Beyond the skills: Using simulation to teach ethics

By

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Abstract

The realities of emergency nursing practice are that nurses work in complex environments. Educators need to start looking past just preparing nurses for the psychomotor competencies required, to also examining how nurses can provide safe, competent, compassionate *and* ethical care. Enhancing ED nurses' abilities to be sensitive to and reflective about the complexity of their ethical environment will better prepare them to consider how they might choose to act in response to those forces. The inability of practicing nurses, or the educators facilitating their learning, to see the ethical issues in their daily practice is the primary concern I addressed with my project. I am interested in making ethics something ED nurses learn to discuss, something that is explicitly addressed rather than being hidden in coffee room discussions and classrooms. Using the pedagogical approach of transformative learning theory, in combination with simulation as a teaching strategy, I worked within an existing course framework to facilitate making ethics an explicit part of learning about nursing practice in the ED.

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Our lives begin to end the day we become silent about the things that matter.
(Martin Luther King)

A few years ago, I had a position in the emergency department (ED) as a clinical resource nurse. The intent behind the position was to support new staff in developing the skills necessary to work in the ED, act as a resource for complex cases, and also be a mentor. Interestingly, I found myself being pulled into conversations with staff less about the psychomotor skills they were struggling to develop and more about issues and questions that reflect the ethical complexities of working in this environment. Much of my time as a resource nurse was spent listening to concerns about the long wait times for patients to be seen, lack of basic care offered to the elderly patients that had been in our department for over 12 hours waiting for admission, concerns over the negative attitudes of fellow staff, the mental exhaustion that comes from not getting breaks, the self-doubt that occurs when a patient dies and the nurse feels responsible, the anger around having to care for the violent patient that is spitting and swearing at the nurses all through the shift, the weight of feeling as if they were not doing enough to care for their patients, and the limited resources available to allow staff to do the kind of job they would like to do.

While advanced technical skills and knowledge are essential, ED nurses work in one of the most ethically challenging and complex environments in healthcare. Yet, these ethical challenges are minimized and often unacknowledged. Often issues faced by nurses in practice are labeled as 'the realities of practice' as if to claim they are something we have to accept. This minimizes the challenges ED nurses encounter and also does not offer any direction in terms of how to act in this complex environment. Enhancing ED nurses' ability to be sensitive to and reflective about the complexity of their ethical environment will better prepare ED nurses to consider how they might choose to act in response to those forces. As an ED nurse and educator

I found myself drawn to find a way to break the silence about the ethical challenges of ED practice and better prepare nurses for practice in the ED.

Project Overview

During my practice as an ED nurse, I have become frustrated with the apparent lack of focus on the ethical challenges of practice in the ED and concerned that as an educator I was not properly preparing nurses to work in the ED. In fact, was I setting them up for frustration? As educators, do we create an idealistic image of ED practice where nurses attain a high level of critical care skills and knowledge, perform life saving interventions, and enjoy a level of autonomy as an ED nurse without ever addressing how they plan to live out this ideal in a less than perfect work environment? I felt a need to reconsider how I viewed education of ED nurses and broaden the focus beyond just technical skill and advanced biomedical knowledge to include ethics.

My focus in this project, therefore, is embedding ethics into simulation scenarios that are part of an education program where nurses are certified for practice in the ED. Although nurses in the ED are expected to continually advance their knowledge in caring for critically ill patients, a focus on how ED nurses can practice ethically in an environment full of competing obligations and priorities, higher patient volumes, and still provide quality of care to their patients is often missing. Gordon (as cited in Fagin, 2001) argues that nurses need to be "morally, emotionally, and educationally prepared" to provide care in the complex environment of healthcare. Throughout my years of experience as an ED nurse and educator, I have not seen much attention to the moral or emotional preparation of ED nurses but an ever-expanding focus on competencies related to complex psychomotor skills. Beyond just the psychomotor skills and biomedical knowledge required by ED nurses, I want to help them to develop ethical knowledge and the

skill to identify ethical issues in their daily practice, reflect on how contextual forces and competing ethical obligations affect their ability to provide care, and find ways to better navigate that ethical terrain.

Cranton and King (2003) encourage educators to critically question and reflect on what it is we do, discard old habits, and be open to new alternatives. It is this critical questioning process that has guided the project and how it is structured. In the first section, I critically reflect on my own transformative process as both an ED nurse and educator considering the complexity of ED nursing. In section two, I explore (a) how ED nurses are being prepared for practice, (b) the priorities embedded within ED education and (c) the ethical aspects of ED practice that are not being addressed by ED educators. In section three, I provide the background for this project including an overview of the advanced specialty program for which this project was designed and how simulation is an effective teaching strategy. In section four, I outline the options that I explored in order to enhance the simulation design. In this section, I address the theoretical perspective that guided the redesign, review the process I entered with colleagues to review the existing scenarios, identify assumptions that the educators had related to the scenarios, as well as the decisions related to the overall goals of the scenarios. In section five, I discuss the steps I took in redesigning the two scenarios beginning by creating a narrative and identifying potential learning opportunities. I then present how I considered the redesign around instrumental and communicative learning to address both the technical skills as well as the ethics embedded in ED nursing practice. Finally, I discuss additional considerations addressed to ensure the success of the simulation. Through this project, ED nurses and educators can join me in a journey that will have them questioning their practice, rethinking how they interpret their environment, and maybe even inspire them to alter their behavior (Smith, Witt, Klaassen & Zimmerman, 2012).

Critically Reflecting on ED Nursing

My goal as an educator is to help ED nurses realize their full potential and to feel more confident to manage the complexities of patient care. I want ED nurses to question what they see, explore what they know, and analyze what does not make sense. My role as an educator is not to get in the way of a students learning, but be a bridge for nurses to realize their own possibilities as they aspire to become amazing ED nurses. Creating these bridges requires me to continuously reexamine the environment in which this bridge must exist. To begin that process, I critically reflected on the complexity of ED nursing practice and reexamined this complexity from a relational perspective. What I have come away with is that to facilitate students to become amazing ED nurses they must learn to make use of daily challenges to inform their practice instead of just simply learning to cope.

Complexity of ED Nursing Practice

The Abyss
Terrorized by truth
Startling reality
Seeing the unfathomable
Imaging the could-be
Abandoned by humanity
Tormenting darkness
Spinning with uncertainty
Powering the will-be
Acknowledging animosity
Alarming brutality
Shielding from envy
Languaging the ought-to-be
Searching for community
Permeating aloneness
Longing for accompaniment
Valuing a hope-to-be
Sandra Bunkers (2002, as cited in Mitchell and Bunkers, 2003).

In considering how to best articulate the nature of work in the ED, I was struck by this poem that expresses the startling reality of working in this complex environment. ED nurses are

valued for their ability to work in a high paced critical care environment, but, at what cost? In my practice, too often ED nurses leave at the end of the day feeling, 'I did the best job I could, considering…' expressing the conflict felt between how they would have liked to be able to practice, and the realities of the work environment (*valuing a hope-to–be*). The ED nurse is expected to be able to reprioritize patient care needs every moment; the choice to attend to the needs of one patient at that moment means the needs of another has to wait (*spinning with uncertainty*). Take for example the ED nurse assigned to triage, he or she makes technical as well as ethical choices every moment in determining which patient gets into the ED before someone else (*powering the will-be*). There are guidelines to identify priorities but the triage nurse may be confronted with a choice about whether to push through a child with croup at 2AM before someone that is more "critical" just so the family can get home; this may not be technically correct but may be what is best for the needs of that patient. (*languaging the ought-to-be*) Does the nurse at triage feel empowered to make this choice or does he or she feel obligated to follow the dictates of policy even when it does not feel right? (*terrorized by truth)* Does this nurse at triage even see decisions such as this as being not just technical but ethical as well?

Ethics is a practice that is "both a way of being and acting within a shifting moral context…between one's own identity and values and those of the organization, and others" (Varcoe, Doane, Pauly, Rodney, Storch, Mahoney, McPherson, Brown & Starzomski, 2004, p. 319). The chaos in which ED nurses must learn to thrive is that of competing priorities and conflicting values that accumulate to create a challenging and complex work environment.

To better understand and articulate the complexity of ED nursing, Doane and Varcoe's (2007) relational inquiry perspective is helpful. Within their relational inquiry framework, Doane

and Varcoe highlight the intricate connection between the intrapersonal, interpersonal and contextual factors that are part of the ED nurses' daily practice (See Appendix A). What this implies is that any change in a contextual factor influences both interpersonal relationships as well as challenges one's intrapersonal perspective. On the same hand, the intrapersonal perspective that a person holds will impact how the ED nurse interacts in both interpersonal relationships and the contextual factors embedded within his or her work. Given how intrapersonal, interpersonal and contextual elements shape each other, these authors contend that despite a nurse's best intentions and efforts, it is not merely up to the nurse. That is, there are competing obligations and priorities that often make a nurse's job immensely challenging and shape the way in which a nurse is able to respond. Thus, while the nurse's role in establishing the nurse-patient relationship is vital, it is also important to appreciate and acknowledge the "personal and contextual factors that make trusting, respectful, and therapeutic relationships challenging" (p. 192). I examined the complexity of ED nursing looking specifically at the contextual, interpersonal, and intrapersonal factors that underlie the challenges of practice in the ED in order to awaken a new perspective regarding the nature of the 'Abyss'.

Contextual factors. Contextual factors are those reflected in the environment in which the ED nurse must thrive and are often the primary focus of concerns expressed by nurses. In Canada, all health authorities are attempting to deal with issues of a growing population, increased age of those receiving services, increased acuity of patients, growth in both mental health and substance abuse concerns, the public's increasing expectations of the system, as well and the ever growing technology that both enhances and challenges the delivery of healthcare (Storch, 2013; Valdez, 2009). The system has become economically based and hierarchically driven, dominated by a "discretionary fiscal strategy, decreased human resource management

and an illness focus approach" (Boychuk- Duchscher & Myrick, 2008, p. 196). This leaves nurses to provide excellent care in a demanding environment with less than ideal resources. The results of the fiscal restraints in healthcare have left nurses to provide care in environments that have inadequate staffing levels, questionable staff mix, efficiency driven care, deskilling and casualization of nurses, where patient goals often subordinate to institutional goals, and where a hierarchy still remains between nurses and physicians in relation to authority and autonomy (Boychuk-Duchscher & Myrick, 2008; Rodney, Buckley, Street, Serrano & Martin, 2013; Shriver, 2003). These global issues in healthcare have a direct and profound impact on the nation's ED's.

It is estimated that 15.8 million Canadians a year receive the service of ED's (CIHI, 2012). Alberta Health Services (2013) reported 2 million visits to ED's in 2012. According to CIHI (2012), only 9.1% of those patients get admitted making the ED by far the busiest area of hospital in terms of throughput. The current trend towards efficiency has targeted this patient volume area and in Alberta targets are being imposed by the government for ED's to meet a maximum length of stay in the ED of four hours (Alberta Health Services, 2013). A complete interrogation of this demand imposed on ED's in Alberta is beyond the scope of this paper, however, it does provide fuel to the argument that the government is concerned with efficiency and the underlying assumption in healthcare currently is that "considerations of efficiency trump considerations of quality care" (Buckley et al., 2013, p. 188). ED nurses are continually challenged to meet these demands of throughput while being confronted with a fluctuating and uncertain patient population.

The essence of the ED is its unpredictability and, unlike inpatient units, there is no predicting patient volume nor is there an ability to close the doors and restrict the number of

incoming patients (NENA, 2013; Valdez, 2009). ED nurses are required to have expertise in critical care, palliative care, care for the aging population, trauma, resuscitation, maternity, pediatrics, mental health, substance abuse and also have recently been called upon to be experts in managing environmental disasters, responding to terrorist attacks as well as be up-to-date on the latest public health issues such as the H1N1 crisis (NENA, 2013; Shriver, 2003; Valdez, 2009). As the primary entry point for patients into the healthcare system, there are always new expectations placed on ED nurses to know more and manage any new crisis as the healthcare system is continually challenged beyond its capacity. ED nurses must learn to work the system in order to ensure the best care for their patients as they juggle the demands of the system with the interpersonal relationships and their own intrapersonal perspective.

The nature of working in the current context of the healthcare system means that ED nurses are often faced with daily practical or political issues of "cajoling, tricking, or badgering a recalcitrant system into doing what ought to be done" (Chambliss, 1996 as cited in Storch, 2013, p. 4). In the example above of the ED nurse at triage, in order to get the young child with croup seen, the ED nurse at triage may go to a physician that she knows will be most open to her request, miss her break so she can provide the care this child requires so as not to burden an already busy department, or override a computer system to place this child as a higher priority. It is at these moments in everyday decisions that nurses make a choice based on more than one right option. ED nurses are continually negotiating the contextual obligations of the environment in which they work while navigating through various interpersonal relationships; this is where the art of ED nursing as a moral endeavor endures.

Interpersonal factors. Interpersonal factors account for yet another dimension of the complex web of relationships that the ED nurse must navigate daily in his/her daily practice.

These interpersonal factors include, but are not limited to, relationships between: nurse-patient(s), nurse- nurse, nurse- management, nurse-family members (See Appendix A). Each of these relationships are part of ED nurses' daily practice and do not occur as isolated entities, but overlap and compete for the ED nurses' attention. The demands placed on the ED nurse by each of these relationships are often in direct competition with each other, and may be in direct conflict with the ED nurse's intrapersonal values. The challenge is determining the correct course of action when confronted by more than one seemingly correct response.

Gadow (1999) cautions nurses from assuming they work from some moral high ground when in fact the cornerstone of nursing is "dialectically layered" (p. 66). Dialectic is to enter into a space to not find truth, but uncover the underlying interrelated layers that affect everyday nursing practice. This implies that neither view should be seen as morally superior, and that each view cannot exist without the other. The challenge to the ED nurse is to determine which to attend to at that moment, and the choice is frequently a choice between two or more correct responses making this an ethical challenge. There is a need to acknowledge the ethical complexity that exists in ED nursing and understand how the multiple factors can leave the ED nurse uncertain about how best to prioritize between more than one correct action. Faced with issues of conflicting/ competing priorities, ED nurses are left to juggle between what they feel is right in that moment, which may be in competition with what is being asked of them by others.

