaks.

- Educational workshop objectives included:

  1. Describing the clinical instructor's role in clinical instruction.

2. Describing and analyzing teaching of ethics in practice

3. Engagement in conversations with nursing students and other health care professionals about ethical dilemmas in practice

4. Practicing how to respond to nursing students about ethical dilemmas/issues in practice.

- The educational workshop utilized a three pronged approach and included two interventions using simulation: a short lecture, critical incident video with debriefing and role playing with debriefing.

- The initial part of the module included a 20 to 30 minute lecture with participants on nursing education theory. The discussion emphasized the clinical instructors' role and responsibility in the clinical setting with the nursing student.

- In intervention number one, participants watched a critical incident video made by a faculty member and graduate nursing students enrolled in a graduate nursing education course, for a different purpose. The video was of an ethical dilemma faced by a nursing student in clinical practice. There was an opportunity for the participants to discuss the incident and subsequent responses after watching the video. The intervention assisted participants to reflect on and analyze clinical teaching strategies in applied ethics with a nursing student. The intervention utilized a semi-structured interview guide and debriefing to explore meaningful learning. See Appendix C.

- o In intervention number two, participants were asked to split up in pairs to role-play an ethical situation that involved a clinical instructor (CI) and a nursing student in clinical practice. These clinical role-play situations were developed by the PI. One participant played the nursing student and the other played the role of the clinical instructor. Some scenarios required an additional health care member ie. nurse or physician and another participant was asked to play this role. Each participant took a turn playing the role of the clinical instructor which provided an opportunity for the participant to respond to the student's ethical concern. Following the role-play, the group debriefed to explore meaningful learning.

Following the workshop, participants completed the post-learning assessment and written narrative questionnaire. See Appendix D and E. Participants wrote out their reflections in the form of narratives based on a few prompting questions. See Appendix E. The narrative reflection focused on how the participants viewed and communicated their meaningful learning (Polit & Beck, 2012). Data was manually collected from the audio tapes by a transcriptionist and themes were reviewed by the PI and a third party not involved in data collection.

The follow-up assessment four weeks post-education intervention sought to assess if the clinical instructors were able to use their new teaching strategies in the clinical teaching practice setting with students. The questions contained additional application type questions. The format consisted of open-ended questions. See Appendix F. All

data collected was used to analyze the descriptive data and changes between the pre and post intervention assessment were measured.

A Likert numerical rating scale utilized in the pre and post intervention assessments were constructed by the PI. Care was given to assess data collection instrument's readability, reliability, and validity construct. Feedback from peers and the capstone project committee was sought out on each instrument prior to implementation. A small group of peers were utilized to informally review the assessment instrument for appropriate application, consistency and readability and to identify any potential barriers such as grammatical errors and flaw in the item questions such as jargon (Polit & Beck, 2012). The scale was analyzed for descriptive statistics utilizing software that consisted of distribution, mean, median and mode. The open-ended questions were analyzed and organized into a category scheme and coded for their correspondence to the categories.

Debriefing Instrument

Standardized debriefing as outlined in Standard VI (7) of the *Standards of Best Practice: Simulation* by the International Association for Simulation and Clinical Learning [INASCL] (2011) was followed when debriefing with the participant group. The Debriefing for Meaningful Learning (DML) developed and studied by Dreifuerst (2012) was utilized (Appendix C).

Data Procedure and Analysis

Data was gathered using a Likert scale, semi-structured debriefing guide, open-ended questions, and written narratives. All data collected was de-identified, coded, and stored on a password protected flash drive and secured network university computer. The

data analysis included a correlation of the demographic survey and other instruments.

Data from the pre- and post-intervention assessments was inputted into Microsoft Excel

and SPSS to generate descriptive statistics and statistical analysis. The data described the

mean, mode and median of the numbers on the Likert scale for each variable. Given that

two measures was collected in the pre and post intervention assessments from the same

group and therefore not independent, a nonparametric test. (Mann Whitney U). This test

was used to assess changes in ethical knowledge, skills and comfort of these concepts. A

table was used to display the relationship of statistical change between the pre and post

assessments.

Data collected from the follow up assessment open-ended questionnaires and the

post debriefing written narratives were used to describe themes generated from said

education. The follow up assessment consisted of an open-ended question format. Data

written by participants from narratives and open-ended questions was transcribed by a

third party and re-checked by the PI. All qualitative data was analyzed for themes and

shared concepts. "A content analysis involves breaking down the data into smaller units,

coding and naming the units according to the content they represent and grouping coded

material based on shared concepts" (Polit & Beck, 2012, p. 564).

Costs

The PI covered all expenses of the project. The costs incurred were for a

transcriptionist, refreshments at the 4 hour educational workshop and data analysis

software purchase. There were no unusual or additional costs for the setting of the

project or to the participants for participation in the project. The facilities and equipment

utilized for intervention of the project included use of classroom and audio technology to audiotape the educational module. There were no charges for their use.

Human Subjects Protection

Permission to conduct this QI project was obtained from the Institutional Review Board (IRB) at the University of Southern Maine prior to data collection. Through a recruitment email, participants were informed about the nature of the project, asked to participate and informed of their right to refuse to participate without consequences to their employment, the PI's responsibilities, and any potential risk or benefits. Informed consent was discussed face to face prior to meeting for the educational workshop. This discussion occurred a few days prior to the intervention so participants had time to view the ethics primer prior to the educational session. Individuals had a right to refuse to participate or withdraw from the project at any time without penalty.

Demographic data collected was kept separate from other data instruments. The instruments were de-identified by creating a manual code for the demographic data that was separate from the code for the pre- and post-assessment data. In the demographic survey, participants were coded A, B, C, D, etc. For the pre-post assessments, and narrative data, participants were coded using different categories such as 1, 2, 3, 4, etc. The data analysis included a correlation of the demographic survey and other instruments. For further protection of participant's privacy, a graduate assistant (GA) was employed to deliver, proctor, collect and manually code all instruments.

The PI was committed to blinding the results, by employing a GA to manually de-identify the data and made it a priority to respect confidentiality of all participants. Any

reporting was done in the aggregate or in "themes" and no individual data was disseminated or shared with identifiable data.

To ensure minimal influence or coercion, individuals were made aware that this project is voluntary with no compensation for participation. Participation was completely voluntary. Participants could elect not to participate and could withdraw at any time. There was no risk to their employment as the PI has no hiring or evaluation responsibilities with clinical instructors at this institution. Participants were assured that there would be no change to their faculty status if they choose not to participate in the project.

Data was recorded using a digital voice recording device. A third party was hired to transcribe the written and audio files and had access to the data for transcription purposes. Audio tapes were shared with the transcriber only. The digital recordings of the educational session were transcribed using code names by a third party and subsequently destroyed at the end of the project. Digital recordings were not shared in any other way except to transcribe data. The digital recordings were destroyed once transcription was complete.

The informed consent form and other identifying information were kept separate from the data and kept in a secure location in a locked office at the university. The transcriber used codes to de-identify information on the tapes. Once the data was collected, it was kept with the PI in a secured file. Data was stored on a password-protected computer and on a secured USM network drive. Email was used to solicit participants using USM secured email account. The educational workshop occurred in a

classroom on the USM campus. The audio/digital recordings were put on an encrypted, password protected flash drive. The transcriptionist was asked not to share the password with anyone and only save transcription documents on the flash drive. The PI was the only one to have access to the project folder on the secured network drive. Additionally, the USM computer password was changed to restrict possible access to the project folder for added security.

Data for the project was stored on the encrypted computer system at the USM School of Nursing. Access to the data was limited to the PI, GA and transcriptionist and stored with no identifying information. The information collected was kept as confidential as possible. Participants of the educational session were asked not to repeat what was discussed in the educational sessions but the PI could not ensure that other participants' privacy would be respected.

The project was a non-invasive intervention. The risks to participants were considered minimal, although the participants could have experienced some emotions around discussing and recalling ethical experiences in practice. Should the participants have experienced discomfort they could have contacted the principal investigator by email, phone, or setting up an office appointment. The PI is a registered nurse who deals with confidentiality and privacy issues on a regular basis and has completed site HIPAA requirements including CITI training.

The knowledge gained from this educational workshop using simulation methods with clinical instructors to augment their teaching skills which could have potentially impacted student learning and outcomes may be disseminated. The results of this project

will be published in the capstone report and manuscripts written for conference

presentations or submitted to a peer-reviewed nursing journal and/or book chapters.

Chapter 4 Results

The goal of the project was to improve the educational experience of clinical

instructors in the teaching of ethics to students in the clinical setting. An educational

workshop on the teaching of ethics to nursing students in the clinical setting utilizing

simulation as a teaching methodology was provided to participants (n=8). The workshop

educated clinical faculty on teaching ethics in clinical practice utilizing a 3 step process:

ethics primer/short lecture, critical incident video with debriefing and role playing

scenarios with debriefing.

By providing an educational intervention with clinical instructors, the project set

out to determine if a shift in ethics knowledge and confidence in teaching ethics was

attained. A 9-item pre and post assessment instrument using a Likert scale (1-5) was

developed and implemented. The doctoral capstone committee and peers were consulted

for readability during development prior to implementation. The results of the semi-

structured questions were integrated in this section as part of the qualitative data

collection. Clinical instructors (n=8) participated in a 3-step process that involved an

educational workshop developed to focus on ethics knowledge and skill in clinical

teaching. The results of this intervention are described in this chapter.

Recruitment of Participants

The doctoral capstone committee was consulted to obtain approval for project

readiness for submission to IRB to attain approval. Once IRB approval was obtained, the

doctoral capstone committee was again consulted for final approval prior to

implementation of the project. The committee advised some recommendations to the

module and an addendum was submitted to the IRB and final approval was obtained on

March 10th, 2015. Participants from University of Southern Maine, School of Nursing,

were recruited the week of March 23rd, 2015 via email. Informed consent was obtained

by the primary investigator (PI) in a face-to-face appointment with each participant.

