

Original Article

The Effects of an Ethical Empowerment Program on Nurses' Ability of Ethical Care Delivery to Patients with Decreased Level of Consciousness in Intensive Care Unit

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ABSTRACT

Background: Nurses should be empowered for ethical care delivery (ECD) to patients with decreased level of consciousness (LOC) in the intensive care unit (ICU). However, there are limited data about the effects of ethical empowerment programs on nurses' ECD ability. **Objectives:** The aim of this study was to evaluate the effects of an ethical empowerment program on nurses' ability of ECD to patients with decreased LOC in ICU. **Methods:** This quazi-experimental study was conducted in 2019 in Al-Zahra University Hospital, Isfahan, Iran. Seventy-two nurses were randomly recruited from the ICUs and randomly allocated to an intervention and a control group. Participants in the intervention group were provided with an ethical empowerment program. A researcher-made questionnaire was used to measure participants' ability of ECD to patients with decreased LOC at three time points, namely before, immediately after, and 1 month after the workshop. Data were analyzed through the Chi-square test, the independent-samples *t*-test, and the repeated-measures analysis of variance. **Results:** The difference between the intervention and the control groups respecting the pretest mean score of ECD ability was not statistically significant (124 ± 5.88 vs. 126.17 ± 9.07 ; $P = 0.10$). However, the mean score of ECD ability in the intervention group was significantly greater than the control group both immediately after the workshop (142.58 ± 7.22 vs. 127.14 ± 8.13 ; $P < 0.001$) and 1 month after the workshop (147.57 ± 5.45 vs. 128.51 ± 9.52 ; $P < 0.001$). **Conclusion:** Ethical empowerment is effective in significantly improving nurses' ability of ECD to patients with decreased LOC in ICU. This program is recommended for improving nurses' ECD ability.

KEYWORDS: Empowerment, Ethical care, Intensive care unit, Level of consciousness

INTRODUCTION

Decreased level of consciousness (LOC) is a life-threatening condition caused by the various factors such as metabolic, toxic, and intracranial disorders.^[1] Studies in Western countries reported that mortality rate among patients with decreased LOC is as high as 25%–48%.^[2,3] According to the World Health Organization, around twenty million patients with decreased LOC are annually admitted to hospitals worldwide.^[4] More than 85% of these patients require hospitalization in the intensive care unit (ICU).^[5]

Patients with decreased LOC in ICU have complex clinical conditions, are almost completely dependent on health-care providers and life support facilities,

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are extremely vulnerable, and hence, need close attention and effective care.^[6] Therefore, nurses in ICU need to have considerable knowledge and clinical decision-making skills to effectively manage their patients' critical conditions^[7,8] and provide care based on the principles of ethical practice.

Ethical care delivery (ECD) entails careful attention to the factors such as human values, compassion, and patient privacy^[9] and is based on experience, emotions, and interpersonal communication.^[10] For ECD to patients with decreased LOC, nurses need to support patients in any condition, create a safe environment for them, and protect their human rights.^[11] ECD facilitates nurses' professionalization.^[12,13] However, studies show that despite educations in universities and hospitals about ECD, some nurses have limited ECD-related knowledge,^[13] limited competence in ECD,^[14] and limited adherence to ECD.^[15] A study showed that from patients' perspectives, only 41.8% of nurses had close adherence to the principles of ECD, 51.8% of them had moderate adherence, and 6.4% of them had poor adherence.^[16]

Given the poor status of ECD in some settings, strategies are needed to empower nurses for ECD.^[17] Empowerment of nurses promotes their organizational confidence and commitment, job satisfaction, productivity, engagement in clinical decision-making, self-efficacy, and autonomy, provides them with better learning opportunities, improves their care quality, professional accountability, and organizational effectiveness, reduces their occupational stress and sense of depersonalization, and enhances patient satisfaction.^[18] Therefore, nurse empowerment is currently considered a professional necessity in nursing.^[14,19]