One of the most challenging interpersonal factors for ED nurses is related to the interprofessional relationships that develop when working so closely with the physicians in the ED. In the ED, it is the combination of the physician's medical expertise in treating illness and trauma, and the nurse's expertise in managing care and demonstrating compassion in this critical care environment that makes the ED such a highly respected specialty care area. However, in the

pursuit of personal, professional goals and obligations to the ED patients, physician and nurses' values can conflict. Coulehan (2005) admits that the medical culture of today is "hostile" towards many of the values held by nurses such as "altruism, compassion, integrity, fidelity, and self-effacement" (p. 897). Although this cannot be assumed to be the case for all ED physicians, when health professionals caring for a patient attend blindly to their own agenda without appreciating the positive contribution that each professional brings to the care of the patient, the end result can have a negative impact on the care being provided to patients. ED nurses who do not see value in their roles and unquestionably relinquish power to others can also contribute to nurses' sense of fulfillment in their practice.

Kuhn, Goldberg and Compton (2009) found the emotional exhaustion experienced by ED physicians to be associated with the potential for "bad outcomes", which are described as "unsuccessful treatment or identification of an illness or death". Wolf and Zuzelo (2006) identified similar "regrettable outcomes" from a group of nurses who identified concerns regarding a patient dying thirsty because a nurse chose not to question an NPO order on a palliative patient. I would argue that nurses may have a broader perspective on what would be considered a bad outcome for patients. A bad outcome could relate to not just the fact that the treatment was unsuccessful, but that the patient died without dignity, that a patient was made to wait for hours in pain waiting to be seen, or they sent a patient to the unit in soiled linen. Neither of these perspectives is more correct than the other but highlights the difference in values or priorities that nurses and physicians may have. In my experience as a clinical resource nurse, it was discussions related to issues around these "regrettable outcomes," such as a patient needlessly suffering because the ED nurse was so overwhelmed with attending to all the other priorities at that moment, which weighs on ED nurses over time.

O'Mahoney (2011) found that ED nurses are "overburdened, ignored, (and) undervalued" (p. 34). Interestingly, however, ED physicians were not found to experience a significant amount of depersonalization and still had a sense of accomplishment in their work (Kuhn, Goldberg and Compton, 2009), suggesting that despite the common work environment, ED physicians and nurses have different experiences. Doane et al. (2004) found that nurses often question if they have any "moral authority or right to exercise their moral agency (leaving them with) a sense of powerlessness" (p. 246) implying that despite the nurse's own sense of the right course of action, he/she will defer to what the department demands, or how someone with greater authority feels is the correct choice.

Interpersonal influences on ethics in practice can be affected by bias imposed by colleagues, or succumbing to the hierarchical system in which the physician's perspective holds the power. Varcoe et al. (2004) expressed concern that ethical/moral issues in practice are often identified as those issues that relate to medically relevant ethical questions such as right to life issues, decisions to withdrawal or withhold treatment, and undervalue everyday nurse's concerns as "ordinary, or not seen as ethical" issues at all. Authority is often deferred to the physician in current healthcare practice, so it is not surprising that ED nurses feel a sense of powerlessness in making some decisions. Being able to understand the hierarchy and power influencing ED nurse's work is a significant factor in everyday ethical practice. ED nurses work within a shifting moral context dominated by positivist views, where biomedicine holds a privileged position over nursing values, and nurses are often in a position of attempting to "do their best" (Varcoe et al., 2004). Nurses often then question challenging the dominant ideology and compromise their personal and professional values due to a sense of powerlessness when they are confronted by the realization that the physician's power often supersedes that of the nurse

(Wolf & Zuzela, 2006). It is not just the contextual, interpersonal, and intrapersonal factors that ED nurses must acknowledge and learn to work within, but also the complex power imbalances that affect the interrelationship of the three factors.

In the example above regarding the ED nurse at triage, if the physician agrees with the nurse's decisions to have the child seen in order to get them home more quickly does this validate the nurse's decision? What if the physician does not agree, could this nurse be disciplined for not following policy? What if a more senior nurse challenges the first nurse's decision and maybe even implies that the nurse is being too sensitive and needs to be more objective? The hierarchy of power in the ED and how it can influence an ED nurse's decision to act in a certain way is important to understand. Boychuck-Duchscher and Myrick (2008) identified that nurses tend to "overlook the role of oppression…and aim at efforts to adapt to rather than change the circumstances" (p. 193). Coverston and Rogers (1999) argue that because nurses are "unfamiliar with the language of ethical discourse" (p. 9), there is greater difficulty to participate at all levels to act on their moral responsibility. There is a risk that instead of being advocates for safe, competent and compassionate care, nurses will settle for what is easy. This idea that ED nurses are unfamiliar with the language of ethics and therefore may conform to the dominant ideologies pervasive in healthcare put both the quality of patient care and the ED nurses' intrapersonal perspective at risk. In fact, Nash (2002) argues that a person cannot separate their intrapersonal image of themselves as a moral person from the ethical judgment and decisions they make as professional and it is this interrelationship between multiple factors that is at the core of everyday ethical decision making.

Intrapersonal factors. Intrapersonal factors are those internal values, beliefs, and assumptions that each ED nurse brings to his or her practice that influence how an experience

may be interpreted, but also how each nurse may choose to act, or not act, in a given situation. Doane, Pauly, Brown, and McPherson (2004) found that practicing nurses were often "confused about the place of personal and professional values" in daily practice issues. Many nurses may believe there is no place for personal feelings in caring for patients and that the patient's values and needs are of primary importance, or may view emotion as a sign of weakness.

Factors influencing an individual nurse's perspective on ethics in the ED will be influenced by intrapersonal factors such as ethnicity, socio-economic class, culture, religion, and past experiences. Mezirow (2000) argues that each person has an internal frame of reference that "selectively shapes and delimits perception, cognition, feelings, and disposition" (p. 16) that guides action and reaction to an experience. An individual's frame of reference is constructed from a personal set of assumptions that are influenced by society's values, culture, family, religion, education, personal conscience, and self-concept (Mezirow, 2000). Individual expression of these frames of reference is expressed as one's point of view that, according to Mezirow (2000) is a function of values, feelings, beliefs, judgments, and attitudes that affect how each person interprets situations as well as guides his or her behavior. Doane and Varcoe (2007) argue that despite professional obligation, intrapersonal factors such as an ED nurse's personal values may "mute their sense of obligation" in a given situation based on the frame of reference through which they view the patient in that moment. How the ED nurse then interprets the situation will dictate how they choose to act, or not act.

Hohschild (1983, as cited to Banks and Gallagher, 2009) described the "emotional labor" of nursing and suggested that often there is suppression of feelings in practice that may be the reason patients or families view an ED nurse as 'uncaring' or 'disinterested'. ED nurses are in close proximity to patients and families during times of crisis, trauma, and illness, and the ability

to be aware of feelings, beliefs, and emotions have a place in ED practice. In fact, Banks and Gallagher (2009) argue that it can contribute to the motivation for ED nurses to act in a situation, enable nurses to respond with sensitivity to patient suffering, and aid in the identification of ethical and unethical behaviors. ED nurses must be able to acknowledge their own feelings and be aware of their own underlying values in order to see how these factors influence not only the interpretation of events but how their emotions and values may empower them to act in an ethically challenging situation.

Looking back at the above example of the ED nurse at triage, ensuring the young child gets seen quickly may have less to do with the acuity of his symptoms and more with the nurses values and beliefs, as well as the knowledge that this condition can be quickly addressed and treated. The ED nurse could be concerned about having this child exposed to the environment of the ED at 2 AM, or have a sense of compassion for the parents who are exhausted and desire to allow them a quick visit to get their child back to bed. This nurse has to make an ethical choice considering a variety of factors. Factors that complicate the triage nurse's decision may be that his/her intrapersonal preference to have this child seen quickly are in conflict with departmental policy; the physician's sense of justice to see the sickest patient; a fellow nurse's courage to act against the standards; or the inability to accomplish the goal of having the child seen quickly due to contextual factors such as no available space. Nurses are often left feeling frustrated or dissatisfied with the care they were able to provide and are confronted with an ethical dilemma where the nurse must then choose between equally correct choices.

Compounding affect of ethical dilemmas on intrapersonal perspective. Wolf and Zuzelo (2006) suggest that nurses who experience frequent moral/ethical conflicts may, over time, learn coping behaviors to minimize the emotional and physical response brought on by the

stressors found in everyday practice. These coping behaviors may be in direct conflict with the ED nurses values and beliefs, but seen as a necessary means to survive the complexity of the work environment. Mezirow (1991) suggests that when confronted by situations that challenge underlying values and beliefs adults' will "block (them) out or resort to psychological defense mechanisms to provide a more compatible interpretation" (p. 4).

Coping mechanisms may be seen in ED practice by the normalizing of ethical issues in practice, denying that ethical challenges are occurring, trivializing or minimizing the issues, displacing responsibility to others, blaming the 'system', dehumanizing or blaming the victims (Rodney, Kadyschuk et al., 2013; Wolf & Zuzelo, 2006). Nurses who continually feel challenged in their ability to provide quality patient care risk an "internal shift to their own moral compass" which could lead to errors in judgment or somehow justify sub-standard care (Rodney, Kadyschuk et al., 2013). ED nurses may compromise their own values to fit with what they feel they can do rather than what they would like to do and distance themselves from patients or even avoid going into patient rooms unless necessary. The concern then is not only the potential for ED nurses to experience ethical/moral conflict, distress or even burnout, but the reality is that these unresolved ethical challenges can accumulate over time affecting the nurses interpersonal relationships with colleagues, patients, and families, ultimately affecting the ability, or motivation to provide quality care to patients.

Ethical/ moral distress is defined as feelings of guilt, concern, or distaste arising out of competing and conflicting occupational expectations that constrain a nurse's ability to act in a morally responsible way (CARNA, 2010; Boychuk-Duchscher & Myrick, 2008; Rodney & Buckley et al., 2013; Wolf & Zuzelo, 2006). Distress can be manifest itself as feelings of anger, guilt, frustration, powerlessness, or self-blame and nurses can experience physical symptoms

including palpitations, headaches, and sleep disturbances that over time can interfere with interactions with patients as well as fellow staff members (Nathaniel, 2006; Rodney, Kadyschuk et al., 2013). Burnout is defined as a "syndrome of emotional exhaustion, depersonalization and diminished personal accomplishment" that results from unresolved moral distress (O'Mahony, 2011, p. 33). Burnout has been associated with increased absenteeism, decreased job performance, increased staff turnover, and can lead to nurses mechanically carrying out their daily tasks ultimately compromise patient care (McAllister & McKinnon, 2008; Nathaniel, 2006; O'Mahoney, 2011; Rodney, Kadyschuk et al., 2013). Repetitive exposure to unresolved ethically challenging situations can lead nurses to experience mental and physical symptoms that can negatively impact a nurse's job satisfaction and morale. O'Mahoney (2011) argues that the constant exposure to ethical challenges in the ED, due to patient volume and the nature of the environment, ED nurses are at the greatest risk for ethical/ moral distress.

Does stress and burnout need to be a natural consequence of working in the ED? Another perspective is that nursing in the ED is known to be an intense experience; dealing with patients and families when they are at their most vulnerable creates an environment fraught with stress, loss, grief, and pain. Also, I would argue that if we solved the current healthcare crisis tomorrow, nursing in the ED would still be immensely challenging due to its close proximity to suffering, uncertainty, and conflict (Doane &Varcoe, 2007). ED nurses need to learn to work within this chaos and not "suffer or succumb" to the stressors but be "witness to it, and be instructed by it" (Doane &Varcoe, 2007, p. 201). Mitchell and Bunkers (2003) argue that the danger to nurses is not constantly being witness to difficult situations and suffering but turning away and choosing to somehow view our obligations to care for our patients as somehow controlled externally from who we are as a person. Administrators view technical competencies

and psychomotor skills as the panacea to a healthcare system in crisis leaving those providing the care to have "sharper minds than ever, (but) their hearts appear to be listless and their moral compass adrift" (Coulehan, 2005, p. 893). As an educator, it is necessary to find ways to have ED nurses bear witness to the ethical complexity of their work environment and empower them to thrive amid the chaos and not succumb to the abyss. This perspective transformation begins by critically reflecting on how ED nurses are prepared for practice and how an ethical perspective could be beneficial.

I have examined how contextual, interpersonal and intrapersonal factors impact the way an ED nurse navigates ethically within the ED. Contextual factors are those that ED nurses must learn to navigate in the course of daily practice as they live out their intrapersonal beliefs and values as a nurse. However, caring for patients is never done in isolation and decisions around care and treatment come from a team of professionals working together for the best interests of the patient. The interpersonal factors that an ED nurse must learn to work within is another dimension to the complexity of preparing an ED nurse's for practice (Doane &Varcoe, 2007). Finding ways through high fidelity patient simulation (HFPS) to better prepare ED nurses for the challenges they may experience in practice and helping them learn to navigate within those challenges to provide high quality care is crucial and what this project was aimed toward.

Preparing Nurses for Practice in the ED

It has been my experience that educators have attempted to instill larger amounts of knowledge, and focus on competency training for complex skills, to meet the ever-expanding scope of practice and demands of the ED environment. However, the need to prepare nurses for the ethical challenges they will face seems to have been given less attention. In order to reconstruct a new perspective around preparing nurses for ED practice, I needed to shift my

focus on how best to prepare nurses to thrive amid the complexities of the ED. To accomplish this, I first needed to identify the educational priorities for ED nurses that dominate in the literature, as well as where education related to ethics fits in to the priorities in ED education. Focusing on education around ethics from a relational perspective, the goal of this project was to find a way to address the complex psychomotor skills required for the ED along with the ethical complexity experienced in daily practice.

Priorities in ED education

The expected knowledge base for an ED nurse is quite broad and preparing nurses for practice in the ED is primarily directed toward competency based education (Harding, Walker-Cillo, Duke, Campos & Stapleton, 2012; NENA, 2011; Valdez, 2009). Valdez's (2009) examination of educational priorities for the future of ED nursing ranked ethical decision-making at number 39, below priorities that focus more on technical competence and skill. The top educational priorities identified by ED nurses include critical thinking, competencies in technical skills, triage, and medication safety (Valdez, 2009). The core competencies created by the National Emergency Nurses Affiliation (NENA) for ED nurses overlooks preparing nurses for the ethical challenges of ED practice as well and focus primarily on biomedical knowledge and technical skill.