Once informed consent was obtained a meeting time for the educational workshop was

decided based on participant's availability. A total of ten potential participants were

recruited by email. There were eight participants available to attend the educational

workshop. Of the 8 participants 6 returned the completed pre-assessment instrument

prior to the educational workshop via email to the PI's graduate assistant. These

completed documents were stored on a password protected flash-drive. Once the pre-

assessment materials were obtained from the participants, the ethics primer podcast was

delivered to the participants via email. Participants were instructed to view the podcast

prior to the face-to-face educational workshop. The 4 hour face-to-face educational

workshop was delivered on Friday, April 10th, 2015. Written narratives were collected

post education and a post assessment follow-up instrument was distributed 4 weeks after

the education was delivered. The follow-up instrument included semi-structured open-

ended questions. The PI's teaching assistant collected the completed documents and

secured them on the flash-drive.

Description of Data Preparation and Collection

Prior to beginning data analysis it was important to closely examine the data

provided by the participants. Once collected the de-identified coded demographic data set

were first reviewed by the PI. Participants responded to the 9 item pre-assessment

instrument and these responses were examined to ensure that only one numerical choice

was circled. Range checking was conducted to determine that all responses were within

the valid response range of 1 to 5. Missing data was evaluated and data was checked for

data entry error. No data were found to be inappropriately entered or missing. There was

100% participation in the educational workshop and post assessments immediately

following said educational module. However, only 6 out of 8 pre-assessment instruments

were returned and only 3 follow up assessments instruments at week 4 of post education

were returned by participants.

Quantitative Analysis

Eight clinical instructors who volunteered to participate in the study were

administered instruments for data collection at the time of the intervention. All of the

participants were female (100%). As Table 1 illustrates, most participants were 40-49

years of age (75%) and had attained an educational level of MSN (62.5%); four

participants (50%) had less than 2 years teaching experience and four participants (50%)

had greater than 5 years of teaching experience. The number of years teaching clinical

ranged from less than 2 years to greater than 10 years and 3 participants (37.5%) had

formal education in nursing education, in the form of college courses while 5 (62.5%) did

not. (Table 1)

Data was gathered in the pre-assessment instrument regarding past education and

past experiences with ethics and clinical instruction. Utilizing a Likert scale, responses

ranged from 1 (none) to 3 (moderate). Six out of eight pre-assessment instruments were

returned prior to the educational module. Three (50%) participants reported moderate

amount of undergraduate education in ethics. Five (83.4%) participants reported no

graduate education in ethics and four (66.6%) reported none in continuing education. Four (66.6%) reported some experience teaching ethics in clinical instruction and encountering ethical situations during clinical instruction. Four (66.6%) reported that some ethical situations were addressed in clinical instruction. This data is displayed on Table 2.

Participants were asked to describe the lecture or course that included ethics education or teaching. The responses included "ethics content was included in my BSN", "some bioethics – online and in class lectures", "social work classes in my BS program", "teaching in a leadership course in an undergraduate nursing education curriculum".

Additionally, in the pre-assessment materials participants were asked to describe the top ethical issues in clinical practice as a teacher. Participants responded, "discussing end of life care and teaching students how to address some of these issues"; "being aware of your own beliefs and how it influences there view", "maintaining confidentiality in clinic setting" and "I have not had enough clinical hours teaching to state top ethical issues in practice".

A descriptive analysis of the knowledge and confidence data obtained from participants' response to the items in the pre and post intervention assessment was conducted and is illustrated in tables, 3A, B and 4A, B. Participants were asked to circle a number from 1 to 5 on a Likert scale (1= none; 5= extreme). Concepts that visually demonstrated the largest shift in knowledge and confidence were in morals vs. ethics, ethical issues, moral distress, ethical decision making framework and recognizing ethical dilemmas and managing conflict.

Pre and post testing is a testing model designed to examine the change in overall learning of concepts in a group of individuals. Examining the difference in scores from pretest scores to posttest in a small sample can be very challenging. It is important to consider what can be validly determined and supported. Therefore, a mixed method design was used to evaluate the change.

The pre and post intervention assessment results of the educational intervention were analyzed using measures of central tendency, specifically the median and the mode in Microsoft Excel program and nonparametric testing, specifically the Mann Whitney U in SPSS.

An aggregate of the answers for each pre and post intervention assessment were setup in a table in Microsoft Excel. Measures of central tendency, specifically the median and mode, were measured. Mean and variability or range of variation was not measured given the data set was not normally distributed. A nonparametric, Mann Whitney U test was used to analyze the variance between the two data sets of the pre and post intervention assessments to determine the level of significance of change (Table 6).

The frequency of the response in each scale was inputted in a Microsoft Excel spreadsheet and the median and mode for each item in the scale was calculated. The lowest median and mode scores on the pre-assessment instrument for knowledge was 0 on item 4 (large) and 5 (extreme). The highest median and mode score on the pre-assessment for knowledge was 3 on item 3 (moderate). The lowest median score on the post-assessment for knowledge was 0 on item 1 (none) and 5 (extreme). The lowest mode score on the post-assessment for knowledge was 0 on item 1 (none), 2 (some) and 5

(extreme). The highest median and mode score on the post assessment for knowledge was 4 on item 4 (large). Table 5 displays the median and mode for participant responses to the 9 item pre and post assessments in this project.

A non-parametric Mann Whitney U test of differences among repeated items was conducted. The data set in Table 6 compares the pre and post intervention assessment of concepts in both knowledge and confidence categories. The test rendered statistically significant for a change of concepts in ethical issues both in knowledge (*p=.02*) and in confidence (*p =.029*); for moral distress in knowledge (*p=.043*) and in confidence (*p=.043*); for ethical decision making framework in knowledge (*p=.02*) and in confidence (*p=.029*); for recognizing ethical dilemmas in knowledge (*p=.02*) and in confidence (*p=.005*); for managing conflict (*p=.043*) and in confidence (*p=.02*) and for ethical resources in confidence (*p=.043*).

Qualitative Analysis

Audiotapes of the debriefing process of the educational module were obtained and transcribed by a third party. The PI spent two weeks listening to the audio tapes a total of four times and reading the transcriptions on three separate occasions. A third party reviewed the transcripts for data findings. In order to organize the data, key patterns, ideas and themes were identified using color coded pencils. Predetermined categories, such as confidence in teaching and teaching tools were constructed by the PI based on the review of the literature. The written transcription was read completely line by line looking for patterns several times prior organizing the data. The PI organized the data into like categories and key patterns emerged. The analysis was constructed and

interpretation was determined by the PI guided by the foundational knowledge found in the literature.

Debriefing analysis. Those key patterns that emerged from the manual analysis of the qualitative data from the debriefing of each intervention during the educational workshop were role modeling for student, teaching skills, role development for clinical instructor and improving communication skills. The overlapping relationship of patterns is displayed in Figure 1. The unequal overlap across each pattern in Figure 1 suggests the complexity of the interrelationship of each concept.

Role modeling. In the debriefing, several participants discussed how the clinical instructors were role models for students during ethical situation in practice. One participant shared "I like that idea of role playing and presenting situations that you know and developing that skill set". Other participants shared "role modeling the right thing to do" was an important factor in their clinical teaching. Empowering students in performing the right action and with the best communication was also important to participants. This also included role modeling those ethical principles. "They [students] look up to you to 'do the right thing'. Sharing stories of their own struggles with acting on ethics was important. One participant said, "I think sharing stories makes me seem more human as the teacher".

Developmental role. Participants noted that there is a developmental curve for the clinical instructor as well as the student in learning ethics and process of ethical decision making. "It takes significant skill [to manage the clinical teaching in addition to the ethical piece] for the clinical instructor". Participants recognized their own limitations

with ethical decision making skills by responding "I can do fact finding…but I am not quite good at the next step" (sic). There may be a tendency to "avoid conflicts with staff". "Students expect you to engage in those difficult conversations". Several participants pointed out that empowering the students is an important task. In addition, participants noted having difficult ethical conversations with the students can be uncomfortable. Participants acknowledged that "being in a place of discomfort" in ethical situations are challenging and often found they wondered how to handle it effectively in the moment. The participants also discussed opportunities in clinical teaching ethics that "bring it back to the patient and patient rights 'cause there is a lot of ethical principles in that". One participant stated, "so from my perspective, I have to constantly coach myself to do that [teach ethical principles]." These situations have significant learning potential for both student and teacher by recognizing that experiential learning is occurring in both the student and instructor in the ethical moment.

Teaching skills. Many participants liked how role-playing in the educational workshop helped developed their skill set and could see themselves using this approach with students. A participant reflected, "I like setting up a situation and asking what if and what would I do or not do". One participant stated, "so to me, playing this out was probably more effective than you giving me a piece of paper. The biggest struggle is thinking of the right questions to ask [of the student]". After the intervention participants elaborated on this new teaching skill by noting "obtaining the tools in how to handle the situation was helpful" and by roleplaying the situation they came to the conclusion that "pausing and asking the students, how would they want to handle it…. is so powerful" and "it is powerful to empower them [students]".

Improving communication skills. Participants reflected on their own communication skills with students and staff during teaching and some of the challenges they face as clinical instructors. Participants said "it felt like we needed to address the ethical dilemma with the nurse" and "to keep a positive angle so that you get the nurse on your side". Yet another challenge to maintain savvy in communication skills was to be "non-confrontational" and continually work on "maintaining a neutral place" [with the staff]. Participants noted that retrieving all the facts of the situation was important to them. One participant stated "as the instructor I did not know what to say…I couldn't react" and "I was at a loss as the instructor". Another participant reported, "I felt like I wanted to whisk my student away from the situation and not react in a big way because the nurse was being really inappropriate… yah that was hard". Although challenging, the participants worked together to come up with responses to each ethical situation during roleplaying. The participants noted, "we pondered as a group how would we respond as a clinical instructor" Important to one participant "was to check myself when I was with the student and nor react like the nurse". Other participants added just how important their response was, "we were all kind of pondering….how would we, as a clinical instructor, then approach the nurse". Others noted a strong desire to respond by noting "we wanted to address the issue and not just let it slide". One participant noted reflectively that "you could use that non-judgmental approach in a lot of situations and role model it". While another noted, "I learned that's how I should respond but didn't because I was in distress about it.". Important to the reflective piece of a desire to respond, one participant noted "…I think they [students] look at you to do the right thing".