Mallak and Kurstedt's model is one of the methods for ethical empowerment of nurses.^[20] Mallak and Kurstedt considered empowerment as a broad concept and defined it as a type of participatory management. They highlighted the importance of education and effective management in employee empowerment and noted that empowerment is a behavior with intrinsic behavior motivation which helps employees effectively perform their tasks and responsibilities.^[21] Mallak and Kurstedt's model has four main principles, namely autonomy, beneficence, nonmaleficence, and justice. These four principles are the basis for ethical decision making. However, there are limited studies into the empowerment of nurses for ECD and limited educational programs in this area in Iran. Therefore, the present study was conducted to address this gap.

Objectives

The aim of this study was to evaluate the effects of an ethical empowerment program on nurses' ability of ECD to patients with decreased LOC in ICU.

METHODS

This quazi-experimental study was conducted in 2019 using a two-group design. The study setting was Al-Zahra University Hospital, Isfahan, Iran. Participants were 72 critical care nurses randomly selected from ICUs in the study setting through the simple random sampling and using a table of random numbers. Thus, 36 cards with number one and 36 cards with number two were placed in a sealed envelope, and the nurses were asked to choose one card; it should be noted that all cards were the same shape and size. Thus, the people who chose number one were in the experimental group and the people who were assigned number two were in the control group. The inclusion criteria were an ICU work experience of 6 months or more, agreement for participation in the study, and no participation in any similar empowerment program during the study. The exclusion criteria were reluctance to stay in the study and any absence from the sessions of the study intervention. The sample size was calculated based on an earlier study in which the mean baseline ethical sensitivity score of nurses was 68.0 ± 11.61 and after the intervention changed to 75.89 ± 8.76 .^[20] Then, with an α of 0.05, a β of 0.20, and considering the μ_1 , μ_2 , S_1 and S_2 of 68, 75.89, 11.61, and 8.76, the sample size was estimated at 27 in each group. However, considering the possible attrition, we recruited 36 participants in each group. Participants were blind to group allocation.

Data collection instruments

Data collection instruments consisted of a demographic questionnaire and a questionnaire on nurses' ability of ECD to patients with decreased LOC in ICU. The six items of the demographic questionnaire were on age, gender, marital status, education level, ICU work experience, and employment type. The ECD questionnaire was a researcher-made questionnaire developed based on the existing literature^[22] and the comments of experts in the nursing and medical ethics. It included 38 items on ECD to patients with decreased LOC in ICU in two main dimensions, namely professional commitment (twenty items) and clinical service delivery (eighteen items). Items were scored on a five-point Likert scale from zero to four as follows: 0: "No idea;" 1: "Never;" 2: "Rarely;" 3: "Sometimes;" and 4: "Always". The possible total scores of the questionnaire and its professional commitment and clinical service delivery dimensions were 0–152,

0–80, and 0–72, respectively. The face validity of the questionnaire was approved by 11 experts in nursing ethics. For reliability assessment, twenty nurses twice completed the questionnaire with a 20-day interval, and intraclass correlation coefficient was calculated to be 0.823.

Intervention

Study intervention was an ethical empowerment program based on Mallak and Kurstedt model which was implemented in two steps [Table 1]. In the first step, a workshop on the four principles of ECD, i.e., autonomy, beneficence, nonmaleficence, and justice, was held in two consecutive days from 08:00 to 14:00. Educations were provided using lecture, videos, scenarios, group discussions, and experience sharing. In the second step, participants were provided with the telephone numbers of the study authors and several experts in nursing ethics so that they could ask their questions through the short message service during the first one month after the workshop. Participants' ability of ECD to patients with

decreased LOC was assessed through the researcher-made ECD ability questionnaire at three time-points, namely before, immediately after, and 1 month after the workshop. In the control group, the ethical care booklet was provided to the nurses after the workshop. Booklet includes four main principles, namely autonomy, beneficence, nonmaleficence, and justice.