One could interpret that education for ED nurses should not focus on ethical issues, as there are other priorities. However, I would argue that all of the 42 identified trends in healthcare (Valdez, 2009) are issues with moral complexity and do lead to ethical challenges. I do not intend to imply that technical competencies are not necessary in ED practice. Understanding the nature of the technical skills and competencies that ED nurses must maintain provide clarity to nursing practice and identify role boundaries as well as foster accountability

(Cowan, Norman & Coopaman, 2005). What I do suggest is that we need to see value in competencies beyond just the skills. ED nursing education primarily centers on how ED nurses 'ought' to care for patients in the ED. Ethics however, is the ability to reflect on "how the 'oughts' can be put into action" (Storch, 2013, p. 6). In creating a project that addresses ethics in the ED, it was necessary to first consider what assumptions and perspectives the nurses entering the course may have regarding how to define ethical issues. According to CARNA (2010), nurses should consider the complexity of relationships in their everyday practice including; what are the hidden values in a situation, whose values are given priority, how are opinions being influenced by cultural or religious perspectives, what principles can guide our action, and ultimately how do we care for one another (p. 4). It is these intrapersonal, interpersonal as well as the contextual factors that are important to understand and examine as part of ED nursing and how they contribute to conflicting values and competing priorities that the ED nurse must navigate his/her way through, and it is these factors that make the landscape of the ED multidimensional and complex (Doane and Varcoe, 2007).

Ethical perspective

The expectations of the ED are that nurses attend to the sickest patient first, the one with the most life threatening injury. What about the screaming and combative patient who takes time and attention away from the elderly patient with a hip fracture needing the bedpan, or the patient who has not had an analgesic for more than four hours? The ED nurse assigned to triage is also making technical as well as ethical choices every moment in determining which patient gets into the ED before someone else. It is in the choices to act, or not to act, in the moment of caring for patients in the ED where nurses are making moral/ ethical decisions. Problems arise when ED

nurses attempt to guide the everyday aspects of their practice utilizing the principles of autonomy, justice, beneficence, and non-malifecence alone.

The dominant ideology that pervades the healthcare system of principle-based ethics is too "abstract to provide helpful guidance in complicated everyday ethics" (Banks and Gallagher, 2009, p. 32). Varcoe, Doane, Pauly, Rodney et al. (2004) argue that nursing has "uncritically adopted biomedical ethical theory" (p. 317). Benner (1996) argues that principle-based ethics excludes the "good embedded in everyday skillful ethical practice" (p. 259). Going back to the example of the triage nurse, the question here is being able to apply the principle of justice to whom…the child, the parents, or the many other people that have been waiting longer to be seen? The triage nurse could argue by getting the child in sooner is a matter of beneficence, or doing good, but at what cost? Is there a potential that in making another person wait it could be doing harm to that person thus breaching the principle of nonmalifecence? Consider that the choice that this triage nurse has made also conflicts with departmental policy and could also be in conflict with the points of view of the physician. The complexity of ED nursing is often not served well by placing daily ethical issues within the domain of biomedical principles leaving nurses feeling frustrated in how to act within this moral complexity. Chambliss (as cited in Storch, 2013) argues that the "greatest ethical danger is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing (an ethical) decision at all" (p. 4). Education from a relational perspective considering contextual, interpersonal, and intrapersonal factors, offers a clearer perspective to rethink ethics education.

ED nurses are often caught in the middle; being most in tune with the needs of the patients they care for, but having little power or control over decisions made in regard to policy. ED nurses' voices can gain power and be heard if nurses can transform their perspective on the

everyday challenges they encounter in practice. If ED nurses can see the ethical tension that they are constantly working under and give voice to (a) their own values and assumptions in practice; (b) the multidimensional relationships between patient, family, physicians, the organization, and their own professional obligations; (c) how power inequities are shaping their decision-making and action, they may be better able to navigate within the ambiguity, uncertainty and complexity of the ED. Moreover, they may begin to see the ethical choices they face and affect the options available to them.

Nursing by its very nature is a moral endeavor; moral agents demonstrate a capacity for "rational and self-expressed choice…(and) action that requires recognition of and reflection on moral challenges" (Rodney, Kadyschuk, Liaschenko, Brown, Musto & Snyder, 2013, p. 163). Reflection is an active process that requires the ED nurse to consider multiple perspectives as well as those factors that may influence their choices. Doane and Varcoe's (2007) relational perspective again offers one view in which to understand the multiple forces that can influence a nurse's identification and interpretation of ethics in the ED. This broader perspective on ethics allows ED nurses to view, interpret and explore options on how to thrive amid the chaos and complexity of the ED. My current practice in an advanced specialty-training program was the ideal place to try out some new strategies for preparing nurses for practice in the ED.

Project Background

I currently teach in an advanced critical care nursing program (ACCN) that prepares nurses for practice in the ED. This was an ideal location for this project as the target population of students is nurses interested in expanding their knowledge in an area of practice, therefore an open and willing group. Also, this program consists of a small faculty group making collaboration and implementation of changes much more simplified. I will provide a brief

overview of the ACCN program and strategies used to prepare ED nurses for practice. I will then expand on the use of HFPS as an affective teaching strategy for preparing nurses for practice in the ED and why it was an ideal choice for the focus of this project.

Overview of Advanced Specialty Education program

Due to the complexity of skills and broad knowledge based required of nurses in the ED, it has been found that some type of advanced preparation for nurses is required. The National Emergency Nurses Affiliation (NENA) (2011) argues that the challenges presented to ED nurses are multidimensional and the uniqueness of emergency nursing requires knowledge, experience, and advanced preparation to ensure quality care. The ACCN program consists of four online courses and a final clinical placement in an ED. All of the ACCN students enter this program with a variety of life and work experience; all are post-graduate nurses with 1-20 years of nursing experience that may or may not be in the ED. The curriculum has been developed around the priorities for ED nurses set out by NENA (2011). The ACCN program focus is on advancing knowledge, skills, attitude, and professional accountability to ensure "safe, competent, collaborative and ethical practice" in the ED (ACCN, 2010).

HFPS is valued as a teaching strategy in the program to advance knowledge and skills as well as expose the nurses to aspects of ED practice that are essential for ED practice. My concern with the current focus of the HFPS scenarios in the ACCN program are that they focus on competency in psychomotor skills inherent to ED practice and provide opportunities for connecting knowledge related to assessment, monitoring and interventions to new nurses coming to the ED and yet overlook complexities of practicing in the ED. For example, in the current ACCN simulation scenario #1 (See Appendix H), the students are presented with an ED patient that they are asked to assess. The intent of the scenario is to have the students become

comfortable with the components of a critical care assessment and prioritizing interventions in comparison to the assessment and admission process that they are familiar with from work on the nursing units. This leads to a scripted scenario with defined objectives that do not leave room to consider competing demands or conflicting priorities that are part of ED practice. The questions that I believe are left unanswered in this first HFPS scenario are: What would change in how you do this assessment if the patient was unresponsive or uncooperative? How could you manage this assessment when there may be another patient that is a higher priority? How do your own (or colleagues) values, assumptions, and bias potentially influence your assessment or actions?

The simulation scenario #2 (See Appendix I) has the students entering a room where a code is in progress with the intent that they will respond as advanced life support providers to gain experience with advanced life support skills and interventions. However, again the scenario is scripted and completely avoids any attempt to have the students engage with the patient thus isolating the students from challenges related to the stressors and ethical issues related to critical events in the ED. In this case I was left questioning if having family in the room would affect their actions or feelings? Do nurses react differently in a crisis if they are detached from a relationship with the patient?

In reflecting on the current ACCN simulation scenarios I found myself thinking there was something missing, and I wondered why ethics could not also be part of the HFPS? Simply recreating the ethical content in the ACCN course work would meet the needs of providing the theoretical and cognitive knowledge related to ethics in the ED but would not provide the students the opportunity to experience how they will respond to these issues in practice nor provide them with an opportunity to explore new options for action. Specifically, it would not address the 'relational' complexities of ethical decision-making and action. HFPS provides the

opportunity to not only practice the technical skills but to facilitate the student's ability to identify, discuss, and respond to the contextual, interpersonal as well as intrapersonal factors ethics embedded in ED nursing.

Simulation as a Teaching Strategy

HFPS has become popular in both undergraduate and professional healthcare education as a way to mimic real patient care and expose learners to a variety of clinical experiences in a controlled atmosphere. Jefferies (2007) argues that this is more than just the latest trend, but that simulation allows students to "critically analyze their actions, reflect on their own skill sets, and critique decisions of others" (p. 5) all within a safe environment. Students in simulation can make mistakes that in practice could be harmful, but in simulation these mistakes can be turned into opportunities from which skills, knowledge and confidence can grow without the risk to patient care (Jefferies, 2007; Ziv, Ben-David & Ziv, 2005). Simulation can also be a way to involve students in a complex and emotional situation in a safe and controlled setting and provide the opportunity for them to try out new roles or strategies for dealing with difficult situations without fear of repercussion. Simulation has the potential to enhance the dialogue around ethics in ED practice as well as provide an environment for the nurses to explore options in how they can live out ethics in the practice environment.

Although it may be easy to be distracted by the uniqueness of the technology behind HFPS, it is important not to sacrifice the relational reality (including the intrapersonal, interpersonal and contextual complexities) inherent to nursing when choosing to make use of HFPS as an educational strategy (McGovern, Lapam, Clune, Martin, 2012). Smith, Witt, Klaassen, Zimmerman and Cheng (2012) took HFPS beyond just the acquisition of skills, and developed scenarios to support fourth year nursing students learning about legal and ethical

issues. The faculty created a scenario to cover issues such as advanced directives, conflict management, leadership, documentation, and respect for cultural differences within a case related to a patient in cardiac arrest. The evaluations from both faculty and students suggest that this strategy worked well to bring legal and ethical issues to life by making them part of real practice issues and not just abstract classroom topics (Smith et al., 2012). Examples in the literature of simulation being used to learn from experience and teach more than just the acquisition of psychomotor skills include: Communicating bad news to patients (Chen, 2011); Issues of incivility in nursing practice (Clark, Ahten, Macy, 2013); Creating ethical dilemmas to assess professionalism in medical residents (Gisondi, Smith-Coggins, Harter, Soltysik &Tarnold, 2004); Legal issues in nursing (Klaassen, Smith & Witt, 2011); End-of-life care (Leighton & Dubas, 2009), Dealing with medical errors (Ziv, Ben-David & Ziv, 2005).

In order to ensure that HFPS supports a high level of learning and be a satisfying experience for the students, Jefferies (2007) suggests that consideration be given to supporting active learning, the diverse learning styles of students, enhancing collaboration, and setting expectations that appropriately challenge students be addressed in the planning phase of any simulation experience. Not only do adult learners have diverse styles of learning that need to be considered, but also active learning is known to be a significant motivator in adult education and transformative learning. Ways in which to address different learning styles, as well as actively engage students in the simulation experience, is necessary for its success (Jefferies, 2007). Beyond just educating ED nurses about what ‘ought’ to be done in a situation, I suggest what is missed being spoken about is how to live out one’s personal and professional values within the complex environment of ED nursing. The ethics of ED nursing is the ability to find ways in

which to live up to one's own personal vision of being a good nurse while working within a web of relationships that often impose competing demands and conflicting priorities.

Toward that end, I reexamined each of the original scenarios using the lens of transformative learning theory. It was through this that I was able to open my mind to explore new options in relation to how I could redesign the scenarios to maintain the essential psychomotor skills and knowledge and enhance ED nurses' ability to be sensitive to and reflective about the relational complexity of their ethical environment.

Exploring Options for Enhancing Simulation Design

Creating effective learning opportunities for ED nurses is a challenge due to the multidimensional nature of practice in the ED and it would be easy to continue to do things as they have been done in the past. It is also very easy to become enamored by the level of technology available with HFPS and risk allowing the technology to drive the scenario, leading educators and students to become preoccupied with the psychomotor skills of HFPS and sacrifice the relational and interpersonal aspects of nursing (McGovern, Lapum, Clune, Martin, 2012). McGovern et al., (2012) argue that it is easy for HFPS to focus on tasks, however, more effort should go into designing scenarios that place expectations on students to address all forms of knowledge including empirics, esthetics, personal knowing, and ethics.

In preparing for this project, I had to consider not only the theoretical perspective that I would enlist to inform my choices in the redesign, but I also needed to review each scenario to determine what needed to be kept and where there were areas for improvement and hence redesign. I will first discuss how transformative learning theory supported the design of the simulation scenarios to better prepare ED nurses for practice. Second, I will review the process that the faculty took to a) review each of the scenarios to determine the strengths and weaknesses

and b) identify their own underlying assumptions related to the scenarios and expectations around the learners. It was through this process that the overall learning goals of the HFPS experience were identified.

Transformative Learning Theory

Determining a theoretical perspective to guide the creation of scenarios that values multiple forms of knowledge, works well with the experiential aspects of HFPS, and that opens ED nurses' minds to broaden their ethical perspective of ED practice was necessary. One of the features that drew me to transformative learning theory was that it specifically addresses the value in both technical competency as well as humanistic and ethical knowledge. Mezirow (2000) describes the technical knowledge as instrumental learning, and the personal, ethical, and humanistic knowledge as communicative learning. At this point, I would argue that HFPS has done a great job in focusing on the instrumental aspects of learning, but it is the communicative learning that is missing in the development of HFPS scenarios for ED nurses and my challenge was to find space for ED nurses to elaborate, differentiate and reinforce or create new meaning about their practice (Mezirow, 1991). Using transformative learning theory, I was able to redesign the ACCN HFPS scenarios continuing to value the psychomotor skills and theoretical knowledge required of ED nurses but also acknowledge the moral dimension of practice in the ED.

Transformative learning theory is a lens through which learning is viewed as more than the transmission of knowledge, but a "process of making new or revised interpretations of the meaning of an experience" (Mezirow, 1991, p. 1). Learning, in fact, is not the desired outcome of transformative learning theory, but is seen as an "activity of making an interpretation that subsequently guides decision-making and action" (Mezirow, 1991, p. 375). Meaning that is

attributed to a new experience is influenced by past experiences, personal values and assumptions. Making meaning out of a new experience is a process that allows for the creation of a new frame of reference through which all future experiences will now be interpreted. It is impossible to be fully aware of the diversity of values and experience that the ED nurses will bring when they enter the ACCN program. However, Mezirow (1991) does offer suggestions for how a person's frame of reference can become distorted (epistemic, sociocultural, and psychic). I made use of these potential sources of distortions in consideration of how best to move forward in this project.

Epistemic distortion is related to how knowledge is viewed and used. What this means is that if an ED nurse places greater value on knowledge that is empirically verifiable, learning related to other forms of knowledge would be seen as less valuable to that nurse. Also, an epistemic distortion can occur when an ED nurse assumes that all problems must have a solution thus creating anxiety, or a barrier to learning when confronted with problems that have multiple or no correct answers. To prevent such distortions from occurring, multiple forms of knowledge are valued equally within transformative learning theory. Instrumental learning focuses on how to control ones environment and problem solve (Mezirow, 2000). The other domain of learning is that of communicative learning that focuses on feelings, intentions, values, and moral issues (Mezirow, 2000). Transformation, according to Mezirow, can occur within either domain of learning however the focus of my project is to bring communicative learning out of the shadows within HFPS but still keeping the instrumental learning components.