Written narratives post intervention. The written narratives post intervention asked the participants to evaluate how this educational workshop added to their knowledge and how their learning had impacted their thinking about clinical instruction. Additionally, participants were asked what key knowledge, skills or attitudes emerged that would be useful in their clinical teaching and if they thought their clinical teaching would be improved as a result of this education. The key themes that emerged from manual analysis of the qualitative data from written reflective narratives post education were a greater self-awareness, increases in ethics knowledge, confidence in teaching ethics, and tools for teaching ethics. The relationship of these themes is displayed in Figure 2. This figure represents the interplay the relationship of each concept to one another. In other words, each concept could rely on the other to move clinical instruction of ethics forward.

Self-awareness. Participants discussed ways in which this experience helped them explore self-awareness about their role development and their issues of teaching ethics in clinical instruction. A few participants reported how "it brought ethical issues and situations to the surface"; "hearing others point of view allowed me to have a greater understanding of ethical issues."; and "my reaction [emotional] to unethical or inappropriate situations – my own role modeling/professionalism amongst peers as well as students." Within self-awareness, there was a greater awareness of intentionality into one's own teaching as one participant described, "I would like to be more intentional about incorporating ethics and responses in our seminar discussion/post-clinical debriefing" and importantly "to try to include more ethical teaching in the clinical

setting." Intentionality of teaching ethics was a sentiment that seemed to be shared by multiple participants.

   Increases in ethics knowledge. Participants acknowledged where personal gains were made in the acquisition of ethical knowledge and in the identification and understanding of ethical issues. Participants reported that, "it was beneficial to clarify specific ethical issues that arise in clinical education"; "debriefing helped a lot" and how debriefing each situation "helped to consider the balancing act and the importance of communication, clarification and negotiation as we promote student learning and advocate for students." Also, one participant acknowledge this learning by noting that the education workshop had "stimulated me to label my advice and clinical teaching so that students also recognize that is an ethical situation and what the principles are that they are encountering." Participants learned that ethical situations can be emotional for all. This emotion seemed to be a strong sentiment shared by multiple participants. Another participant acknowledged and described what to do during this time of emotion, "There is a lot of emotion in most of these ethical situations. I learned to gather more info before rushing to judgment; to put it back to the student about what they need to know; to practice/rehearse the ethical dilemma if possible and identify key components and to stay calm [and] non-accusatory in negotiations."

   Confidence in teaching ethics. Following the educational intervention, participants reported recognizing that they felt more confident to include ethics during clinical instruction. Participants reported that this intervention was "helpful to be more prepared for different scenarios/ethical dilemma eg. have an empathetic response to a very uncomfortable situation." Some participants noted that they felt more empowered

after the educational module. "I feel empowered with new skills and a desire to seek

more clinical instruction tools" and; "[It] made me realize how important it is to address

ethical situations that occur in clinical one on one but also role-playing and teaching prior

to clinical". Other participants reflected on teaching by "recognizing what I already

know and do well and those things that I don't do well". This experience "gave me

validation of what is effective" and "I feel more confident to try and address issues at the

time it occurs."

  Tools for teaching ethics. Participants reported that the education intervention

helped them to recognize how role-playing could provide them with the tools for

interaction and improve communication in clinical instruction. Participants noted that the

education workshop had provided opportunities "to dialogue/communicate with students

and staff, and modalities of thinking for future clinical courses" and; "[It] gave me tools

to address issues I would have previously been unconfident handling such as introducing

topics of ethics, to help students think through responses". This workshop, "helps me

think through my own responses." Another participant reported how and what was

learned, "I learned great on the spot responses and redirects. I, realize [that] I, as

instructor may role model more than teach sometimes" and "these simulations occur in

'real life' situations and practicing how to respond to them is greatly important before

entering clinical." Further, participants acknowledged that, "keeping neutral and how to

address some issues in the moment" was crucial to their learning. Participants also

reported on their ideas about teaching clinical such as, "helping students communicate

feelings, develop responses" and "I have an idea about bringing cards to debriefing with

concepts on them and using them when students and I discuss specific dilemmas."

Summary

Along with the audiotapes, transcripts of the audio tapes, survey questions and data obtained from the written narratives and follow up survey, the overall response from participants indicate that the educational module effectively met the key learning objectives of the educational intervention. These included:

- Describing the clinical instructor's role in clinical instruction.

- Describing and analyzing teaching of ethics in practice

- Engagement in conversations with nursing students and other health care professionals about ethical dilemmas in practice

- Practicing how to respond to nursing students about ethical dilemmas/issues in practice.

In the follow up survey one participant acknowledged that "this learning module was very helpful and allowed me to think of the different ways in which I can implement ethics into clinical" and "I think it is very important for all nurses to be aware of the ethical issues which will arise throughout their practice. I feel more confident in approaching the subject in a more direct manner."

After completion of the analysis, the qualitative data was assessed, cross-checked and evaluated with the quantitative data results reporting a change in confidence and knowledge. For example, the participants shared consistent statements that reflected on their confidence in teaching ethics in the qualitative data set and a comparison of the pre and post intervention assessments noted a statistically significant change in knowledge

and confidence in recognizing ethical dilemmas and managing conflict in the quantitative

data sets. This assessment shares specific outcomes for participants in teaching ethics

during clinical practice. Triangulation of data allows the findings to be more useful to

others, reinforces validity and reliability of the data and supports how widespread the

impact of this intervention on clinical instructors could be (Lennie, J., Tacchi, J., Koirala,

B., Wilmore, M. & Skuse, A, 2011). Triangulation of the different sources of data is

represented in Figure 3.

Eight participants (n=8) were recruited to attend an educational workshop on the

teaching of ethics to nursing students in the clinical setting utilizing simulation as a

teaching methodology. This chapter reported on the demographic data and results for the

analysis of the qualitative and quantitative data sets. These results will be used to discuss

the project aims and subsequent conclusions in the following chapter.

Chapter 5

Discussion

This project supported a shift in addressing ethics knowledge, skill and comfort in teaching ethics for 8 clinical instructors in an undergraduate university SON setting. The project provided information on the conceptual knowledge or experience needed to teach ethics in practice and to a lesser extent on barriers and challenges to teaching ethics in clinical settings. The project provided support that professional development for clinical instructors is useful in their preparation to teach ethics during clinical practice.

Simulation has become a widely accepted and valuable methodology within nursing education and effective in teaching clinical (Jeffries, 2012; Hunt et al., 2015). Given clinical instructors serve an important role in developing a student's ethical formation in practice, it is critical for a SON to provide faculty development and this development is warranted. Simulation was a useful teaching strategy in this setting that prepared 8 clinical instructors for teaching ethics during clinical practice instruction.

This chapter discussion will address the project questions:

- What knowledge or experience (ethical or teaching) is needed by clinical instructors to teach ethics in practice settings?

- What current ethical expertise is used in clinical teaching practice in an undergraduate education setting?

- What barriers or challenges exist for clinical instructors to teach ethics in clinical practice?

- How will an educational workshop on ethics using simulation methods for clinical instructors, influence or impact their ability to teach ethics in clinical education?

Clinical educators as mentors – developing expertise. Nurse educators have an impact on the development of students' moral reasoning and moral behaviors (Numminen & Leino-Kilpi, 2007). Experience is gained when an individual actively learns to recognize salient ethical features in practice (Benner, 1991). It is vital for clinical instructors to develop the ethical competence needed to teach ethics within clinical practice and include opportunities for nursing students to learn ethics. (Benner, 1991; Dahlke et al., 2012; Epstein & Carlin, 2012; Erdil & Korkmaz, 2009; Numminen & Leino-Kilpi, 2007; & Rodney et al., 2002). Developing the clinical instructors' abilities to teach and apply ethics in practice will facilitate nursing students learning of applied ethics and have an impact on their future practice.

This project identified that 33.3% of the clinical instructors participants (n=6) had some education either in graduate or continuing education in ethics and 50% had a moderate amount of ethics content in their undergraduate education. Although the participants had been prepared with some underlying education in ethics from nursing programs, the project supported an opportunity for growth in ethical experience during clinical instruction. By providing an educational intervention to the 8 clinical instructors in this setting using simulation as a teaching method, the project specifically, resulted in a shift in knowledge and confidence in teaching ethics. In this project, the greatest shift in knowledge and confidence were reported in morals vs. ethics, ethical issues, moral distress, ethical decision making framework, recognizing ethical dilemmas and managing conflict. For the participants, ethical learning was strengthened as a result of this

educational intervention. Also, this finding suggests that some amount of ethics within

an undergraduate education is insufficient in preparing clinical nursing instructors with

the skill and knowledge to be confident enough to include ethics within their clinical

teaching practice and that further professional development in nursing education is

needed. Like in many other areas of nursing practice where further studies are needed,

advanced education in nursing education is warranted when teaching nursing students.

Nursing students' clinical practice and experiences with clinical instructors plays

a significant role in shaping the nursing students developing professional ethics and

values (Dahlke et al., 2012). The analysis of this project supports that the participants

considered their role as clinical instructors as important to helping student develop their

ethical learning in practice. Prior to the intervention, this awareness was not at the

forefront of their teaching. As a result of the simulation educational intervention, the

participants felt it was their responsibility to role model how to effectively communicate

and practice ethically in their everyday dealings with all individuals. There was

consensus from participants that empowering students to ethically act using effective

communication was also important to their teaching. This responsibility towards ethical

learning was especially important when conflicts during health care situations arose

between staff, clinical instructor and student on differing values, roles and limited

knowledge of ethics. Since participants felt significant responsibility to the student's

ethical learning in practice, it was crucial to develop an understanding of the importance

and value of including ethical discussions within clinical instruction; as well as, integrate

the teaching tools used by the clinical instructors for applying ethics in practice during

clinical instruction.