Ethical considerations

The Ethics Committee of Isfahan University of Medical Sciences, Isfahan, Iran, approved the study (code: IR.MUI.RESEARCH.REC.1397.306). Necessary permissions for the study were obtained from the authorities of the university and the study setting. The aims and the methods of the study were explained to the participants, and they were ensured about the voluntariness of participation and confidential management of the study data. Moreover, they were ensured that participation in the study would carry no cost or risk. Written consent was obtained from all participants.

Table 1: The ethical empowerment program

Phase	Characteristics	Methods
First main objective: Empowerment of nurses for ECD to patients with decreased LOC in ICU	<p>First day: The autonomy and the justice principles</p> <p>Aim 1: Increasing nurses' internal motivation for ECD</p> <p>Main content (provided in 1.5 h): Necessity of nurse empowerment for ECD; definition of decreased LOC; classification of decreased LOC; clinical manifestations of patients with decreased LOC; an overview of the principles of ethical practice; the autonomy and the justice principles of ethical practice</p> <p>Question and answering about the main content</p> <p>Presentation of two 15 min videos about challenging ethical conditions</p> <p>Aim 2: Internalization of professional behaviors</p> <p>Main content: After video presentation, participants were divided into two groups with a group manager. Then, group members discussed the questions which had been provided to them during video presentation in 30 min. A group member recorded or wrote a summary of the group discussion. After group discussion, all participants in both groups joined a group and group managers provided a summary of group discussions in 20 min</p> <p>Aim 3: Improving nurses' independent problem-solving skill</p> <p>A scenario which presented a challenging condition respecting the autonomy and the justice principles was provided to participants. They were asked to think about the scenario, identify the problem, determine appropriate nursing measures, make appropriate decisions, and present their results during 30 min at the beginning of the workshop in the second day</p> <p>Second day: The beneficence and the non-maleficence principles</p> <p>Participants presented their results respecting the scenarios provided to them in the first day. Then, the beneficence and the nonmaleficence principles were explained to them in 60 min, and they were divided into two groups to work on the provided materials. Finally, a summary of the program was provided to them in 30 min and a booklet entitled "Ethical care" was provided to them</p>	<p>Lecture</p> <p>Video presentation</p> <p>Group discussion</p> <p>Scenario presentation</p> <p>Teamwork</p> <p>Experience sharing</p>
Second main objective: Promoting learning retention	<p>The mobile phone numbers of several experts in nursing ethics were provided to the participants so that they could ask their questions through the short message service over telephone during the first one month after the workshop</p>	

ECD: Ethical care delivery, LOC: Level of consciousness, ICU: Intensive care unit

Data analysis

Data were analyzed using the SPSS software version. 16.0 (SPSS Inc., Chicago, IL, USA). The measures of descriptive statistics (namely mean, standard deviation, and frequency) were used for the data presentation. The Kolmogorov–Smirnov test was used for normality testing. Between-group comparisons respecting participants’ demographic characteristics were made through the Chi-square and the independent-sample *t*-tests. Moreover, the repeated measures analysis of variance and the independent-sample *t*-test were used for within- and between-group comparisons respecting the mean score of the ability of ECD to patients with decreased LOC. The level of significance was set at <0.05.

RESULTS

There were no significant differences between the groups in terms of participants’ age, gender, work experience, education level, marital status, and employment type [$P > 0.05$; Table 2].

Before the intervention, the intervention and the control groups did not differ significantly from each other respecting the mean score of ECD ability (124 ± 5.88 vs. 126.17 ± 9.07 ; $P = 0.10$). However, the mean score of ECD ability in the intervention group was significantly greater than the control group both immediately after the

workshop (142.58 ± 7.22 vs. 127.14 ± 8.13 ; $P < 0.001$) and one month after the workshop (147.57 ± 5.45 vs. 128.51 ± 9.52 ; $P < 0.001$). The results of the repeated-measures analysis of variance also showed that the variations of the total mean score of ECD ability in the intervention group were statistically significant across the three measurement time points. Further analysis showed that the mean score of ECD ability immediately after the intervention was significantly greater than the pretest mean score and significantly less than the mean score of ECD ability at 1 month after the workshop [$P < 0.05$; Table 3]. Contrarily, the mean score of ECD ability in the control group did not change significantly across the three measurement time points ($P > 0.05$).