The second distortion that can occur, according to Mezirow, is through the sociocultural lens that reflects a person's belief systems that pertain to power and hegemony. In this sense, the ED nurse is less likely to question practice that is enforced by the institution and again may be

more likely to follow the social norms of the unit. Transformative learning theory provides guidance in this respect in that Mezirow (1991) argues that transformative learning theory is the way to "control our experiences rather than being controlled by them" (p. 375). Instead of ED nurses feeling pressure to conform to expectations of others, they are encouraged to critically reflect on the issues in their practice, examine the underlying assumptions related to the concern and consider alternative perspectives regarding the meaning of an experience. The acknowledgment in transformative learning theory of the role of power and influence in distorting perspective also reflects the complex ethical nature of ED nursing. HFPS offers a safe venue for ED nurses to practice ways to control, or at least work with some of the challenges found in ED practice and critical reflection is a key aspect of the debriefing phase of HFPS.

Finally, Mezirow (1991) cautions that interpretation of experiences can be influenced through one's psychic lens in which a person's underlying assumptions generate anxiety that impedes action. The ED nurses may believe that to question issues in practice could lead to being singled out by management, or avoid showing emotion for fear of being labeled as not having the right personality to work in the intense and challenging environment of the ED. The utility in both transformative learning theory and HFPS is the value placed upon experiential learning thus providing an environment for students to try on new roles and experiment with new ideas to ultimately transform perspectives, and alleviate some of the fear of the unknown in respect to ED nursing practice.

Transformative learning is an active learning process in which adults are encouraged to critically reflect in order to "reconstruct the dominant narrative" under which they define their reality and make choices in regards to action (Mezirow, 1991). Using HFPS can not only serve to challenge the dominant narrative around the meaning of ethics in ED nursing, but also

challenges the perception that psychomotor skills and advanced critical care knowledge alone prepares ED nurses. I began the process of finding a place for ethics within the HFPS scenarios by first reviewing the two existing HFPS scenarios.

Reviewing Existing Scenarios

Redesigning the HFPS scenarios began by first critically reflecting on each scenario with fellow faculty members. This dialectical process was necessary to fully explore all options relating to the redesign of the scenarios, and determine what was necessary to keep and where we thought as faculty the scenario could be enhanced. I will present a synopsis of the review done on each of the existing simulation scenarios. Each scenario was reviewed to identify the learning objectives and underlying intent of the scenario in relation to preparing nurses for practice in the ED. I will also identify aspects of each scenario that had not performed well in the past which became an obvious starting point in which to guide the redesign.

Scenario #1 (See Appendix H). The first scenario involves a patient being admitted with sepsis of unknown origin who is on Levophed to support his blood pressure. The students are asked to complete a full assessment on this patient, identify his need to be on oxygen, identify that his blood pressure is lower than the ordered parameters, and determine the need to titrate the medication. In the past, many students have not had previous experience with Levophed and did not have the knowledge to titrate the medication safely. The instrumental learning objectives included: recognizing the difference between assessments of the critically ill patient versus a ward patient, demonstrating a thorough and accurate head to toe assessment including safety checks, and recognize abnormalities in the assessment and identify the correct course of action.

The underlying intent of scenario #1 was that the ED nurses take past knowledge of assessment and combine that with the knowledge from the course in order to identify how an

assessment of an ED patient would differ. One of the concerns raised was how the original setup was too scripted and did not allow for individual exploration, and assumed that all ED nurses had no previous experience with critical assessments. From the perspective of transformative learning, learning is about making new interpretations of an experience in order to "elaborate, differentiate, reinforce, or create a new meaning scheme" (Mezirow, 1991, p. 5). It was important then in preparing the redesign that consideration was given to this identified need to focus on the expectations in regards to assessing patients in the ED by building on the ED nurses prior knowledge. The scenario then needed to be complex enough to challenge experienced nurses but not so complex as to draw attention away from the intent of completing a comprehensive critical care assessment using critical thinking skills.

Scenario #2 (See Appendix I). The second ACCN scenario has the students responding as part of a code team to a patient in cardiac arrest with the expectation that they integrate themselves into the team, communicate effectively with team members, demonstrate skills related to advanced cardiac life support, and demonstrate knowledge related to care of critical ill patients. The key instrumental learning in this case was to integrating the knowledge and skills related to basic and advanced cardiac life support. Although affective communication is considered important in this case it was often over shadowed by the intensity of responding to the cardiac arrest.

In discussion with faculty about this scenario, concerns came up about the flow of the scenario. Asking the students to enter into a code in progress may occur in practice, but, as new learners, are they able to identify what their roles should be? I believed this scenario could flow better if it began where the students do have experience and a level of comfort and then find a way for it to progress into an arrest to be able to allow them the opportunity to practice new

skills. Considerations for the redesign needed to look at how to introduce the ED nurses to the patient in this scenario in a better way while still meeting the need to have them experience a critical incident and practice advanced skills.

During the review process, the primary concern was that the original scenarios focus on presenting a defined case to the learners and set up a linear series of problems for them to solve, thus limiting the scope of the scenario to be very task orientated. Young (2007) expresses concern related to this form of learning in that it "objectifies and decontextualizes the patient". Mezirow (2000) also cautions that for transformative learning to occur the ED nurses needs to be encouraged to negotiate and act in relation to his or her own meanings rather than those "uncritically assimilated from others" (p. 8). As educators creating simulation scenarios, we risk indoctrinating students to the meaning we take from an experience and create scenarios that reflect what we want the students to learn. However, the reality of practice in the ED is its multidimensionality, problems are not linear, patients are not predictable, and ED nursing immensely complex.

Case studies and problem-based learning are frequently used to design HFPS scenarios focusing on specific predetermined learning needs or skill-based competencies determined by the instructors. Case studies are also a common approach used to teach ethics to allow the opportunity for students to take the theoretical aspects of ethics and apply strategies for ethical decision making to a real situation. Students then follow a series of steps to resolve the pre-determined problem that has been chosen by the instructor. Case studies and problem-based learning are often created to have students come to a logical conclusion with little to no understanding of the context, richness of human experience and emotion, or complexities of the sociopolitical environment (Brown & Rodney, 2007).

Chen (2011) argues that case studies are "tidy and simplified (thus) prevent engaging in the nuance and complexity that accompanies real individuals with real emotions" (p.108). By conforming to a rigid case during simulation, educators risk avoiding the reality of ED nurses in practice and desensitize them to both the intricacies of the work of nursing and humanistic and complexity of work in the ED (Nathaniel, 2006; McGovern et al., 2012). Thus, in order to bring awareness to the complexity of ED nursing, it was necessary to consider moving beyond problem based learning and linear case studies in the redesign of the HFPS scenarios in order to embed ethics into the scenarios. However, further inquiry regarding the existing scenarios revealed that each faculty member had slightly different expectations about what knowledge the students should have, what skills at which they should be proficient, and what the overall goal of using HFPS was. This lead to an exercise to determine the underlying assumptions related to each scenario.

Identifying Assumptions. In preparing for the redesign, I first set out to identify the underlying assumptions faculty have in regards to the student population. Brookfield (1998) argues that critically reflecting on our practice aids in detecting "hegemonic assumptions" that may be working against us as educators. Assumptions can be as simple as assuming that all students have experience with the intravenous pumps, but by making this assumption an aspect in the HFPS is created that inadvertently draws the student's focus away from the intended goals as they may struggle to perform what may have been assumed to be a 'simple' task. Also of concern is that challenges experienced with meeting instrumental learning can overshadow the experience and influence the ability of the ED nurses to be open to aspects of communicative learning.

The ACCN faculty was asked to consider assumptions they had regarding the knowledge level of the ED nurses, the basic skills they have, maturity level and openness to change. Acknowledging assumptions ahead of time also helps educators to critically reflect on the teaching strategy in order to make improvements. Cranton and King (2003) encourage educators to get into the habit of regularly reflecting on teaching strategies and one part of the process is to accurately reflect on the content of a problem. When questioning why students did or did not perform as expected in HFPS, it is helpful to identify the content of the problem; that is, was it an issue with the design of the scenario, or were assumptions made about the level of knowledge or experience of the learners that was not accurate?

During the reflection it was identified that in the original scenarios it was assumed that the students would be knowledgeable about the medication Levophed. It was discovered that this was not addressed during the course and therefore lead to anxiety among the participants. It was also noted that due to the lack of comfort with this medication, the ED nurses focused on this one task at the expense of other potential learning opportunities. The discussion then became centered on the expectations of the students in relation to their motivation to learn as well as the preparation necessary prior to attending the HFPS experience.

Despite all faculty members acknowledging the ED nurses as adult learners, this did not always lead to common understanding about what this means. Brown and Rodney (1997) argue that adult learners are more likely to become "engaged when they are involved in creating their educational experience" (p. 143). An engaged student in HFPS will then tap into his/her own capacities as a learner to experience simulation more like a real experience rather than responding by simply jumping through the necessary hoops laid out by the educators. This brought us to question then whether we hand the necessary materials to the students ahead of

time (such as a learning module related to Levophed) that are required for successfully completing the scenario, or is it feasible to redesign the scenario that better addresses the intent of preparing ED nurses for practice?

Mezirow (2000) suggests that the goal of adult learning is to help students to realize their full potential. Mezirow cautions educators that in addition to laying out the learning objectives as part of a course, adult learners also have very personal learning objectives. The ED nurses that will be engaging in these HFPS scenarios will vary in age, experience, and education and thus have different personal and professional learning goals. Also, adult learning theory and transformative learning theory support that if an ED nurse enters a HFPS that does not offer a challenge in some way, transformation/learning will not occur. The end result of this discussion was the creation of a list of assumptions to move forward with regarding each scenario.

Assumptions acknowledged for Scenario #1(assessment) include:

- Assume students are skilled at basic assessment techniques including vital signs (V/S) a focused abdominal assessment and a pain assessment.
- Knowledge of, but some may not have practice in, full ED admission assessment.
- Assume students have knowledge and experience giving oral and intravenous (IV) medications
- Assume students posses effective communication skills

Assumptions acknowledged for Scenario #2 (arrest) scenario include:

- Able to perform basic life support skills
- Knowledge of IV direct administration
- Knowledge related to defibrillation
- Knowledge related to basic 12 lead cardiogram interpretation

- Knowledge related to assessment and management of patients with acute coronary syndrome (ACS)
- Basic knowledge of pharmacology related to ACS
- Assume students posses affective communication skills

Considering the assumptions as the starting point, the goals of the scenarios were created to expand on the ED nurse's prior knowledge, offer opportunities to challenge their skills, and connect the theory related to the course with the experiential learning of the HFPS.

Overall Learning Goals

Following the review of each scenario, and considering the overall goals of the ACCN program, the faculty agreed that the primary focus of the scenarios (assessment and cardiac arrest) would remain as the salient learning points for ED nurses. Visualizing the overall goals of each scenario should reflect students needs, overall objectives of the course, as well as the underlying theoretical perspective (Jefferies, 2007). Transformative learning theory facilitates ED nurses to critically examine their practice, their beliefs, and the environment in which they work in order to empower them to transform their own learning and frame of reference for engaging with their patients. According to Parker and Myrick (2010), transformation occurs when students "confront the disorientating dilemma and critically appraise the previous frame of reference about the experience in question" (p. 328). The challenge with this perspective is that due to the diversity of learners, each may leave the experience having attained different outcomes specific to their own goals, needs, and past experience. This requires that the overall goals be broad enough to appreciate the diversity of learners and be open to the potential learning opportunities inherent in the scenario.

The overall learning goals for scenario #1 are: 1) Students will gain an appreciation for

the necessary skills and knowledge required to perform a comprehensive ED assessment; 2) Students will be able to identify and discuss the intrapersonal, interpersonal, and contextual factors that influence their patient care. Learning goals for scenario #2 include: 1) Students will identify and provide appropriate interventions to a patient in cardiac arrest; 2) Students will be able to identify and discuss the challenges associated with patient/family-centered care during a critical incident in the ED.

Reviewing the existing scenarios allowed the faculty to pause and reflect on the goals of using HFPS, and identify some of their assumptions related to the learner and the experience. This was not only a valuable step to move forward from, but also enlisted all faculty to engage in a new perspective regarding what it was we want students to be able to get out of learning through simulation. This reflective process aided in identifying areas that could be improved on in the existing scenarios, which then informed the redesign using transformative learning theory.

Redesigning the Simulation Scenarios using Transformative Learning Theory

Instead of creating a separate scenario to address issues of ethics in ED nursing, the goal of my project was to embed ethics into existing scenarios to better reflect the complexity of ED nursing. In taking existing HFPS scenarios and embedding ethics into them, ED nurses are invited to identify and respond to the ethics encountered in everyday practice through a simulated event in order to better prepare them for how they can provide safe, competent, compassionate and ethical care in the complex environment of the ED. Brown and Hartrick-Doane (2007) argue that "knowing *what* is often separated from knowing *how*…(which can) lead to objectification and depersonalization of nursing practice" (p. 101), making HFPS a great means to connect theory to practice. Benner (1996) also argues that ethical judgment can only be developed through "experience…by imitating others, questioning skills, habits and practice"

(p. 260). HFPS offers ED nurses the opportunity to experience a challenging and ethically complex situation. During HFPS, the ED nurse can be encouraged to question his or her practice, learn from others, and openly talk about the issues encountered in practice. Transformative learning theory not only allowed me to reconstruct my own narrative in relation to the possibilities that HFPS offers in relation to educating ED nurses, but also lead me to consider that what is often missing in HFPS design is the voice of the patient who was the center of the simulated experience.

I will review the steps I took in redesigning the two simulation scenarios using the perspective of transformative learning theory. I will discuss why I thought it was necessary to first consider the patient in each scenario and his/her story that brought them to the ED. It was from this narrative that I was able to identify a variety of potential learning opportunities that informed how to proceed with the redesign. I will then discuss how I planned out the redesign considering both instrumental and communicative learning. It is in the communicative learning that I will focus on a) how I created disorientating dilemmas as a means to bring ethical issues into the scenarios, and b) the actions taken to help facilitate critical reflection through both an informal and formal debriefing process structured around the sim-TRACT framework (Gum, Greenhill, & Dix, 2011). I will conclude with additional considerations that went into the redesign.

Creating the Narratives

My biggest concern in redesigning the HFPS scenarios was falling back into the trap of letting the technical skills and competencies define the scenario. Many times a HFPS is designed with the tasks in mind; the objectives of the scenario are to get the nurses to practice a particular psychomotor skill and the patient is then created around this task. As a group, the ACCN faculty

identified the general focus of each scenario (assessment and cardiac arrest) to be important in preparing the ED nurses for practice. However, how to go about bringing these concerns to life in HFPS needed to be about more than the skills through which they are defined.