These qualitative findings outlined in the results section were similar to the literature findings that discussed how clinical instructors play a significant role in shaping nursing students professional ethics and values (Benner, 1991; Purtillo & Doherty, 2011). Benner (1991) emphasizes the importance of developing what she termed skillful moral comportment that is fostered in practice for nursing students. Experience is gained when an individual actively learns to recognize salient ethical features in practice (Benner, 1991). Benner and colleagues contend that instructors must help students find the "keel of their boat" (Benner et al., 2010, p. 169). "They [students] come with pretty flat-bottom boats and the trouble with a flat-bottom boat is, when the wind blows, you just scatter across the water. And the wind blows this way; you scatter back across the water" (Benner et al., 2010, p. 169). This analogy can also apply to clinical instructors as well; that they must find their keel also and SON must provide this development.

The proposed educational workshop was designed to provide an opportunity to enable clinical instructors to assist nursing students obtain a good grasp of everyday ethical comportment, develop moral reasoning, demonstrate appropriate skill at responding ethically and demonstrate the skill of ethical reflection to discern moral dilemmas (Benner et al., 2010, p. 28). When a nurse is able to act ethically and cultivate ethical environments to work in, a positive impact will be made on patient safety and quality care. As students learn to act from a state of understanding and ethical action in practice they will begin to model a preferred moral environment in the organizations in which they work. Further, given that the clinical instructor is a nurse, this change may possibly improve their own ability to deal with difficult ethical issues they encounter in practice. At the very least this intervention will likely lead to nurses reflecting more

deeply on ethics of everyday practice. It may also support changes within their own practice as the literature findings conclude that nurses continue to struggle with ethics of practice and arriving at ethical actions.

Clinical instructors have a significant role in assisting nursing students in understanding clinical situations and to convey ethical learning opportunities when working with nursing students. Discussions with the project participants were consistent with this individual moral imperative. Similarly, SONs have a responsibility if they are selecting instructors without formal education in nursing education that they provide learning activities that help instructors develop this understanding and skills needed to include ethics within their teaching.

Novice to expert. The literature review strongly supported that faculty members require professional development, mentoring and encouragement to develop into the educator role and continue in their role as an educator (AACN, 2005). The demographics of this project revealed that 37.5% of the clinical instructors participants (n=8) had less than 2 years teaching clinical. Benner's "Novice to Expert" Conceptual Model (1984) is relevant and important in understanding the development of the participants' role as clinical instructors when applying an educational intervention. Benner (1984) purports when nurses move into a new role they become novices again. The clinical instructor participant's demographic data suggests that this is also true for nurses moving from clinical to teaching.

The narrative experiences of participants in a situated ethical context during the educational workshop support that learning and challenges of role modeling ethical

action for nursing students was paramount for the clinical instructors in this setting. The

educational intervention highlighted the importance of practicing the role of clinical

instructor. It also supports the need for ongoing development as a clinical teacher given

limited background and the shift that occurred in knowledge and skill acquisition of

teaching ethics in practice. Professional development of clinical faculty is important to

improve the instructor's ability to teach applied ethics in clinical settings since, in theory,

these teachers move along a novice to expert continuum as described by Benner (1984).

Clinical instructor participants were within the novice to advanced beginner level in their

ethical teaching role with nursing students in clinical practice. Professional development

in teaching is warranted and would guide the clinical instructors as learners to move

along this theory of development towards attaining expertise as clinical instructors.

Use of simulation. A positive shift in learning for clinical instructors was

reported in the post education assessments and their responses support the need for

additional faculty development particularly with attention to applying ethics in practice to

improve student development in ethical formation. The participants noted that active

learning methods such as providing opportunities to practice interactions in a way that

simulation can provide contributed to increasing their knowledge and confidence.

The trend for faculty development using simulation to enhance the teaching

ability of the faculty members to effectively facilitate learning in a clinical setting was

also reported in the studies by Krautschield et al., 2008; Shellenbarger and Edwards

(2011) and Hunt et al., 2015. In the findings discussed by Shellenbarger and Edwards

(2011), simulation for graduate nurse educator students supported the opportunity for

clinical instructors to better understand the clinical teaching role through educator

development. Similarly, Hunt and colleagues (2015) concluded in their study with

clinical instructors that the "simulation prepared them for clinical teaching, increased

their confidence", and assisted them in giving teaching tools to provide student feedback

(p. 468).

These conclusions regarding simulation education discussed here in this project

are similar to simulation education studies by Krautschield et al., (2008) and Hunt et al.,

(2015). The findings by Krautschield et al., (2008) in a qualitative study described

simulation as a "powerful strategy to enhance the teaching ability of the faculty members

to effectively facilitate learning in a clinical setting" (p. 433). Themes found in the

Krautschield et al., (2008) study were similar to results in this project; both focused on

enhancing clinical teaching tools or strategies for clinical teaching as well developing an

awareness of their teaching behavior and skills. "Faculty emerged as more reflective

teachers and practitioners after the simulation" (Krautsfield et al., 2008, p.433). In this

project, participants became self-aware of their responsibility to teach ethics during

clinical instruction and through reflection they were able to gain strategies in how to

implement this teaching with nursing students during clinical. Hunt and colleagues

(2015) study reported on findings that used simulation to promote professional

development of twenty-six clinical instructors. Similar to this project that utilized role-

playing, the study utilized role played situations that required instructors to intervene for

patient safety (Hunt et al., 2015). The findings noted that "clinical instructors thought the

simulation prepared them for clinical teaching, increased their confidence, and assisted

them to provide student feedback" (Hunt et al., 2015, p. 468). Similarly, the participants

in this project described how role playing and debriefing raised their consciousness

regarding ways to teach ethics in clinical practice, increased knowledge of ethics and provided them concrete tools for teaching ethics.

Lewin's (1951) and SLT (1977) model of change that was explored as a conceptual basis for this project, also, can support trends in learning using simulation as noted by the participants in the self-reflective statements of the descriptive data. Learning how to apply ethics in clinical instruction during the simulation supports this change in meaning for the participants practice as clinical instructors. This project tapped into the participant's perceived self-efficacy as clinical instructors to move their thinking and behaviors forward through unfreezing and refreezing steps along a process or continuum. Exploring these models of change were suitable for this project given it involved human interactions.

The findings of this project are similar to these studies utilizing simulation as a teaching method and are limited in generalizability to the clinical instructor population given the small sample size. This project provided qualitative and descriptive data that seemed to support that improving clinical instruction in ethics can be realized when using simulation as a teaching method.

Ethical teaching in the practice setting. Clinical instructors have a significant role to convey ethical learning with nursing students and need to role model the practice (Benner, 1991; Doane, 2002; Lindh et al., 2007). A positive shift in knowledge and confidence, as described in this project, can be the impetus to improve teaching of ethics in clinical practice with nursing students.

In this project, 66.6% of the clinical instructor participants (n=8) reported some experience teaching ethics in clinical instruction and encountering ethical situations during clinical instruction. This finding supports the concept that clinical instructors are often exposed to ethical situations during teaching and that opportunities do exist in clinical instruction for clinical instructors to gain expertise in the teaching of ethics in clinical situations. This finding is congruent with other literature, specifically on ethics, that indicates ethical issues frequently emerge within clinical practice settings and every day ethical concerns often involve inter-professional conflicts or organizational and system problems (Robichaux, 2014).

This project demonstrated support for the need to develop the clinical instructor's ability to manage ethical conflicts in the clinical setting while teaching nursing students. In this project, participants acknowledged the challenge of ethical conflicts that emerge on the units during clinical instruction. This finding is congruent with the review of the literature by researchers (Goethals et al., 2010; Robichaux 2014; Rodney et al., 2004) that explored the challenges to practice ethically in the clinical setting. Participants acknowledged in narratives that role playing in the educational workshop helped to improve their ability to manage ethical conflict in clinical settings with nursing students and staff. Similarly, this trend was seen in Shellenbarger and Edwards' (2011) study whereby participants acknowledged through descriptive data collected how difficult it was for clinical educators to manage student actions while also safeguarding the patient and addressing patient concerns during the clinical teaching role.

This project revealed that an improvement in participant's knowledge and confidence in ethics, including ethics in clinical practice, for nursing students occurred.

A quantitative Mann-Whitney U test identified positive changes (level of significance *p* <.05*) between the pre and post assessment for clinical instructors in knowledge and confidence of ethical issues and resources, moral distress, ethical decision making framework, recognizing ethical dilemmas and managing conflict. These findings may provide insight to what knowledge or experience (ethical or teaching) is needed by clinical instructors to teach ethics in practice settings that can be used to explore future research on a larger scale.

Key patterns in the qualitative written responses were indicative of concepts that emerged from the qualitative data analysis including themes of role modeling for students, developing teaching skills, developmental role of the clinical instructor and improving communication skills. These findings were noted by clinical instructor participants as important concepts of teaching that were learned and understood by them as a result of this project. Similarly, these themes were found in the study by Hunt and colleagues (2015) who noted an increase in confidence after the intervention. In that study, significant responses included instructors reporting that they were provided with teaching tools for clinical instruction. This project provided qualitative and descriptive data that support other larger studies thus providing insights on what knowledge is needed to teach ethics in clinical practice.

Barriers, challenges and concerns. Nurses often experience a great deal of difficulty navigating the moral culture and environments and find it difficult moving toward taking ethical action in their practice sites (Rodney et al., 2002). Participants in this project felt that applying ethics was difficult in clinical practice as nurses, especially challenging as a clinical instructor. This is possibly due to barriers of being an outsider

within the acute care setting as well as having limited experience in facilitating student exploration of ethical issues in practice and having limited formal education to support them in the role of clinical instructor.

Many clinical instructor participants felt a greater burden to role model ethical learning due to their professional role as educator. They felt an enormous responsibility, perhaps aware for the first time as a result of direct participation in this project, to model best practice in ethical action and wanting to do so well. As indicated in the results section participants recognized and agreed "it takes significant skill for the clinical instructor" to navigate the ethical climate of most clinical units and situations. Instructors recognized their own limitations with ethical decision making skills by responding "I can do fact finding…but not quite good at the next step". Participants mentioned a tendency to "avoid conflicts with staff" and noted that "students expect you to engage in those difficult conversations". These findings align with the other reports in the literature where support becomes difficult for nurses when not practicing ethics, to advocate and learn the role of ethics in practice (Goethals et al., 2010).