There were no significant between-group differences respecting the pretest mean scores of the professional commitment and the clinical service delivery dimensions of ECD ability ($P > 0.05$). However, the mean scores of both dimensions in the intervention group were significantly greater than the control group both immediately after and 1 month after the workshop [$P < 0.001$; Table 3]. Moreover, the mean scores of the professional commitment and the clinical service delivery dimensions of ECD ability in the control group did not significantly change across the three measurement time points ($P > 0.05$), whereas these mean scores significantly increased in the intervention group ($P > 0.05$). Accordingly, the mean scores of these two dimensions in the intervention group immediately after the workshop were significantly greater than the corresponding pretest values and were significantly less than the corresponding values at 1 month after the workshop [$P > 0.05$; Table 3].

Table 2: Between-group comparisons respecting participants’ characteristics

Characteristics	Groups, mean \pm SD or n (%)		P
	Control	Intervention	
Age (years)	34.77 \pm 5.94	36.06 \pm 6.97	0.41 ^a
ICU work experience (years)	8.54 \pm 6.12	9.91 \pm 6.14	0.35 ^a
Gender			
Female	34 (97.1)	34 (97.1)	1 ^b
Male	1 (2.9)	1 (2.9)	
Marital status			
Married	27 (77.1)	25 (71.4)	0.47 ^b
Single	8 (22.9)	10 (28.6)	
Type of employment			
Permanent	7 (20)	9 (25.7)	0.62 ^b
Conditional permanent	5 (14.3)	6 (17.1)	
Contractual	15 (42.9)	15 (42.9)	
Postgraduation service	8 (22.8)	5 (14.3)	
Education level			
Master’s degree	3 (8.6)	5 (14.3)	0.46 ^a
Bachelor’s degree	32 (91.4)	30 (85.7)	

^aThe results of the independent-sample *t*-test, ^bThe results of the Chi-square test, ^cThe results of the Mann–Whitney U-test. ICU: Intensive care unit, SD: Standard deviation, sig<0.05

DISCUSSION

The findings of the present study showed that the ethical empowerment program effectively improved all aspects

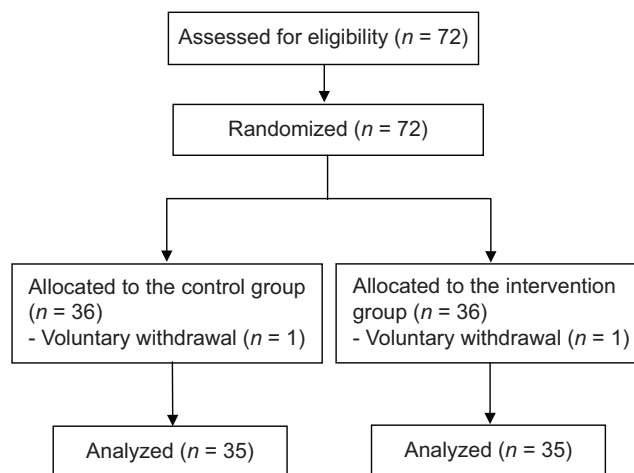


Figure 1: Consort flow diagram of the study

Table 3: Between- and within-group comparisons respecting the mean scores of nurses; ability of ethical care delivery and its dimensions