HFPS is valued for its ability to replicate real life situations and allow the students to explore options, test limits of their abilities, and make mistakes without harming patients in the process. To make the HFPS scenarios mimic real life there needed to be a patient that the ED nurse could identify with, who had a story, a family, and their own values otherwise there was risk of focusing on skills alone at the expense of the relational and contextual aspects of nursing (McGovern et al., 2012). Without a story for the nurse to relate to, the ED nurse would be more inclined to view the patient in HFPS as merely a prop upon whom the nurse was expected to perform certain skills. This dehumanization of the patient is not something anyone wishes ED nurses to carry into their practice. Even if during the scenario all aspects of this patient's story never become exposed, having a patient narrative as a foundation can help the simulation team respond in the moment to learner's actions that reflect the personality and values of a real patient rather than one that is a scripted case example.

Similar themes regarding the power of narratives and using real life experience arise in the literature about how to better facilitate ethics education in nursing (Brown & Hartrick-Doane, 2007; Brown & Rodney, 2007; Corley, 2002; Wolf & Zuzela, 2006). Nurses can take away important knowledge from patients' stories that can provide nurses with the language and self-awareness to discuss their concerns and dilemmas that appropriately reflect the underlying ethical tensions that exist in everyday practice. It is through narratives that ED nurses can become more aware of the intrapersonal, interpersonal as well as contextual factors that influence their daily practice that ultimately influence the ED nurses' ability to carry out the

complex technical skills they are so eager to master. Narratives are also an excellent forum for transformational learning in that they can awaken emotion, facilitate nurses to identify their own bias and assumptions, unravel the complexity of the underlying factors, and gain an appreciation for the varying perspectives on the same issue (Brown& Rodney, 2007).

The two patients that I brought to life came out of my own experiences as an ED nurse, as well as stories other nurses had relayed to me over the years (See Appendix C &D). Neither Mary Horsethief or Steven Brown are based on one single patient but an accumulation of patient stories that I have experienced that I thought would work best with the overall goals of the two scenarios. It was from these patient's stories that I identified potential learning opportunities that the ED nurses might encounter while participating in the HFPS. These potential opportunities not only reflect the true nature of ED nursing in its multidimensionality and complexity, but I wanted to allow the ED nurses entering the simulation experience to be afforded the opportunity to make their own meaning out of the experience. Viewing the learning opportunities from a more myopic perspective risked not only indoctrinating the students, but also falling back to scripting the scenario to meet my needs as an educator instead of those of the ED nurses.

Identifying Potential Learning Opportunities

Potential learning opportunities identified in each patient's narrative include: psychomotor skills, challenges to the student's knowledge, as well as issues related to values, beliefs and ethics. Identifying the potential learning opportunities (Figure 1) inherent in each narrative allows the student more control over their experience and directs the learning to their own needs. Jefferies (2007) suggests that in designing HFPS scenarios the educators must identify objectives that reflect the outcomes of the simulation experience and specify "expected learner behaviors" (p. 27). Behavioralist traditions would suggest that objectives should be

observable and measurable, however, the objective of any transformative learning experience is for the learner to "be struck by a new concept or way of thinking and then follow through to make a life change" (Brock, 2010, p.123). A new concept may be demonstration of a new skill, or integrating assessment findings with knowledge related to pathophysiology. A new way of thinking could be advocating for the needs of another, or critically reflecting on one's own bias and taking responsibility for how it impacts the care of the patient. Introducing the ED nurses to expand their perspectives on the interrelationships of the multitude of factors affecting their daily practice is one way to introduce a new way for ED nurses to interpret the challenges they face. Each ED nurse will come with different experience and learning needs and will be struck by different aspects of the scenarios, many times not those intending by the educators designing them. Appreciating the variety of opportunities for learning in each scenario ensured that each ED nurse could take away from the experience learning that was significant for them at that moment.

The learning opportunities created by designing the HFPS around a patient narrative allowed for the ability to offer challenges at various stages throughout the scenario instead of setting defined expectations, and thus better facilitating transformation. It was from these potential learning opportunities that I then moved forward in redesigning the two scenarios considering how best to attend to aspects of both instrumental and communicative learning.

(Figure 1)

Mary Horsethief- Assessment	*Steve Brown- Arrest*
• Presentation of abdominal pain along with patient history suggest pancreatitis (a serious condition requiring medical treatment and pain control) • Poorly healing leg wound and living conditions suggest high risk for antibiotic resistant organism and require contact isolation • Prior history of cocaine and alcohol abuse may bias some staff regarding this patient's need for analgesics • Patient's recent history of choosing not to seek medical attention for her pain may lead nurse to think this is a less serious issue • Addictions, as well as homelessness, puts the patient in a position of powerlessness that may place her at risk for having symptoms minimized or devalued • Dealing with bias being imposed by others when they challenge the care a nurse in providing care	• Skill and knowledge related to caring for a patient in the ED with chest pain. Assessment, interventions and ECG interpretation. • Skills related to BLS • Skills and knowledge related to ALS and defibrillation • Family presence in the resuscitation room- beliefs, challenges, experience? • Potential conflicting values of nurse and wife if nurse thinks patient should leave • Conflicting priorities: Needing to attend to the critical patient needs but also needing to care for the wife. How do one's own personal values influence if a nurse supports the wife to stay? Are nurses of being judged by the family if they stay? • Strategies for caring for family at the bedside with limited resources • Potential conflict with values/ beliefs of physician who thinks family should not be in the resuscitation room. Who should have the power to make this decision?

Instrumental Learning Objectives

This task-orientated focus on learning reflects the psychomotor and cognitive skills required to prepare nurses for practice in the ED. Instrumental learning is already the primary focus of most HFPS; the ability to replicate real practice situations allows students to experience and experiment with new skills that will benefit them in practice later on. There are expectations related to ensuring competent practice when preparing nurses for practice in the ED and aspects of instrumental learning cannot be overlooked. In redesigning the scenarios, however, I

reconsidered the task-orientated objectives of the scenarios through the lens of transformative learning theory and considered each scenario in relation to the overall goals keeping in mind the concerns related to making the scenarios too complex.

Jefferies (2007) cautions educators when designing HFPS to consider the complexity of problems students are asked to solve. Too easy and students will not be challenged, too complex and the students may become overloaded and lose self-confidence in their abilities (Jefferies, 2007). I considered this issue of complexity in relation to the demands of the tasks and skills being asked of the students, since if they were too complex and beyond their comfort level, the students could be so focused on the tasks, they might forget to attend to the patient. The two scenarios I redesigned are very different (See Appendix J &K). The instrumental learning for scenario #1 continued around the ED assessment, but in ensuring the scenario did not get too complex, I thought it fair to add greater complexity and a multidimensional aspect to the ethical dilemmas. The second scenario demands a more advanced skill set and also has an added stress component of managing a cardiac arrest. In this scenario, I chose to make the ethical dilemma less complex and maybe even more obvious.

Scenario #1: In the redesigned scenario, I wanted to ensure there were multiple areas for learning to occur and accommodate the various levels of experience that the ED nurses attending the simulation will bring. It was also important for the HFPS scenarios to reflect the uncertainty and complexity of assessing an ED patient when you have little to no information on past medical history and undetermined diagnosis. Using the narrative I created around Mary Horsethief, I identified the key aspects of getting the ED nurse to perform an initial assessment was less about following the A-I pneumonic and more about thoroughness. Moving the ED nurse beyond just following a script to assess the ED patient I want them to pose questions based

on findings, and encourage the ED nurse to use not only critical thinking skills but also clinical imagination. Encouraging and supporting clinical imagination allows the ED nurse to "conjure up possibilities" and "grasp the patients needs as they change over time" (Benner, Sutphen, Leonard, & Day, 2010, p.85-86).

The redesigned scenario begins with a patient, Mary Horsethief, just arriving to the ED with complaints of abdominal pain. The patient now presents with a chief complaint instead of a diagnosis and is unclear regarding her medical history, reflecting the uncertain nature of ED practice. The ED nurses are then required to recall their experience and knowledge related to her concerns to determine potential issues that should then guide their assessment. Patient history and assessment will strongly suggest the risk that this patient is experiencing acute pancreatitis. The ED nurses will need to rely on their knowledge of pathophysiology and assessment to determine this potential, but also to determine the severity of this patient's presentation. Determining the severity of this patient's condition should inform the ED nurse regarding the need for interventions including analgesics but also affects the communication to other care providers within the ED.

An added component to this scenario is to also look beyond the obvious concerns that could be in place with this patient. Infection prevention and control is of critical importance throughout healthcare, but especially so in the ED. Patients arrive with unknown conditions, and often-undisclosed histories. Potential for ED nurses to be exposed to, or be participants in exposing other patients to potentially harmful agents is a real concern. Vigilance in identifying those at risk and protecting themselves and others is a significant aspect of ED nursing and I believed it was a required addition to the revised HFPS scenarios. I chose to add to Mary Horsethief's story a history of drug resistant bacteria to challenge ED nurses on how to identify

this population, and stress the importance of initiating infection control precautions on patients in the ED. Isolation precautions may be something that as nurses on a medical/ surgical unit they have experience with but maybe not from the perspective of having to initiate precautions based on their own assessment.

The ED nurses will be expected to assess for physical findings beyond just the patient's complaint related to abdominal pain, but also probe further through questioning the patient regarding aspects of her overall health. The instrumental learning objectives of the revised scenario include:

- Conduct and document a thorough admission assessment.
- Distinguish salient points related to presenting symptoms indicating level of acuity and are able to justify interventions.
- Determine appropriate isolation precautions based on identified assessment and history.

Scenario #2: In the redesigned scenario, I wanted to keep the key instrumental learning related to ACLS management and allow the ED nurses to practice their skills in rhythm interpretation, ACLS drug administration, and defibrillation. However, each arrest an ED nurse encounters has a story, each patient has a family, and there are often emotions that come from these critical events that have been overlooked. I will address much of this communicative learning later, however, the story about what lead up to this patient's arrest was essential instrumental learning for nurses working in the ED to be able to identify those at risk.

I chose to begin this scenario with Steve Brown who has arrived to the ED with complaints of chest pain. Instrumental learning that I have added is related to caring for a patient in the ED with chest pain, 12 lead ECG interpretation, along with the advanced cardiac life

support from the original scenario. The instrumental learning objectives for the revised scenario include:

- Thorough assessment in relation to an ACS
- Recognize patient acuity and prioritize interventions appropriately
- Demonstrate knowledge and skill in both basic and advanced cardiac life support
- Apply strategies for consultation and collaboration with team members

It cannot be denied that in both of these scenarios that communicating with the patient is an essential part of any nurse- patient relationship, and being able to effectively communicate with the patient and family is necessary for ED nurses. However, according to Mezirow (2000) communicative learning is about more than just the words we use to communicate and requires ED nurses to appreciate the "meanings behind the words, the truth, the appropriateness… and the authenticity of expressions of feeling" (p. 9).

Communicative Learning

Communicative learning involves feelings, intentions, values, and moral issues (Mezirow, 2000). Banks and Gallagher (2009) argue that essential for the profession of nursing is that "ability to view another perspective, tolerate ambiguity, recognize multiple and often contradictory meanings of events and develop a moral imagination" (p. 93). Moral imagination means to be aware of the moral complexity of nursing practice meaning the intrapersonal, interpersonal, and contextual factors that influence ED nurses in their daily practice (Benner, 2010; Doane &Varcoe, 2007; Nash, 2002). Nurse educators are in a unique position to be able to help ED nurses to consider the ambiguity and complexity of everyday decisions and allow space for moral imagination to develop by facilitating ED nurses insight and reflection on their own values, beliefs, and emotions as it relates to everyday practice. It is here that the ED nurse can be

awakened to the ethical complexity of the ED and open up their moral perception rather than just focusing on what is right and wrong. To create an environment that allowed space for moral imagination to be part of the highly technical HFPS, I made use of the two key aspects identified by Mezirow that facilitates transformation: disorientating dilemmas and critical reflection.

Creating Disorientating Dilemmas. Transformative learning is most often triggered by a "disorientating dilemma", or some challenging situation in practice that makes the person feel uncomfortable, anxious, or dissatisfied about the outcome (Mezirow, 1991). A disorientating dilemma for a nurse new to the ED may be the skill of starting an IV on a critical patient with other people watching, knowledge that the IV is required quickly, and a patient condition that is less than ideal for the ease of venous access. This will make the new ED nurse feel uncomfortable and he/she may even seek out help from others, take extra opportunities to learn the new skill in order to perform differently next time. However, a dilemma often encountered in ED practice is feeling stretched for time to attend to everything one needs to do, and would like to be able to do for the patient leaving the ED nurse to feel the quality of his/her care is being compromised. A dilemma may be following family wishes to provide aggressive treatment to a 102-year-old patient who the nurse believes should be allowed to die in peace. Dilemmas are experienced everyday by the ED nurse at triage who has to manage a department that is over capacity and makes decisions about who gets a bed and who has to wait in the waiting room.

Doane and Varcoe (2007) argue that there is a tendency to interpret suffering and challenges in nursing as something "negative… to be avoided" (p.201). Hence, the true reality of practice as an ED nurse is being overlooked and sugar coated. I view the true essence of ED nursing coming from having the courage to engage the abyss in order to better understand it

which is better than leaving it in the "shadows, unarticulated and unutterable" (Mitchell and Bunkers (2003) p. 122). Intentionally incorporating disorientating dilemmas related to ethics into HFPS scenarios can not only bring these issues to light, but facilitate ED nurse's understanding of their own values or prior experience. The ability also to question the priorities in the ED, and expose the realities of power inequities in practice begins the ED nurse's process of transformative learning. I wanted to push the boundaries of the ED nurse's comfort in order to create disorientating dilemmas because without a significant challenge the process of transformation will not occur (Mezirow, 1991).

Creating disorientating dilemmas in relation to communicative learning was one of the most interesting yet challenging aspects of the planning for my scenarios. Again it was through the narratives created for each patient that I was able to identify potential challenges that could be brought out during the HFPS and create the objectives of the scenarios. I needed to be cautious that my own bias did not dominate the learning, or inappropriately perpetuate stereotypes. Parker and Myrick (2010) warn educators to consider their intent when planning HFPS and caution about blindly encouraging socialization of learners to "culturally influenced norms and instructor-centric knowledge" (p. 329). Beagan and Ellis (2007) suggest that there is a risk to "normalize and reinforce compromising values" (p. 51). The concern is that instead of reflecting on the ethical issues and committing to finding a resolution during the HFPS experience, blame may be projected towards another person, unit norms and bias may not be challenged, and intense emotion may be evoked without ever identifying the issue as one of ethics. To help mitigate this potential, I invoked the assistance of fellow instructors to read the narratives of each patient and come up with other ideas for potential communicative learning points. I also reviewed literature related to the topics of family presence, cultural bias in the ED,

and issues related to analgesic administration to patient with a history of drug addiction. Through this exploration, I was able to broaden my own perspective and offer the ED nurses participating in the simulation an experience based not just on my own practice but informed by others as well.