As noted in the descriptive data of the participants, nurses who become clinical instructors may have limited expertise in many areas of teaching and this project identified those related to ethics and applying ethics in practice. They may have limited education within undergraduate and graduate education especially given the limited number of instructors who have taken formal nursing education courses previously to becoming clinical instructors. All these factors combined contribute to clinical instructor's having limited ability to teach applied ethics to nursing students in clinical settings.

Preparedness and education are key concepts for the clinical instructor's success in teaching ethics in clinical settings (Hunt et al. 2015). The comparison of the pre and post survey in this simulation educational intervention supports the findings described as gaps in knowledge and confidence in ethics similar to a study done by Numminen and Leino-Kilpi (2007). In the quantitative results, the largest shift in knowledge and confidence for clinical instructors post intervention were in morals vs. ethics, ethical issues, moral distress, ethical decision making framework, recognizing ethical dilemmas and managing conflict. This finding provides insights into what knowledge and skill are needed by clinical instructors in improving clinical instruction using simulation in this setting. Due to the small sample size of this project, further study is needed using multiple settings to be able to generalize these findings to the greater population of clinical educators. However, it does it appear that faculty development of clinical instructors is warranted.

These qualitative findings from the project also describe the developmental learning curve that the participants noted in the attainment of knowledge, skill and confidence in ethical situation during instruction. With limited exposure to ethics in their own practice, clinical instructors need additional education in how to address ethics with students in clinical practice. One way of doing this is in the form of role-playing situations. Practicing how to respond in the situated moment assists the learner to be empowered to teach ethics in practice with students by increasing knowledge, skill and confidence. The results of this project did not directly discuss the clinical instructor's difficulty or personal challenges with navigating ethical situations within in their own

practice as nurses. This project only explored the challenges with ethical situations as teachers.

The research is limited on the process of educating practicing clinical nurses to assume clinical instructor roles (Cangelosi et al., 2009). A nurse who is proficient in clinical practice is most likely not proficient in teaching clinical skills to nursing students (Cangelosi et al., 2009). Clinical instructors frequently do not have any formal education in teaching or preparation for teaching clinical (Dahlke et al., 2012; Dunphey-Suplee et al., 2013). They must draw on their individual personal and professional experiences to guide their teaching during clinical instruction (Dahlke et al., 2012). Thought leaders such as Diekelmann et al. (2003) suggest without additional education, instructors will most likely teach as they were taught, thus with limited background continuing the absence of meaningful inclusion of ethical learning within clinical education. It is important for instuctors to have education courses to draw from during clinical instruction rather than just merely selected based on their clinical expertise alone.

The literature review identified the issue of limited formal education in nursing education to teach in clinical settings as a significant concern. While it may be identified as such, the project results in this setting with a small sample size did not contribute or significantly support those findings. However, of note, the demographics of the participants show that although 5 of the participants had a graduate degree (MS) only 37.5% of the participants had formal education in teaching and 37.5% of the participants had less than 2 years clinical teaching experience. This point may be congruent with findings from Dunphey-Suplee and colleagues (2013) where 31% of clinical teachers reported having no preparation for clinical teaching.

The project findings answered the project questions with varying degrees of description. The project provided some important information on the conceptual knowledge or experience needed to teach ethics in practice and to a lesser extent on barriers and challenges to teaching ethics in clinical settings. It provided data on the current ethical expertise of the clinical instructor participants and opportunities to apply ethics in practice during clinical instruction. An educational intervention can influence the knowledge and confidence of the clinical instructors to improve teaching of ethics during clinical instruction. Given the positive trends noted in the results, the project provided support that professional development for clinical instructors has an impact in preparing the clinical instructor to teach ethics during clinical instruction. In addition, simulation was a useful teaching strategy in this setting to prepare and influence 8 clinical instructors for teaching ethics in clinical instruction. In summary, the project findings provides support that there is a benefit to an education workshop on ethics using simulation to develop clinical teaching role in applying ethics in practice.

Limitations

There were several limitations to this project. The small sample size (n=8) rendered it difficult to make strong conclusions or generalizations from this project. Due to a convenient, as well as a small sample size, one cannot draw any statistically significant conclusions due to the lack of statistical power. That being said the findings provide important information to convey to leadership within the SON in this setting where this project took place.

The findings are valuable in this setting and could suggest steps the SON can take towards revising the part-time clinical instructor orientation and preparation needed for clinical instruction and attainment of hiring nurse educators with formal nursing education as well as prepared with advanced graduate degrees as recommended by the BONs and national agencies. This project supports the need for faculty development in applying ethics in practice during clinical instruction. A small educational intervention using simulation can have an impact in developing a clinical instructor's knowledge and confidence of teaching ethics in practice. A replication of this project on a larger scale is needed to be pursued in order to generalize these findings to a greater population of clinical instructors.

A second limitation was the decision to have a convenience sample which represented only one undergraduate nursing program in the state. Clinical instructors from one nursing undergraduate program in the state were asked to participate in the project. With a small sample size the results are rather insignificant and have limited generalizability. This DNP capstone project falls within the expectations of grounded quality improvement process focused on clinical practice and does not require the doctoral candidate to develop original research therefore, within this project, a small sample size is acceptable and ensuing results are worthy of dissemination for contributions towards future research.

There are potential limitations with using audio tapes for discussion to gather information such as fear of sharing difficulty in teaching or lack of knowledge. There is a possibility that the clinical instructors would not feel comfortable sharing their true thoughts and teaching practices with other peers present for fear of being wrong. On the

other hand, given the small sample size from a common SON, the participants may have

had the benefit of knowing each other which can also affect responses.

Another limitation is that although there was a positive shift in knowledge and

confidence in ethics and teaching ethics it is unclear if this new information can be

sustained in the participants' clinical teaching beyond the timeframe included in this

project. The follow up data was too brief and therefore inconclusive of sustained

application and change in clinical teaching. Further, PDSA cycles are warranted.

Additionally, the construct of the instruments with informal testing of reliability

and validity do not lend it to ensure any significant statistical power in utilizing them. In

future studies, formal testing of the instruments within this project would be warranted.

Recommendations

Implications for education and practice. Implementing a quality improvement

project on ethics using a PDSA model, to improve the quality of nursing education at the

intersection of education and practice informs the profession in ways to improve ethics

education in nursing education using simulation as a teaching method. The project

contributes to improving safety and quality at the point of care by fostering and

mentoring ethical and moral development in nursing students who will become

Registered Nurses. Ethical formation should integrate key components of developing

one's moral agency and moral community and be considered foundational knowledge

and skills of nurse educators. By addressing the learning needs of the instructors, clinical

nurse educators will be able to demonstrate examples of meeting the core competencies

of ethics in the undergraduate Baccalaureate Essentials and ethics as a foundation to

nursing practice to convey to students how to achieve ethical action in every day practice (AACN, 1998; ANA 2015).

The project provided insight into collaborative and creative ways that academia programs can include simulation into the orientation program for educating clinical instructors. According to Purtillo and Doherty (2011), "it is the mutual task of students, classroom learning, and clinical faculty working together to ensure that students trust their developing competencies and abilities to understand their role as moral agents" (p. 130-131).

With limited attention to ethics and without a focus on professional teaching development of clinical instructors that includes ethics in clinical teaching practice, the importance of teaching ethics in clinical practice may not be fully realized in future nursing curricula. This project provided practice-based information for nursing faculty and programs that support for clinical instructors is important. Therefore, a recommendation is to provide faculty orientation and development in ethics to help transform nursing education and meet the future needs of nursing education and practice.

The use of simulation for future similar projects is well suited for application of ethics.   Application of ethics involves knowledge and everyday interactions using effective communication skills that is supported using methods to promote active learning.

Implications for research. Research focusing on clinical nurse educators and ethics teaching/learning is limited (Numminen and Leino-Kilpi, 2007). Exploring future research on teaching ethics in clinical practice using clinical instructors, using subsequent

PDSA cycles to test changes, will likely facilitate the improvement of clinical instruction regarding ethics and student outcomes of applied ethics. Other opportunities for research may include observing clinical instructors addressing ethics during clinical instruction and comparative studies using intervention (simulation with clinical instructors) vs. non-intervention and examining student learning outcomes. Additionally, although this simulation used ethics as a topic for simulation, other scenarios could be developed to model ways to improve clinical teaching of clinical instructors teaching in practice.

Implications for policy. There have been changes to simulation policies and clinical instruction at the SBON and national agencies, supported by large scale research findings, that will allow simulation to count towards nursing clinical time. Recently these changes in simulation and clinical standards at NCSBN allow the use of simulation in place of clinical hours up to 50%. This change in how clinical hours are implemented will require additional education of clinical instructors and nursing faculty members as a whole to understand how to best develop simulation that addresses these learning needs. Faculty members within SONs will need time to explore and develop policies that ensure clinical instructors are well education in both simulation and clinical practice teaching. Additional efforts by nurse educators will need to be made to help nurses and administration at practice settings understand changes being made within nursing education practice and be ready to respond in ways the help ensure a smooth transition for students moving into clinical experiences as well as following graduation. Policy changes within the SON at USM would be proposed to provide simulation education on teaching ethics in the simulation laboratory using best practices**.**

Conclusions

A one-time educational intervention using simulation methods was provided to clinical instructors. The aim of the project was to improve the educational experience of clinical instructors in the teaching of ethics to students in the clinical setting. This project provided teaching strategies for clinical instructors on how to teach ethics to undergraduate nursing students in a clinical setting. This project explored an educational intervention with clinical instructors that supported a change in ethics knowledge and awareness in teaching ethics.