Ability of ECD/group	Time			<i>P</i> ^a		
	Before	Immediately after	One month after	Time effect	Time×group effect	Group effect
Total						
Intervention	124±5.88	142.58±7.22	147.57±5.45	<0.001	<0.0001	<0.0001
Control	126.17±9.07	127.14±8.13	128.51±9.52			
<i>P</i> ^b	0.24	<0.001	<0.001			
Professional commitment dimension						
Intervention	65.69±3.28	74.91±4.37	77.43±3.51	<0.001	<0.0001	<0.0001
Control	66.51±4.97	66.99±4.63	67.54±6.06			
<i>P</i> ^b	0.41	<0.001	<0.001			
Clinical service delivery						
Intervention	58.31±3.73	67.67±3.54	70.14±2.1	<0.001	<0.0001	<0.0001
Control	59.66±4.79	60.15±4.47	60.97±4.86			
<i>P</i> ^b	0.19	<0.001	<0.001			

^aThe results of the repeated measures analysis of variance; ^bThe results of the independent-sample *t*-test. ECD: Ethical care delivery

of nurses' ability of ECD to patients with decreased LOC in ICU. The findings showed a significant increase in the total mean score of ECD ability immediately after the workshop. As the between-group difference at pretest was not statistically significant, the significant between-group differences at both posttests are attributable to the positive effects of the study intervention. In line with this finding, three former studies showed that ethics-related education had positive effects on nurses' moral sensitivity in clinical decision-making,^[23] nurses' ethical reasoning,^[24] nurses' ethical judgment,^[25] and nursing students' moral sensitivity and ability to recognize ethical violations.^[26] Another study found that moral motivation training through lecture, group discussion, film screening, and role playing had positive effects on nurses' moral sensitivity and patient satisfaction.^[27] Two studies also reported that practical courses for discussing ethical issues related to clinical practice enhanced nurses' skills for ethical practice,^[28] their ability to identify ethical dilemmas in nursing practice,^[29,30] and their ability to make ethical decisions based on the principles of nursing ethics.^[31]

Given the significant positive effects of education and empowerment on nurses' ethical practice, courses on nursing ethics should be included in the nursing curriculum to improve nurses' knowledge and understanding about ethical issues.^[20] Moreover, discussion about ethical conflicts in the clinical practice helps nurses better identify ethical conflicts and make appropriate ethical decisions for the management of ethical conflicts.^[31] Providing nurses with constructive feedback and opportunities for reflection can also empower them for the management of ethical

conflicts. Educational workshops are a good strategy for brainstorming about ethical challenges and issues, feedback giving, and knowledge improvement. In workshops, nurses can promote their learning and improve their knowledge in small groups through reflection on new topics, experience sharing, and face-to-face discussions.^[30]

Our findings also showed that the 1-month follow-up education through short messages between participants and experts in nursing ethics was effective in significantly improving participants' ability of ECD to patients with decreased LOC. This finding highlights the importance of follow-up education for increasing the effectiveness of ethical empowerment programs. In line with our findings, a former study showed that ethics-related education through workshops and 24 follow-up messages using mobile phone over 2 months had positive effects on nurses' moral sensitivity.^[32] Ethics is a dynamic discipline, and hence, continuous education is needed to promote learning and improve the effectiveness of education.^[33,34] Moreover, as nurses face different ethical challenges during their daily practice, they need ethical empowerment through different educational courses to improve their knowledge, modify their attitude, and promote their ethical practice. Engagement of nursing ethics experts in ethical empowerment programs for nurses can improve the outcomes of these programs, promote nurses' learning, and facilitate their empowerment.

One of the study limitations was the fact that participants' personal, religious, and socioeconomic characteristics might have affected their perceptions of their ECD ability. Moreover, most participants in both groups were

female (97.1%), and hence, findings may not easily be generalizable to male nurses. Another limitation of the study was the possibility of between-group information leakage during the study.

CONCLUSION

The ethical empowerment program based on Mallak and Kurstedt's model study is effective in significantly improving nurses' ability of ECD to patients with decreased LOC in ICU. Therefore, this program can be used in in-service training programs for health-care providers, particularly nurses and physicians, to improve their ECD ability. Replication of the present study on different groups of health-care providers is recommended to produce clear evidence regarding the effects of ethical empowerment.

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Conflicts of interest

There are no conflicts of interest.

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