Scenario #1: The disorientating dilemmas for scenario #1 (Mary Horsethief) occur at multiple levels depending on the individual learner. The disorientating dilemmas in this scenario could potentially address intrapersonal, interpersonal, as well as contextual factors the ED nurse could encounter in practice. The overall objectives are:

- Consider the influence of bias and barriers that could influence care of a patient.
- Collaborate and communicate effectively with team members to provide care.

In the redesign of the scenario, I began the story with the ED nurse receiving report from paramedics. The paramedics down play the nature of the patient's symptoms and appear angry that they have brought the patient in for treatment for this concern already this week and she chose to leave without being seen. Bias the ED nurses may experience could be their own in relation to the patient or the patient's lifestyle, however bias can also be imposed by the paramedics and new ED nurses are challenged to make their own assessment or have it influenced by another they see as more knowledgeable.

The second dilemma the ED nurse is confronted with is in relation to providing analgesics to this patient. During the scenario an actor in the role of a senior nurse enters the room to question the ED nurse on the decision to provide analgesics for the patient's abdominal pain. The paramedics set the stage by denying the patient analgesics on route to the hospital but also imply that the patient may be 'drug seeking'. The senior nurse in the scenario is also biased to not give analgesics to this patient due to her history of drug abuse and recent admission for an

overdose. Again, the challenge for the ED nurse is whether this senior nurse's bias will influence his/her actions during the scenario.

Scenario #2: In the second scenario, the patient (Steven Brown) goes into cardiac arrest, and I believed it was important to bring family into the scenario. ED nurses must be aware that in their practice families are an integral part of their interpersonal relationships along with learning to collaborate with team members during a crisis. It was also interesting to see how the contextual issues related to a crisis event may affect the ED nurse's intrapersonal perspective as ED nurses are often challenged by the policy regarding family at the bedside and the complexity of implementing this policy when staffing resources are limited. The objectives of the arrest scenario include:

- Explore and apply strategies for consultation and collaboration with team members
- Critically reflect on attitudes and challenges related to caring for family members during critical incidents
- Review outcomes and identify strategies for improvement.

In the redesign I chose to have the patient's wife in the room right from the beginning. Initially she is very helpful in providing health related information during the ED nurses assessment and I assumed that the ED nurses would accept her presence at the bedside. However, once the patient goes into arrest, the dilemma the ED nurses need to manage is whether the wife should stay in the room. How should the wife be cared for as she witnesses her husband's arrest? I did assume that there would be ED nurses that would be quite comfortable allowing the wife to stay in the room and hence not experience this as an ethical dilemma. In order to add a second layer of complexity into the scenario, once the ED physician arrives, he/ she will ask the ED nurse to escort the wife out into the hallway. The ED nurse will again be

confronted by ethical choices: does he/she advocate for the wife to stay, or does he/she allow the physician to hold the power to decide?

I created dilemmas that would stimulate the ED nurses to pause and question their practice. Although principles of justice, autonomy and beneficence could be examined in either case it is through the process of critical reflection that the complexity of ED practice in relation to intrapersonal, interpersonal, and contextual factors are brought to light to facilitate the ED nurses transformation in regards to ethics in the ED.

Facilitating critical reflection. Mezirow (1991) argues that the trigger for transformative learning is a disorientating dilemma that can be a crisis, anxiety, or an event that challenges one's values or beliefs. Disorientating dilemmas occur at multiple points during a simulation and learners may be more or less challenged by aspects of the scenario based on their previous experience. Critical self-reflection involves students reflecting on their assumptions and beliefs in relation to the dilemmas and uncovering the multiple factors that may be influencing their beliefs or actions. It is through this process that the ED nurse will find the freedom to develop new perspectives, and the gain competence and self-confidence to act on new perspectives and thus become transformed (Brock, 2010; Hartrick, 1999; Mezirow, 1991).

One of the challenges in planning for critical reflection was that each simulation suite could only accommodate three students at a time. Often there are more than three in the clinical group so I was challenged with how best to meet the needs of the entire group when some of the ED nurses may be observing from the conference room. I created a plan to have those ED nurses observing to be actively involved in critical reflection during the scenario and then bring the two groups together after to formally debrief the scenario using the debriefing framework of sim-TRACT (Gum, Greenhill, and Dix, 2011) to guide the critical reflective process.

Observers. Ideally, all ED nurses would have the opportunity to run through the HFSP however, due to time and financial constraints, this is not always possible. Instead, I chose to have the ED nurses not participating in the scenario to be in an observation room with a facilitator. The facilitator posed questions to the group and encouraged them to critique the performance of their colleagues during the scenario. The observers were asked to watch for specifics regarding competency related tasks during the scenario, as well as communication, and challenges their colleagues' may encounter during the HFPS. The facilitator in the room posed questions through the scenario to stimulate the observers to consider alternatives as well as made attempts to illicit the observers to acknowledge their own values related to the scenario.

Following the scenario, both the observers and participants were brought together for a formal debriefing, but the observers were given a specific task. The observers were supported to provide constructive feedback to their peers in the hopes of stimulating critical reflection. Parker and Myrick (2010) argue that social discourse is required for transformative learning to occur, meaning that ED nurses must be encouraged and supported to engage in discourse around issues that they witness. One of the issues around ethics in everyday nursing practice is the inability of nurses to communicate their concerns, or use the language of ethics to express the challenges of practice (Coverston & Rogers, 1999). Providing support to students observing the scenario to engage in a critical dialogue with their peers about what they witnessed is a way to not only to actively engage the observers but supports developing strategies for how they may confront a colleague regarding an ethical issue in practice. It is through the debriefing phase that the facilitators guide the ED nurses to reflect on the simulation experience and foster the creation of new perspectives that can guide their future actions (Gum et al., 2007).

Debriefing. Debriefing is viewed as the single most significant aspect of simulation (Fanning & Gaba, 2007; Gum, Greenhill & Dix, 2011; Jefferies, 2007). My intent in this section is not to discuss skills of an effective debriefer but more about the choices made in designing an affective debriefing that facilitates critical reflection and supports the process of transformative learning.

Debriefing is a process that promotes interactive engagement among learners to critically reflect upon their actions, decisions, communication, and ability to deal with the unexpected (Gum et al., 2011; Jefferies, 2007). Debriefing is the ideal space for students to discuss scenarios and together explore options and begin to set up a plan for a new course of action. Gum, Greenhill and Dix (2011) conclude that good debriefing assists educators to "promote a space for transformative learning to occur" (p. 37). In order to facilitate transformational learning in relation to ethics in ED nursing it was necessary to set up a plan for the debriefing phase to prevent the focus of the discussion being on psychomotor skills alone. Gum, Greenhill and Dix (2011) created a conceptual framework for simulation debriefing (sim-TRACT) that designs debriefing session around reaction, analysis, consolidation, and transforming practice. I created outlines for the debriefing of each scenario to assist the facilitator to make use of this framework and ensure both instrumental learning as well as communicative learning were addressed (See Appendix G & H).

Reaction. The debriefing began by allowing the learners to openly discuss the experience and any initial reaction on the impact the experience may have had on them (Gum et al., 2011). This initial phase is important in creating an environment where the learners believe they are in a safe and supportive environment and should be free to vent about any concerns or challenges. The purpose of allowing open discussion will make learners feel safe enough to engage in

rigorous reflection later (Rudolph, Simon, Dufresne, & Raemer, 2007). Mezirow (2000) encourages examination of feelings as essential to understanding the meaning behind experiences. Debriefing, therefore, must occur in a safe place where learners can feel free to express their views without being ridiculed or judged for mistakes. To ensure this for the student, no person other than the two facilitators and the ED students are allowed to participate in debriefing.

In my experience, it is this reaction to a challenge in ED nursing that is often the topic of discussion in coffee rooms and nursing lounges. The opportunity to release emotions, vent frustrations, or even anger are all expected feelings. The role of the facilitator during the reaction phase was that of a co-learner who guides the dialogue rather than directs the outcomes but is also responsible to ensure the overall goals of the HFPS are not overlooked (Fanning & Gabe, 2007). Although it is necessary to allow the emotions of the event to be expressed, it is important to not have them dominate the debriefing. The goal of debriefing though is to acknowledge these emotions and yet move forward into analyzing what lays behind them.

Analysis. In the second phase of the debriefing process it was important for facilitators to guide learners to deconstruct aspects of the scenario to both explore and interpret the experience (Gum et al., 2011). The analysis was directed around the objectives of the scenario but also must leave room for students to explore how to create their own meaning out of aspects of their scenario. Mezirow (1991) argues that to begin to learn, students must explore and try to make meaning out of an experience through critically reflecting on not just what occurred but what factors influenced choices during the HFPS scenario.

Each person enters any learning with an underlying frame of reference that is an accumulation of assumptions, beliefs, and past experiences as well as socially constructed

paradigms of perceptions (Mezirow, 2000). Through nursing education and practice, ED nurses will be exposed to a variety of interpersonal and contextual factors that influence their perspectives of the profession of nursing as well as the choices made in the delivery of care. Unit culture, norms, and values become part of nurses' frames of reference and are molded by the areas of practice, nursing units, or even their immediate working groups creating 'habits of mind" (Mezirow, 2000). These habits of mind are how nurses view and interpret their work and their interaction with patients. These "habits of mind" can also be situations that minimize nursing or personal values in place of medical or organizational expectations or ethics as they are imposed on nurses or have become the dominant narrative of healthcare. This dominant narrative can also be challenged throughout a nurse's career as techniques, skills, and knowledge expand and new ways of doing things continually develop. It will be these assumptions and beliefs, along with cognitive knowledge and psychomotor skills, which guide the ED nurse's actions during the HFPS scenario.

To ensure that learners do not get overly focused on task analysis, the facilitator needs to guide the learners to consider aspects of the experience in relation to content, process, and premise (Mezirow, 1991). Content and process deal with aspects of instrumental learning that considers the factors that influenced a decision related to task-orientated problem solving and how ED nurses control and manipulate their environment. On the other hand, premise reflection requires learners to consider their intentions, feelings, values, and values that influenced their actions and relates to more of the ethical dimension of practice. During the premise reflection, the facilitator invited the ED nurses to consider if any ethical issues arose during the scenarios? For example, questioning the ethical dimension related to the refusal of pain medications to Mary Horsethief by the paramedics and the RN in scenario #1 stimulated discussion about

patients' rights, autonomy, and confidentiality. The facilitator then guided the discussion to analyze intrapersonal, interpersonal and contextual influences on the ED nurses beliefs and choices during the HFPS that guided their actions at the time. It is after allowing the ED nurses to react to the experience, and be facilitated to analyze the meanings behind what they experienced, that the facilitator began helping put the pieces together with consolidation.

Consolidation. The analysis of the HFPS experience in relation to content, process and premise allowed the ED nurses to broaden their perspective of the situation, see things from alternate view points and begin exploring options for new roles, relationships, and action and thus be engaged in the process of transformation (Mezirow, 2000). The next step in the transformative process is planning a course of action based on one's transformed perspective that is the focus of consolidation. Consolidation requires learners to think beyond the boundaries of their own experience in order to visualize and explore new options for relationships and action (Gum et al., 2011). In the example of the ethical dimension of refusing narcotics to Mary Horsethief, the ED nurses were able to identify that there is an ethical component to the bias around refusing treatment and reflected on the multiple factors that influenced the actions during the scenario. Consolidation is about gathering this new perspective to guide their choices and actions in future patient interactions. This process can be very difficult to accomplish independently and requires multiple perspectives making the dialectic of the debriefing session so essential to transformative learning.

Brookfield (2012) argues that critical thinking, and thus transformation, is seen in those "unsettling moments that students remember vividly and respond to strongly" (p. 71). Despite planning disorientating dilemmas within the scenarios, I also wanted to connect the simulated experience to real life practice and create moments that the students would remember. In the

ED, the nurse may be exposed to a challenging situation but does not have the luxury of walking away. It is expected that they continue to care for the patient, work alongside a colleague. Also, transformative learning and ethics is about exploring and understanding the views of others. In order to get the ED nurses to truly consolidate the HFPS experience to what it may mean for them in practice, I wanted to expand the disorientating dilemma into the debriefing session.

Once the facilitator believed the debriefing session had allowed sufficient time for the ED nurses to express their reactions to the scenario and analyze the multiple factors at play, I chose to bring the 'wife' and 'physician' into the discussion to offer their perspectives. Faculty, or staff from the simulation center played these roles and were familiar with common concerns related to why physicians might feel uncomfortable about having family witness a critical event. Also, while planning for the scenario, I reviewed the literature about barriers and challenges to family presence. I presented these findings to faculty as a means to also prepare them for their role. McAllister (2011) argues that it is the "very rub of difference that makes life possible" (p. 112). It is the dialogue among peers, and the opportunity to hear the views of others during the debriefing, that when brought together can inspire learners to transform their understanding but also empower them to act. This additional dilemma served to demonstrate to the ED nurses that their actions in practice linger on in others and do not just stop the moment they walk away and further highlights the influence of interpersonal factors on ethics in ED nursing. It is this process of reacting, analyzing, and consolidating, that if made part of ED nurses' practice, could facilitate transformation.

Transforming practice. The final phase suggested in the sim-TRACT framework is the culmination of the critical reflective process where learners are encouraged to try on new roles and test new perspectives (Gum et al., 2011). All debriefing sessions concluded with a

discussion related to what each ED nurse could take away from this experience with the intent of having the ED nurses visualize how they may move forward in not only understanding but responding to ethics in their everyday practice. It is suggested by Gum et al. (2011) that transformation is observed following HFPS by offering students an opportunity to 'redo' the simulation scenario immediately following allowing them the opportunity to act based on their new perspectives. This again, needs to be considered in relation to feasibility to run scenarios back to back. Since this was not possible in this project, I chose instead to make the process of reaction, analysis, and consolidation an explicit aspect of their upcoming clinical placement.