The project made contributions to nursing education and, in particular, clinical education practice, by informing the clinical instructor of the foundational knowledge needed to prepare students for ethical decision making, creating environments and teaching strategies that support ethical action. By recognizing the importance of transferring knowledge of ethics in nursing practice, an educational workshop to improve the clinical nursing instructor's teaching of ethics to students in the clinical setting was designed and implemented.

The findings support trends as identified in the literature review process that while the clinical instructor may have clinical expertise, they frequently, for various reasons, do not possess sufficient knowledge or experience in teaching and in ethics of care to be competent in applying ethics in practice. Although clinical instructors have clinical experience and are often hired based on this experience, this project provides insight to specific gaps in the clinical instructor's knowledge of ethics and in teaching ethics in practice, as well as what knowledge is needed to apply ethics in clinical instruction.

Without ongoing faculty development in ethics, in simulation and nursing education, clinical instruction of applied ethics will remain suboptimal.

The results of the project supports that ethical knowledge and skill is limited prior to the educational intervention and the post assessment revealed a positive shift in knowledge and confidence in ethics. This finding of limited ethical knowledge and skill also aligns with the literature review in that nurses are often struggling with ethical actions in their own practice. The conclusions should not generalize to a greater population of clinical instructors given the small sample size of this project in this setting.

The literature review and the findings from this project are similar and further support the need for additional study and the development of educational material or workshops for clinical instructors. Additionally, a shift in practice of how nurses are selected to teach nursing clinical courses, as well as content within MSN nursing education programs should be reviewed in lite of recent changes regarding clinical hours and simulation. SONs will need to develop approaches and evaluation measures that ensure that optimal learning occurs within these formal nursing education courses and be a requirement of any Masters prepared nursing program of study.

This DNP capstone contributes to nursing education knowledge and, in particular, clinical education practice by informing the clinical instructor of the foundational knowledge needed to prepare students for ethical decision making, creating environments and teaching strategies that support ethical action. The project provided practice-based information for nursing faculty and programs to develop faculty orientation and teaching

workshops to include ongoing development in ethics in support of meeting the teaching/learning needs of clinical instructors.

This project provided an opportunity to promote faculty development using simulation methods to a small group of clinical instructors in addressing ethics. The use of simulation is well supported and viable method for teaching with outcomes clearly documented (Jeffries, 2012). Using simulation and facilitated effective debriefing methods to promote active learning was a key component to improving teaching of applied ethics in this project. Improving clinical instruction through the use of simulation is a growing method trend and greater opportunities exist for ongoing research in this area.

The simulation, in this project, provided a dynamic and engaging opportunity for clinical instructors to increase or add to ethics knowledge and skill within the clinical teaching role and promote teaching strategies in applied ethics during clinical practice instruction. As a result of improved understanding, this project supports the use of simulation that provides important piece of development in empowering the clinical instructor to increase opportunities to implement ethics and ethical decision making into clinical practice instruction.

This new knowledge can be used to draw on best ways to improve ethics education in clinical education and meet the future needs of nursing practice in applying ethics beyond the classroom as required by the Baccalaureate Essentials for accreditations of programs (AACN, 1998). By identifying specific gaps in the clinical instructor's knowledge in teaching ethics in practice, actions can be taken to develop

future opportunities for teaching workshops that assist clinical instructors in ways to

develop a students' ethical formation in a clinical practice setting. Also, as a result of

adding faculty development into nursing curricula programs of study, clinical instructors

will be able to improve their own teaching practice.

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Appendix A

Informed Consent

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in the Clinical Setting.
INFORMED CONSENT FOR PARTCIPATION IN RESEARCH

Project Title: *A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in the Clinical Setting.*

Principal Investigator(s): Cynthia S. Randall, RN, MS, CNL, Doctoral student, University of Southern Maine, #224 Masterton Hall, Portland, ME 04101, (207) 749-9445. Email: cynthiar@usm.maine.edu

Faculty advisor: Patricia Thompson Leavitt, DNP, FNP, Assistant Professor, University of Southern Maine, 96 Falmouth Street, Portland, ME 04104. 207-780-4906. Email: pleavitt@usm.maine.edu

Introduction:

- Please read this form. You may also request that the form is read to you.
- The purpose of this form is to provide you with information about this research study, and if you choose to participate, document your decision.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete. You can take as much time as you need to decide whether or not you want to participate. Your participation is voluntary.

Why is this study being done?

- The purpose of this study is to improve the teaching skills of clinical instructors in the teaching of ethics to student nurses in a clinical setting.
- I am a doctoral student at the University of Southern Maine (USM) and also a full-time faculty member. I am not getting any compensation for this study. It is completely voluntary and part of my graduate work.

Who will be in this study?

- You are being asked to participate in this project because you are a member of the clinical faculty at USM teaching clinical in the spring semester of 2015.
- The approximate number of participants in the study will be 10-12 clinical instructors.

What will I be asked to do?

- This study involves an educational module on ethics utilizing simulation as a methodology.
- A pre and post learning assessment, audiotaped educational session and written narrative reflection of the simulation will be collected for analysis. In addition, a follow up assessment will occur four weeks laterto collect data on the participants' ability or challenges to implement teaching strategies on applied ethics.
- A face to face educational module will be led by the principal investigator.
- The timeframe for the one-time educational module will be 4 hours in length with appropriate breaks. You will be asked to complete the pre-learning assessment and a view a 10 minute voiceover power point slide presentation prior to the face to face educational module.
- In the educational module, you will be asked to participate in observation, discussion, and role-playing to address ethics in clinical practice.
- The pre and post learning assessment will consist of a rating scale and open-ended questions. The pre & post data will be measured for statistical analysis using descriptive methods.
- The debriefing instrument, written narratives and follow-up assessments will use an open-ended question format for data collection. The educational session will be taped for the purposes of data collection. Data collected from open-ended questions will be used to evaluate themes and common ideas.
- There will be no compensation for participation in the project. You may request a copy of the summary of the final results by indicating your interest at the end of this form.

What are the possible risks of taking part in this study?

- The risks to you are considered minimal in that you might experience some emotions around discussing and recalling ethical experiences in practice. Should you experience such discomfort please contact the principal investigator.
- No risk to employment.

What are the possible benefits of taking part in this study?

- As a result of participation in this educational module and project, you may increase your knowledge and skills in teaching of ethics to nursing students in the clinical setting. You will take part in a simulation experience in the clinical instructor role. This simulation may be modeled for education for future clinical instructors in the nursing program.

What will it cost me?

- The only cost to you is your time and travel to USM for participation in the education module.

How will my privacy be protected?

- The information you provide will be kept as confidential as possible.
- The informed consent form and other identifying information will be kept separate from the data and kept in a secure location in a locked office at USM.
- The educational module will occur in a private classroom on the USM campus.
- The results of this project will be published in the capstone report and possibly in subsequent journals or books.
- Participants of the debriefing session will be asked not to repeat what is discussed but the principal investigator cannot ensure that they will respect other participants' privacy.

How will my data be kept confidential?

- The data will be coded & de-identified.
- The audiotapes will be transcribed using code names by a third party and subsequently destroyed.
- Once the data has been collected it will be kept with the principal investigator in a secured file.
- A third party who will transcribe the written and audio file will have access to the data for transcription purposes.
- Data will be stored on a password protected computer and on a USM network drive. Email will be used to solicit participants using USM secured email account.

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University, the School of Nursing or impact your standing as a clinical instructor employed by USM School of Nursing.

- You may skip or refuse to answer any question for any reason.
- If you choose not to participate there is no penalty to you.
- You are free to withdraw from this study at any time, for any reason. If you choose to withdraw from the research there will be no penalty to you. Should you withdraw, your identifiable data will be eliminated from the assessment analysis and will be destroyed.

What other options do I have?

- You may choose not to participate.

Whom may I contact with questions?

- The investigator conducting this study is Cynthia Randall**.** For questions or more information concerning this research you may contact her at cynthiar@usm.maine.edu or 207-749-9445.
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Cynthia Randall, the principal investigator at cynthiar@usm.maine.edu or 207-749-9445 or the faculty advisor: Patricia Thompson Leavitt, DNP, FNP, Assistant Professor, at 207-780-4906 or pleavitt@usm.maine.edu.

- If you have any questions or concerns about your rights as a research subject, you may call the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

Will I receive a copy of this consent form?

- You will be given a copy of this consent form.
- Return one to the researcher and keep the other for your files.

Participant's Statement

I understand the above description of this research and the risks and benefits associated with my participation as a research subject. I agree to take part in the research and do so voluntarily.

Participant's signature or	Date
Legally authorized representative	

Printed name

Researcher's Statement

The participant named above had sufficient time to consider the information, had an opportunity to ask questions, and voluntarily agreed to be in this study.

Researcher's signature	Date

Printed name

Appendix B

Pre-educational Assessment

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in
the Clinical Setting.
Ethics Education and Experience Assessment Pre-education

Instructions: Please fill out the questions below. There are no right answers. Return completed
form to kathleenhennessey06@hotmail.com

I. Rate your ethics education background

1. Undergraduate ethics/bioethics course in or outside of nursing or ethics lectures within
    a class a course.

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

Describe the ethics course/lecture (if any):

2. Graduate education: ethics/bioethics course, class, ethics lectures within a class or a
    course.

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

Describe the ethics course/lecture (if any):

3. Continuing Education with a focus on ethics?

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

Describe the course/conference/lecture

II. Rate your experience teaching ethics in clinical instruction

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

III. How often do you encounter ethical issues in clinical instruction?

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

IV. How often do you address ethical issues in clinical instruction?

1	2	3	4	5
none	**some**	**moderate amounts**	**Large amounts**	**Extremely large amounts**

What do you see as the top ethical issues in clinical practice as a teacher?

IV. Using the rating scale below please rate your knowledge of ethical concepts & confidence in teaching ethical concepts in clinical setting

Concept	Knowledge of concept					Confidence w/ teaching the concept				
Moral vs. ethics	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**
Ethical issues	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**
Moral distress	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**	**1** **None**	**2** **some**	**3** **moderate**	**4** **large**	**5** **extreme**

Ethical principles & theories	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Concept	**Knowledge of concept**					**Confidence w/ teaching the concept**				
Ethical decision-making framework	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Code of ethics	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Recognizing ethical dilemmas	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Managing intra and inter-professional conflict in difficult ethical situations	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Ethical resources	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme

Appendix C

Debriefing Interview Guide

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
**A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in
the Clinical Setting.**

Debriefing Interview Guide

Questions asked will focus on personal reactions, reflection on action, applying knowledge, new
understanding, thinking and analyzing events looking for patterns of recognition or new meaning.

1.   *What do you think is going on in this situation? What happened? (**for intervention #1 -video**)*

2.   *What knowledge, skills, and attitudes are needed for the situation? (**for both intervention 1 &2**)*
a.   *Did you have sufficient knowledge/skills to manage this situation?*
b.   *What teaching knowledge/skills were needed?*
c.   *What skills in communication/interactions were needed?*
d.   *Was different or additional information needed for the clinical instructor? If so, what?*

3.   *What did you learn about teaching? (**for both intervention 1 &2**)*
a.   *Did this session help with your teaching? If no, what would be useful? If yes, what went well?*
b.   *How could or would you use this in the clinical setting? Would it be useful in the clinical setting?*
c.   *How will this improve your ability to teach?*

4.   *How do you think the simulation went? (**after both interventions**)*
a.   *What worked; what didn't work?*
b.   *What were your favorite and least favorite aspects of the simulation?*

5.   *What would you have done differently if you could do over? (**for intervention #2**)*

6.   *Is there anything else you would like to add or discuss? (**for both**)*

Adapted from: Johnson Pivec, C R, "Debriefing after Simulation: Guidelines for Faculty and
Students" (2011). Master of Arts in Nursing Theses. Paper 14.

Appendix D

Post educational Assessment

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in
the Clinical Setting.
Ethics Education and Experience Assessment Post-education

Instructions: Please fill out the questions below. There are no right answers.

IV. Using the rating scale below please rate your knowledge of ethical concepts &
confidence in teaching ethical concepts in clinical setting

Concept	Knowledge of concept					Confidence w/ teaching the concept				
Moral vs. ethics	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Ethical issues	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Moral distress	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Ethical principles & theories	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Ethical decision-making framework	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Code of ethics	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme

Recognizing ethical dilemmas	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Concept	**Knowledge of concept**					**Confidence w/ teaching the concept**				
Managing intra and inter-professional conflict in difficult ethical situations	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme
Ethical resources	1 None	2 some	3 moderate	4 large	5 extreme	1 None	2 some	3 moderate	4 large	5 extreme

Appendix E

Written Narrative Post intervention

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to
Students in the Clinical Setting
Reflective Narratives on Simulation- post debriefing

Instructions: Please complete all questions. There are no right answers. Use the back of this form if necessary.

1. In what ways has the education you received today added to your knowledge? Please explain

2. Has your learning impacted your thinking about clinical instruction? If so, please describe. If no, why not?

3. Are there knowledge, skills, or attitudes displayed in this simulation that you think would be useful for teaching in the clinical setting? If so, describe, If no, why not?

4. Would you use this knowledge as a teacher in the clinical setting? If so, describe. If no, why not?

5. Do you think this will improve your ability and comfort level to perform clinical instruction? If so, how? If no, why not?

Appendix F

Follow-up Assessment

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to
Students in the Clinical Setting.

Follow up assessment – 4 weeks post education

Instructions: Please complete questions below. There are no right answers.

1. In what way have you been able to implement ethics learning into clinical instruction?
Please describe.

2. If you have been unable to implement ethics learning into clinical instruction, describe
what assistance would be needed or helpful.

3. In what ways will you continue to implement ethics learning into clinical instruction?
Please describe. (**If no, please describe any barriers or challenges you experience or**
anticipate)

4. Is there anything else you would like to add?

Appendix G

Educational Workshop

UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING
A Simulation to Improve the Clinical Nursing Instructor's Teaching of Ethics to Students in
the Clinical Setting.

Educational module for participants in the Randall DNP Capstone project

Participants learning objectives for this educational module:

- Describe the clinical instructor's role in clinical instruction.
- Describe and analyze teaching of ethics in practice
- Engage in conversations with nursing students and other health care professionals about ethical dilemmas in practice
- Practice how to respond to nursing students about ethical dilemmas/issues in practice.

Participants will complete the pre-learning assessment prior to the educational module and return to me. Participants will be asked to view a 10 minute voiceover podcast on ethics and read short article/chapter related to nursing education in the clinical setting any time prior to the educational session.

Framework of the module (4 hrs):

The face to face educational module will be in the three parts:

#1) Nursing education theory discussion: 20-30 minutes. This discussion will emphasize the clinical instructors (CI) role & responsibility in the clinical setting with the nursing student.

Questions to explore in this preliminary session:

What is teaching in a clinical setting? What is learning in a clinical setting? How does the nursing student learn in a clinical setting? What is the role of the nursing student in the clinical setting? What is the role of clinical instructor in the clinical setting? The primary nurse?

Intervention #1   Total time 45 mins (15 mins intervention & 30 mins debriefing)

Video of clinical ethical dilemma involving nursing student– 5 mins

Participants will be given a pre-made video to watch. The video will be on an ethical dilemma faced by a student nurse in clinical practice. The student nurse comes to the clinical instructor with their concern. The CI will ask the student how it went and the student hesitates to answer and seems concerned. The clinical instructor will be asked:

- What do they think is going on?
- Is there an ethical concern? What is the ethical dilemma?
- What would you do in this situation?
- How would you respond to the student in this situation? To the nurse?
- What is the resolution?

Debriefing (group):   This is where meaningful learning will occur (See appendix C)

--- BREAK 10 mins---

Intervention #2: (role-play 10 mins with 15-20 mins debriefing until each participant has a chance to be in the clinical instructor role = total est time 2 hrs 15 mins with one 10 min break)

Participants will role play how to respond to a student &/or other health care professionals about an ethical concern in clinical practice.

1 participant plays the nursing student & the other plays the role of the clinical instructor. Some scenarios may require an additional health care member ie. nurse or physician. Each participant will take a turn simulating how to respond to the students' ethical concern.

Role-play scenario 1: (nurse, student, clinical instructor)

A student overhears the primary nurse for her patient say to another nurse, "I just pretended to treat her. She was sleeping and will never know the difference. She always reports that her pain is 10/10 no matter even if you just gave her some Morphine. Since she is sleeping she must not be in pain. It is so hard to treat someone who is "drug seeking" and "besides, I am too busy with other patients who are sicker". The student concerned approaches you the CI about this.

Role-play how you respond to the student & handle the situation?

Role-play scenario 2: (nurse, student, clinical instructor)

The student's learning assignment today includes a patient with a history of schizophrenia. The student comes to you because she needs to order a piece of equipment. Recently, the hospital has developed a new process for ordering equipment so both go to the unit desk where the nursing coordinator is able to assist you and the student. The student asks the nursing coordinator how to proceed in ordering the equipment for the patient. The nurse says which patient is this for? The student nurse says "for my patient Mr. M in Room 303". The nurse looks at you, turns to her other peers at the unit desk & says with a smirk "Oh, that patient… (as she is twirling her finger next to her head) and begins to laugh.

Role- play how you would respond & handle the situation?

Role-play scenario 3: **(nurse, physician, student, clinical instructor)**

The student has a patient today with a new diagnosis of cancer and has not been told yet. It has been two days. The primary nurse tells the student that the physician does not want the patient to know yet because he/she doesn't think the time is "right". He/she would prefer to wait for the adult children to be at the bedside. The student feels uncomfortable with this decision as the patient is completely capable of making their own decisions and approaches you, the CI, with the concern.

Role- play how you would respond & handle the situation?

Role-play scenario 4: **(nurse, student, clinical instructor)**

The student arrives for the day & receives report on the patient from the primary nurse. The patient is a 22 yo male who was involved in a motorcycle crash. His right arm is fracture with a splint cast awaiting surgery. His left arm is injured with a shoulder sprain. He fractured his pelvis in two places. He had a compound fracture of the left lower extremity involving tib/fib. He has abrasions (road rash) all over his face chest & arm. The nurse (with an annoyed tone) in report states "he is very dependent on the nurse. He can use his left arm but "acts" like he can't pick up a drink or even feed himself.   I have to refuse to do things for him and I suggest you don't "baby" him." The student nodes her head and goes into the room to introduce herself. The patient is crying & visibly upset having spilt coffee all over his johnnie. Crying he reluctantly asks the student nurse for help. The student decides to help the patient. The primary nurse seeing this takes the student aside to and sternly reminds the student not to "baby" the patient. The student comes to you with her concern.

Role- play how you would respond & handle the situation?

Debriefing (group):   **Will occur after each role-play simulation. This is where meaningful learning will occur (See appendix C)**

Prior to leaving, participants will complete post-education learning assessment, written reflection and return to me.

Education module will conclude. Participants will be reminded of the follow-up assessment in 4 weeks.

Table 1

Demographics of Participants.