ED nurses and their instructors were directed to continue the dialogue around challenges related to ethics in practice throughout the remainder of their clinical rotation. The identification, critical reflection and discussion of challenging events, or dilemmas that occur during their clinical placement are explicitly addressed as a means to continue the transformative process. Journaling as well as open discussion with instructors, preceptors, and fellow staff members was encouraged, and by introducing ethics to the current simulation scenarios, I hoped not only to bring attention to daily ethical issues but also begin the process of transforming the ED nurse's perspectives on action they can take to address ethics in practice and appreciate the complexity of ED practice beyond just the skills.

Transformative learning is not without it challenges as students will enter into the learning situations at different stages as well as with differing levels of motivation to change. It is also difficult to measure transformation due to differing levels of experience and values of the students. Transformation can either occur as a sudden dramatic reorientation or more likely be incremental that involves a series of events that cumulate over time which also makes it a challenge for educators to feel confident in determining if they have truly inspired change,

making the evaluation of transformative learning a difficult task (Mezirow, 1991).

The ED nurses were asked to evaluate the HFPS immediately following the experience but this really only addresses their immediate reaction and expectations. Encouraging the process of examining and interpretation of their experiences as ED nurses during clinical will allow them the opportunity to try out new roles and actions. It will also offer the ED nurses the opportunity to begin building confidence in not succumbing to the challenges of ED nursing but use these ethical challenges as a means to inform their practice. My overall hope, was that engaging in the process of confronting dilemmas and critically appraising how they impact ED nurses' views about their ethical practice would become another skill that the nurses use in everyday practice.

Additional Considerations

One of the biggest barriers to using simulation, beyond just the cost and technical needs to run simulation, are the time and resources it takes to develop new scenarios and the access to the simulation lab to run all scenarios requested by various instructors (Jefferies, 2007). Thorough planning is required to ensure all aspects of designing a HFPS scenario have been considered to ensure the learning environment is suited to the underlying intent as well as time and resources are being affectively used. I made use of aspects of Jefferies (2007) Nursing Education Simulation Framework (See Appendix B) as a tool to aid in planning out how best to redesign the two HFPS scenarios for the ACCN program. Two additional considerations that were necessary for the success of this project included issues around faculty and student support.

Faculty support. Jefferies (2007) views educators to be essential to the success of the simulation experience. I did consider the challenge of introducing transformative learning to the faculty group as the theoretical perspective underlying the redesigned scenarios. Cranton and

King (2003) argue that educators should make transformative learning part of their own practice by engaging in the same process being asked of the students, for example, identifying one's own underlying assumptions in regard to what it means to be an educator, critically reflecting on teaching, and engaging in strategies for professional development. Although the expectation of faculty to examine and critique their own practice may not only be an added burden to an already overloaded curriculum, but it may also not be a process others may be willing to participate in.

To alleviate some of the concerns regarding this added burden, I worked with fellow faculty in the ACCN program throughout the planning for this project and did not just introduce the redesigned scenarios that were now to be implemented. Discussion began around the scenarios to address concerns they have regarding the cases being presented, experience with similar cases or situations, and strategies on how to facilitate the learning for students in this simulated environment. Incorporating ethics into the HFPS scenarios was a welcome addition with the biggest concern from facility being related to how to best facilitate critical reflection during the debriefing to ensure both instrumental and communicative learning objectives were addressed. Fortunately, the ACCN program has a small faculty group and they have chosen to co-facilitate all debriefing sessions in order to support each other as we gain comfort and confidence with the new scenarios. I also initiated a peer-evaluation process within the simulation learning center that facilitates all faculty to access recordings of debriefing sessions that they have facilitated and work with a peer to review each simulation session in order to reflect on their role as a facilitator and plan a course of action for improving their practice (Norrena, 2013).

Student support. Factors related to the students that require consideration in planning a HFPS include the learners' motivation to learn, experience, and anxieties related to the

simulation environment (Guimond, et al., 2011; Jefferies, 2007). Jefferies (2007) suggests that students must be self-directed and motivated in order to get the most out of their simulation experience. Mezirow (2000) argues that students must not only be open to new learning experiences but also be emotionally mature in order for transformative learning to occur (Mezirow, 2000). All the ED nurses in the ACCN program have chosen to enter into this advanced specialty training and I assume are motivated to learn. It is by way of a well designed HFPS experience that the ED nurses will be motivated to learn from the experience and by connecting the simulation to practice will further motivate the ED nurses to learn.

Clapper (2010) further cautions educators planning to use HFPS that fear can be a powerful deterrent to learning and any effort to mitigate but also identify underlying anxieties and fears of students should be done prior to any simulation experience. Mezirow (1991) also identifies that fear and anxiety is a barrier to transformative learning. It is also suggested that properly preparing students prior to simulated learning is an important step in alleviating anxiety (Harvard Center for Medical Simulation, 2012). Jefferies (2007) suggests that a pre-brief should be used to address operational issues related to roles and objectives. Designing the pre-brief to address the fears and needs of the learner and create a safe environment will also set ideal conditions for transformative learning to occur (Clapper, 2010).

In attempts to mitigate some anxiety for the ED nurses, I began by prepping the students prior to the HFPS experience through an orientation video. This video was created by the simulation learning center and introduces the students to the simulation lab, the idea behind HFPS, the mannequins and at least lets the ED nurses know some of what they can expect before they arrive. I also set time aside on the day of the scenario to orientate students to the mannequin, discuss the purpose of simulation and the objectives of the learning session, the role

of the facilitator, and the expectations of the ED nurses. The pre-brief is intended to "set the tone" of the learning experience that encourages students to feel safe and clarify course objectives, environment, roles, and expectations, establish a "fiction contract" with students, attend to logistical details, and convey a commitment to respecting learners and understanding their perspectives (Harvard Center for Medical Simulation, 2012). The student will quickly determine if this is a safe environment where they can be free to make mistakes. This pre-brief time is essential to ensuring the ED nurses will more fully engage in the critical reflection required for transformative learning.

Another consideration in regard to student support is the decision by the facilitators regarding the level of assistance given to students during the simulation (Jefferies, 2007). What this means is that if a student is struggling to perform a skill, or is not progressing through the scenario appropriately, will the facilitator enter the room during the scenario to offer advice, assistance or provide teaching? All learners in the ACCN program are registered nurses with practical experience either in the ED or other area of practice. Unless a student appears to be in significant distress, I chose to focus primarily on student-initiated support. During orientation, the students are made aware that, just as in practice, they can call for assistance or advice from their instructor or charge nurse as well as contact a physician for orders or to report concerns related to a patient. There was a phone in the room and all calls were directed to the control room and answered by the facilitator.

Another way to assist learners who may be struggling during a scenario is to have the 'patient' provide cues (Jefferies, 2007). The facilitator in the control room is able to direct the 'patient' to make comments related to his/her pain or even ask questions like "when is the doctor coming?" Also, during planning meetings prior to the simulation, any person assisting with the

operation of the HFPS was introduced to the 'patient' and made aware of the narrative that this scenario was built around. Discussion during the meeting addressed possible actions or comments that the ED nurses may make during the scenario and how individuals could respond. This allowed the individual 'actors' to also see when one of the ED nurses might be struggling, or missing vital cues and could interject appropriately for their character. One example in the second scenario is when the patient's 'wife' noticed that the ED nurses had not acknowledged the patients drop in blood pressure as they were intently focused on interpreting the 12 lead ECG. In order to assist in redirecting them away from a task the 'wife' gently asked, "Why is my husband's blood pressure so low?" Attention to the needs of both faculty and the students when planning a HFPS scenario is essential to it success. All the time an effort can be put into designing a great scenario, but if there is not buy in from the entire faculty, or the students are too afraid to speak up, the process of transformation cannot occur.

Despite the challenges of embedding ethics into HFPS scenarios, there is value in using transformative learning theory to guide the planning and design of HFPS for ED nurses. Parker and Myrick (2010) conclude that HFPS offers the "requisite opportunities (for learners to be) exposed to disorientating experiences during the scenarios and (have the opportunity for) critical reflection and social discourse in the debriefing phase" (p. 332). Through critical reflection, the educators can facilitate the reframing of ED nurses' perspectives and begin the process to build self-confidence and competence to speak to the daily challenges, and feel empowered to act in a way that is morally responsive rather than mindlessly reacting to the daily challenges faced by ED nurses.

Conclusion

Redesigning the HFPS scenarios allowed us to look beyond just increasing the complexity of the skills required during the scenarios and to also consider the art behind ED practice and how to live out one's moral responsibility in the complexity of the ED. Embedding ethics into these simulations not only provides a pedagogical space for teaching ethics, but also places ethics within the context of everyday practice instead of learning about ethics as somehow separate from practice. I believe that this project is an important step in rethinking how ED nurses are prepared for practice. The current state of the healthcare system, and its effects on ED nursing specifically, as well as the discourse around moral distress in nursing and its potential negative impact on the nurse, the patient, as well as the healthcare organization implies that ED nurses must finds ways to provide safe, competent, compassionate and ethical care in a complex moral environment. As an educator, I believe it is necessary to expose ED nurses to the realities of practice in relation to interpersonal, intrapersonal as well as contextual factors to not only better prepare them for practice but also get them to reconsider how they interpret and respond to the daily challenges they my face.

The theoretical perspective of transformative learning theory in conjunction with HFPS can be an effective strategy to move ED nursing education beyond just the skills. Brookfield (1998) reminds us that by encouraging and supporting these types of critical conversations can lead to "unraveling the shroud of silence" in which ED nursing practice is wrapped (p. 200). The ultimate intent of my project was to incorporate everyday ethical issues into ED nursing simulation scenarios for the purpose of not only preparing nurses for ED practice, but also opening the space for ethical discussions in daily practice and helping ED nurses understand that they no longer need to be silent about the things that matter.

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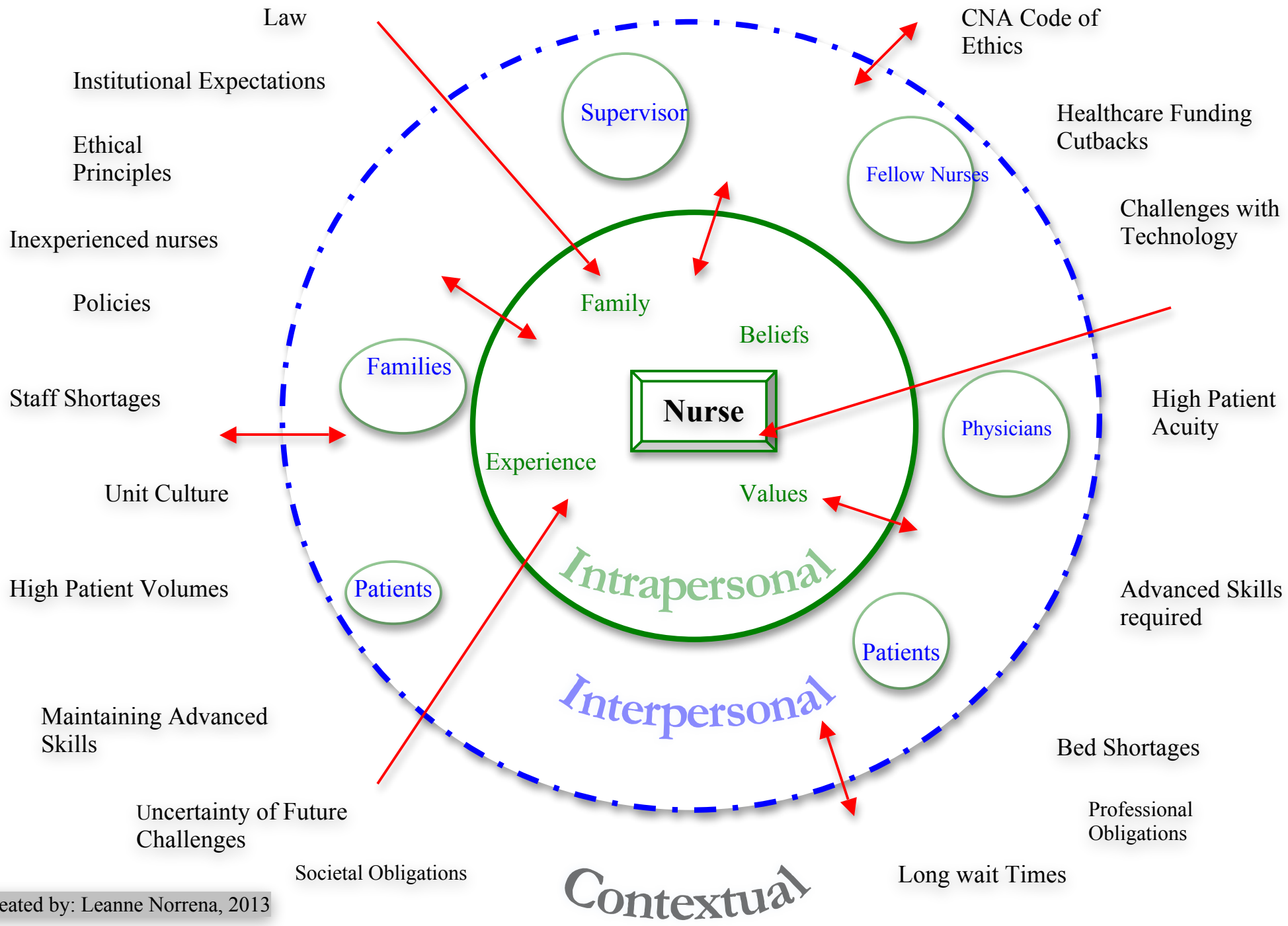
Appendix A:

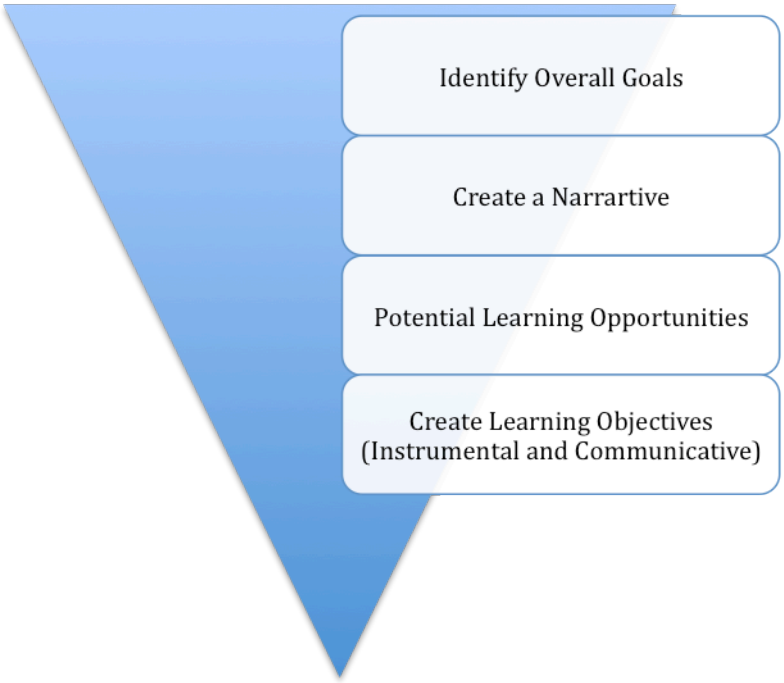
Competing Priorities/ ConflictingValues



Created by: Leanne Norrena, 2013

Appendix B

Process for Redesigning ACCN HFPS Scenarios



Appendix C

ACCN Assessment Scenario- Narrative

Patient background:
Mary Horsethief
Age 42
Aboriginal
Home: Live at drop-in center, originally from Manitoba.
Family: 2 sons, live in Manitoba
Common-law Brian Bone
Social History:
Began drinking at the age of 14 years and has tried many time to stop. She has a long history of abuse and was raised by her grandparents. Brian has been her strength to help get her to quit. She did go on a binge last week where she used Cocaine and drank but she is "all done with that now". Had her last drink 48 hrs ago.