		Frequency	Percent
Age:	20-29	0	0%
	30-39	0	0%
	40-49	6	75%
	50-59	1	12.5%
	>60	1	12.5%
Gender:	Female	8	100%
	Male	0	0%
Educational level:	BS	3	37.5%
	MS	5	62.5%
	PhD	0	0%
# of yrs teaching nursing:			
	<2 yrs	4	50%
	3-5 yrs	0	0%
	5-10 yrs	3	37.5%
	>10 yrs	1	12.5%
# of yrs teaching clinical nsg:			
	<2 yrs	3	37.5%
	3-5 yrs	2	25%
	5-10 yrs	1	12.5%
	>10 yrs	2	25%
Formal education in Nursing:			
	Yes	3	37.5%
	No	5	62.5%

Table 2

Past education and experiences with ethics and clinical instruction (n=6)

Questions	**1** **None**	**2** **Some**	**3** **Moderate**	**4** **Large**	**5** **Extreme**
Undergraduate Education in Ethics	1 (16.6%)	2 (33.3%)	3 (50%)		
Graduate Education in Ethics	5 (83.4%)	1 (16.6%)			
Continuing Education in Ethics	4 (66.6%)	2 (33.3%)			
Experience teaching ethics in clinical instruction	2 (33.3%)	4 (66.6%)			
How often are ethical situations encountered in clinical instruction		4 (66.6%)	2 (33.3%)		
How often are ethical situations addressed in clinical instruction		4 (66.6%)	2 (33.3%)		

Table 3

A - Pre-assessment Instrument (n=6)

Knowledge of Concept

Concept	1 None	2 Some	3 Moderate	4 Large	5 Extreme
Moral vs. ethics	1 (16.6%)	2 (33.3%)	3 (50%)		
Ethical issues	1 (16.6%)	1 (16.6%)	4 (66.6%)		
Moral distress	2 (33.3%)	2 (33.3%)	1 (16.6%)	1 (16.6%)	
Ethical principles & theories	3 (50%)		3 (50%)		
Ethical decision making framework	3 (50%)	2 (33.3%)	1 (16.6%)		
Code of Ethics	1 (16.6%)	3 (50%)	2 (33.3%)		
Recognizing Ethical dilemmas		2 (33.3%)	4 (66.6%)		
Managing intra and interprofessional conflict in difficulty ethical situations	2 (33.3%)	1 (16.6%)	3 (50%)		
Ethical resources	3 (50%)	2 (33.3%)	1 (16.6%)		

Table 3

B - Pre-assessment Instrument (n=6)

Confidence with teaching the concept

Concept	1 None	2 Some	3 Moderate	4 Large	5 Extreme
Moral vs. ethics	3 (50%)	1 (16.6%)	1 (16.6%)	1 (16.6%)	
Ethical issues	2 (33.3%)	2 (33.3%)	1 (16.6%)	1 (16.6%)	
Moral distress	3 (50%)	1 (16.6%)	1 (16.6%)	1 (16.6%)	
Ethical principles & theories	3 (50%)	2 (33.3%)	1 (16.6%)		
Ethical decision making framework	3 (50%)	2 (33.3%)	1 (16.6%)		
Code of Ethics	2 (33.3%)	2 (33.3%)	2 (33.3%)		
Recognizing Ethical dilemmas		3 (50%)	2 (33.3%)		
Managing intra and interprofessional conflict in difficulty ethical situations	2 (33.3%)	1 (16.6%)	3 (50%)		
Ethical resources	3 (50%)	2 (33.3%)	1 (16.6%)		

Table 4

A - Post-assessment Intervention (n=8) _____

Knowledge of Concept_____

Concept	1 None	2 Some	3 Moderate	4 Large	5 Extreme
Moral vs. ethics		3 (37.5%)	1 (12.5%)	4 (50%)	
Ethical issues			3 (37.5%)	5 (62.5%)	
Moral distress			4 (50%)	4 (50%)	
Ethical principles & theories		4 (50%)	2 (25%)	2 (25%)	
Ethical decision making framework		3 (37.5%)	1 (12.5%)	4 (50%)	
Code of Ethics		4 (50%)	3 (37.5%)	1 (12.5%)	
Recognizing Ethical dilemmas			3 (37.5%)	5 (62.5%)	
Managing intra and interprofessional conflict in difficulty ethical situations		1 (12.5%)	3 (37.5%)	3 (37.5%)	1 (12.5%)
Ethical resources		4 (50%)	3 (37.5%)	1 (12.5%)	

Table 4

B - Post-assessment Intervention (n=8)

Confidence with teaching the concept

Concept	1 None	2 Some	3 Moderate	4 Large	5 Extreme
Moral vs. ethics		1 (12.5%)	3 (37.5%)	4 (50%)	
Ethical issues			3 (37.5%)	5 (62.5%)	
Moral distress			4 (50%)	4 (50%)	
Ethical principles & theories		4 (50%)	2 (25%)	2 (25%)	
Ethical decision making framework		3 (37.5%)	3 (37.5%)	2 (25%)	
Code of Ethics		4 (50%)	3 (37.5%)	1 (12.5%)	
Recognizing Ethical dilemmas			3 (37.5%)	4 (50%)	1 (12.5%)
Managing intra and interprofessional conflict in difficulty ethical situations			4 (50%)	3 (37.5%)	1 (12.5%)
Ethical resources		3 (37.5%)	4 (50%)	1 (12.5%)	

Table 5

Measures of Central Tendency (n=8) _____

Median and Mode_____

Rank	Pre-assessment Median/Mode score Knowledge	Post-assessment Median/Mode score Knowledge	Pre-assessment Median/Mode score Confidence	Post-assessment Median/Mode score Confidence
NONE	2 / 1	0 / 0	3 / 3	0 / 0
SOME	2 / 2	3 / 0	2 / 2	1 / 0
MODERATE	3 / 3	3 / 3	1 / 1	3 / 3
LARGE	0 / 0	4 / 4	0 / 0	3 / 4
EXTREME	0 / 0	0 /0	0 / 0	0 / 0

Table 6

Nonparametric test - Mann-Whitney U_____

| Concept	KNOWLEDGE Pre/Post P value	CONFIDENCE Pre/Post P value
Moral vs. ethics	.181	.059
Ethical issues	**.02***	**.029***
Moral distress	**.043***	**.043***
Ethical principles & theories	.282	.059
Ethical decision making framework	**.020***	**.029***
Code of ethics	.414	.282
Recognizing ethical dilemmas	**.020***	**.005***
Managing intra and interprofessional conflict in difficult ethical situations	**.043***	**.020***
Ethical resources	.059	**.043***

*Level of significance *p <.05*
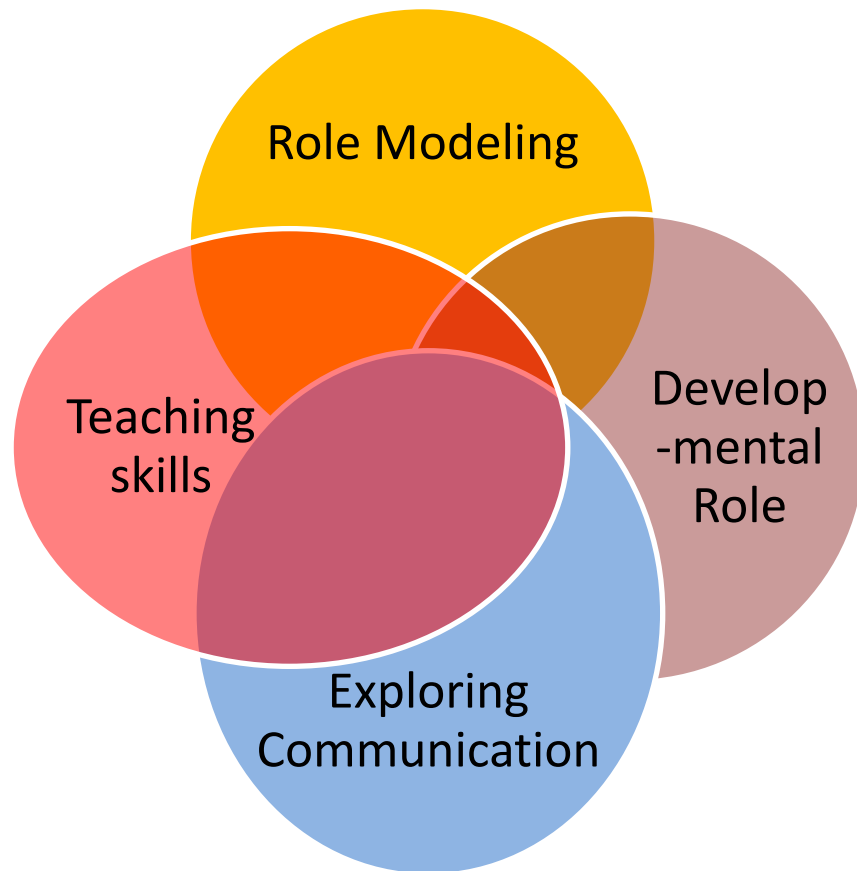
Figure 1

Debriefing Analysis. The unequal overlapping relationship of the pattern suggests the

complexity of the interrelationship of each concept.

Figure 2

Written Narrative Themes. This figure represents the interplay the relationship of each concept to one another.
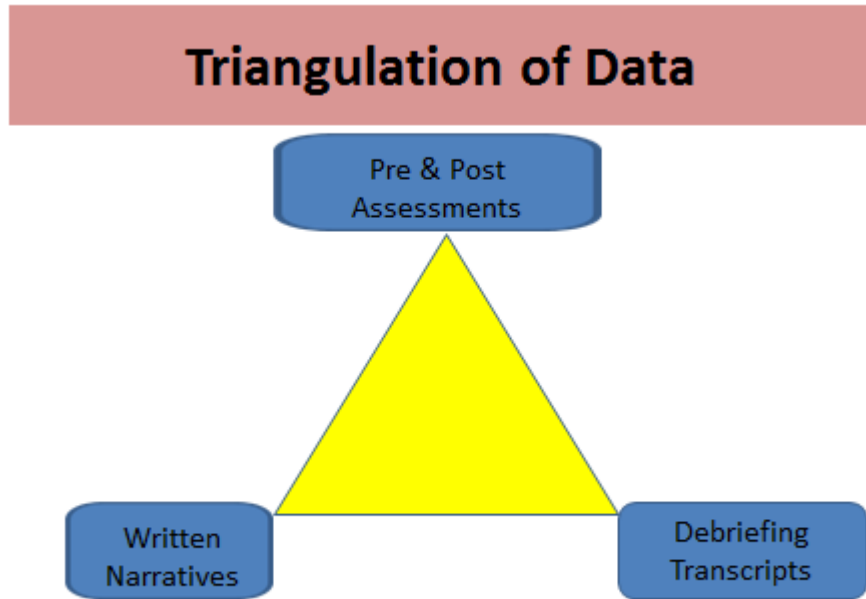
Figure 3

Trangulation of Data. Data was cross-checked and compared with each method.