Current History:
- epigastric pain started and goes through to back
- She has had this same pain a few times this week but when went to the ED the waits were too long she could not take it. She was in so much pain she just wanted to go back to the drop-in center to sleep.

Medical History:
- In hospital 6 months ago for alcohol withdrawal. Ended up having to stay due to some sores on her feet and she was told she would have to have antibiotics for a long time. She had to come to the hospital everyday for a needle but these sores are still there.
-Homecare comes to see her at DI to change her dressings.
- Last time in the hospital the doctor told her she had diabetes and is supposed to be on some pills but she thinks she has run out.

Allergies:
Gravol- makes her throw up
Sulpha- hives
Penicillin- hives

Presentation:
Unkempt female with a dirty dressing to leg. Mary has a pleasant demeanor and willingly answers questions and shares her life story with the nurses if asked. If treated with a negative attitude becomes more abrupt and guarded. Patient is in obvious discomfort.
EMS providing report appear frustrated with patient "have picked her up many time this week", their report appears to minimizes the patient concerns

Disorientating dilemma:

- Imposed bias of EMS related to minimizing patient symptoms. Challenges the ED nurse to trust her own assessment and knowledge to judge for herself how best to manage the

care of this patient. How does bias affect our judgments? Could there be a fear on the part of the nurse of not "fitting in" or appearing "too soft"?

- Senior nurse challenges new ED nurse about this patient's need for pain medication. Is aware of patient's recent cocaine abuse and believes she is 'faking' her symptoms

Potential learning points:

- Presentation of abdominal pain along with patient history suggest pancreatitis (a serious condition requiring medical treatment and pain control)
- Poorly healing leg wound and living conditions suggest high risk for antibiotic resistant organism and require contact isolation
- Prior history of cocaine and alcohol abuse may bias some staff regarding this patient's need for analgesics
- Patient's recent history of choosing not to seek medical attention for her pain may lead nurse to believe this is a less serious issue
- Addictions, as well as homelessness, puts the patient in a position of powerlessness that may place her at risk for having symptoms minimized or devalued
- How to overcome bias imposed by others to ensure providing the best care for your patient?

Appendix D

ACCN Arrest Scenario- Narrative

Patient:

Steve Brown
62 year old male
Caucasian

Social History:
Married for 36 years and has 2 sons who live in Calgary. Works at an oil and gas company. Is a social drinker but has a high stress job. Wife is concerned that he works too hard. Very active person who runs marathons and hikes frequently.
Current History:
Was on the treadmill at home when began to experience midsternal chest pain radiating to his left arm. Began about 2 hours ago as his wife had difficulty convincing him to come into the ED.

Medical History:
Has had similar episodes in the past but they have been relieved with rest. Has not spoken to his primary care provider about this yet but plans to on his next check-up.
Father did have an MI when he was 60 years old but patient believes that was due to his lack of exercise and poor diet.

Allergies:
Sulpha drugs
Shell fish

Presentation and progression:
Patient presents already having had his initial assessment in the ED by another nurse. His initial ECG was inconclusive but continues to have pain 5/10. His wife is concerned that he is not being truthful and concerned he is minimizing his symptoms. Patient is talkative and pleasant but does avoid discussing his pain.
Patient condition getting worse and unstable until he finally becomes unresponsive and goes into cardiac arrest. Wife is in the room the whole time and is witness to the arrest and does not want to leave her husband. Once MD arrives he requests that the nurse escort the wife out of the room. Note: wife is crying and upset, asking questions but is not hysterical or getting in the way. Will challenge the nurse about wanting to stay but when requested to by the MD she will willingly leave.

Expectations:
Nurses perform an assessment relevant for ischemic chest pain
Respond to deteriorating condition and call for help
Perform BLS on patient
Once crash cart arrives perform ACLS skills including defibrillation
Consider the needs of the wife during the critical event

Disorientating dilemma:

- Attending to the needs of a family member during a critical event
- Person in position of power challenges

Potential learning points:

- Skill and knowledge related to caring for a patient in the ED with chest pain. Assessment, interventions and ECG interpretation.
- Skills related to BLS
- Skills and knowledge related to ALS and defibrillation
- Family presence in the resuscitation room- beliefs, challenges, experience?
- Potential conflicting values of nurse and wife if nurse thinks the wife should leave the room
- Conflicting priorities when limited staff in the room how to you appropriately attend to the needs if the wife? Is it easier if you just have her leave?
- Strategies for caring for family at the bedside with limited resources
- Potential conflict with values/ beliefs of physician who feels family should not be in the resuscitation room. Who should have the power to make this decision?
- What is the nurse's role in advocating for the family when the decision of the MD conflicts with the values of the wife and nurse?

Appendix E

Assessment Scenario- Debriefing Outline

Reaction:

How do you think that went?
What was the experience like with the mannequin, was it difficult to engage with it like a real person?
Anything you would do differently? What aspects of the scenario do you think influenced your actions?

Analysis:

What were the key points about Mary's assessment that stood out?
What do you think is going on with Mary?
What is significant about pancreatitis?
How did it feel using NI protocols? Is this something you are comfortable with?
Anyone identify any ethical issues/ challenges in the scenario?
Can you justify why you did or did not...?
How do you see this case progressing?
How did you feel about the paramedics report? What bias did he bring?

IP&C:

What lead you to believe that contact precautions were necessary? How do you feel about making these types of decisions in the ED? What if this had been more contagious?
Any challenges in caring for a patient on isolation?

Consolidation:

What is the problem with inserting bias into your report? Do you think you inserted bias into your report to the staff nurse?
What did you think about the staff nurse's judgment that this patient should not have any narcotics? Do we have the right to refuse care to a patient? Is this ethical
Would things have been different if this was a well-dressed female patient who came from a white-collar background?
What are some of the challenges associated with caring for our homeless population in the ED? Do we make assumptions? Do they receive the same quality of care?
What are some strategies you can use to help advocate for your patients despite possible pressures challenging what you feel is right?

Appendix F
Arrest Scenario- Debriefing Outline

Reaction:

How do you think that went?
What was the experience like with the mannequin? Was it difficult to engage with it like a real person?
Anything you would do differently? What aspects of the scenario do you think influenced your actions?

Analysis:

Chest pain assessment:
Have you ever assessed a patient before with chest pain? What are the key things you are looking for?
What concerned you about the patient's ECG?
What are key issues that concerned you about his condition?

BLS and ALS experience:
Have you had experience doing CPR before? Did you find it stressful?
How comfortable are you with ACLS protocols?
What are nurses covered to do in a code situation without MD present? (Clarify if different from their home sites)

Team work:

How do you think you worked as a team?

Caring for the wife:

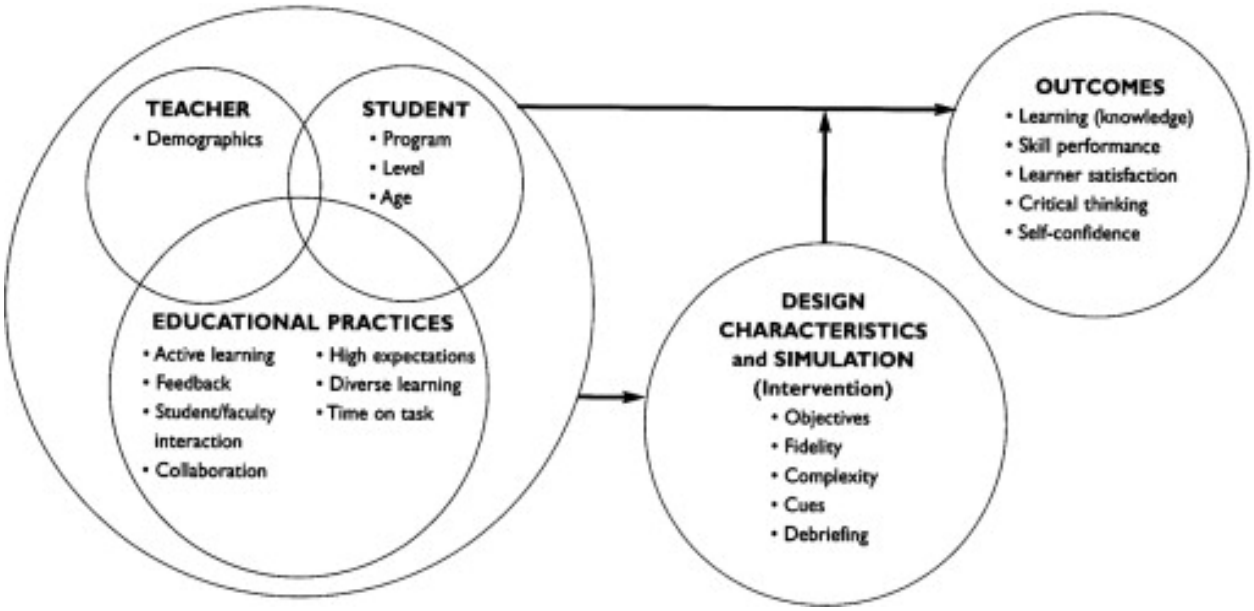
Have you every experienced having a family member in the room during a crisis?
What are the biggest challenges to caring for the family during a crisis?
Is it something that makes you uncomfortable, why or why not?
How did you feel when the doctor wanted to have the wife removed from the room?
What do you think some of the reasons would be?
Did you feel obligated to follow his request? Why?
Does the wife have the right to choose to stay in the room?

Consolidation:

Anything you would do differently another time?
What are some ways we can communicate well during a crisis situation?
Are there any challenges you foresee going in to do your clinical shifts in the ED now?
How can you best deal with this?
How could you advocate for a family member in the future? What might prevent you from doing so?
How would you react if it was your family member that was in the ED?
What reason do you think the ED physician had for asking the wife to leave? Were they justified?

Appendix G

Jefferies Nursing Education for Simulation Framework (2007)



Appendix H

Original Assessment Scenario Storyboard

Overall Goal
Recognize the difference between assessment of the critically ill patient versus a ward patient

Learning Objectives
1. Demonstrate a thorough and accurate head to toe assessment including safety checks (siderails, call bell, BVM at HOB, oxygen source, ID band/ allergy band
2. Recognize abnormalities in the assessment and identify the course of action, e.g. low BP
3. Communicate a concise, thorough report to a colleague using SBAR tool or assessment flowsheet

Scenario Introduction
Mr. Lopez is a 48 yr old Hispanic male. He felt unwell, flushed, nauseated, dizzy, and short of breath while out with friends last night, and became progressively worse with signs of sepsis. We received him via EMS at 0830- He is drowsy, orientated to person and year only, and obeys commands. Pupils are unequal. Motor power is moderate x 4 limbs. BP was low at 80/60, HR 98. He is in sinus rhythm with no ectopy noted. Levophed was initiated and titrated up to 0.1 mcg/kg/min. He weighs 90 kg. BP 5 mins ago was 92/62. Respirations are mildly labored at 18/min. SpO2 82% on 3L/NP- just changed to 100% non-rebreather mask, and I have not re-checked O2 sat. I had trouble distinguishing his breath sounds but the patient has bilateral air entry. IV is NS running at 250 mL/hour and the first dose of ceftriaxone was started; the other IVs are a NS runner and the levophed. I inserted a Foley catheter and it is draining clear, amber urine. They are querying sepsis, so blood and urine cultures were sent. 12 lead ECG was done and was normal. We are waiting on all labs. No family is present.

Phase 1
- Introduce selves to patient and do safety checks: siderails up, brakes on, BVM at HOB, suction, oxygen source and amount delivered correct for device used, ID/Allergy band.
- Check IV infusion and calculate correct rate.
- Assessment is systematic and thorough, and adapts to patients needs/limitations, ie. patients shortness of breath

Phase 2
- Recognize the need to titrate the levophed and increase the dose correctly - followed by an increase in BP if they do this
- Recognize the pupils are unequal, and respond by conducting further pertinent assessments, and reporting this finding to the primary nurse or physician

Scenario Conclusion
- Primary RN comes in to get report. Students give report using effective communication to RN assuming care of patient: concise, thorough, accurate

Appendix I

Original Arrest Scenario Storyboard

Overall Goal

- Have the students experience and respond to a critical event in the ED.

Learning Objectives

- Communicate accurately and thoroughly with team members; defined as delivering concise information and confirming that request has been heard, action delivered
- Demonstrate accurate sequencing of basic and advanced cardiac life support skills including CPR and manual ventilation, medication calculation and delivery; safe use of electrical therapy
- Accurately identify the cardiac rhythm displayed on the manual defibrillator and analyze potential causes referring to algorithms
- Critically assess medications ordered for appropriateness, dosage, and delivery methods

Scenario Introduction

While receiving report on Mr. Green, who is in the ED with complaints of chest pain, there is an overhead page for a Code Blue to room 2. Students are directed to the room just as the code cart arrives.

Phase 1

- Enter the room to find CPR in progress. Students are expected to assume roles of managing the airway, providing CPR and attaching the defibrillator. Ensure IV access and identify VFib on the monitor

Phase 2

- Code team leader arrives and receives report from student.
- Identifies VFIB on monitor and requests to Defibrillate at 200J
- Students expected to participate as part of the team ensuring safety, and high quality CPR at all times

Phase 3

- After 2 min of CPR- team leader will recheck rhythm and find patient in asystole.
- Students expected to resume CPR, and follow verbal orders to provide Epinephrine 1mg.

Phase 4

- After 2 min of CPR - team lead order to recheck rhythm will find patient in a Normal sinus rhythm on the monitor
- Students to check for pulse and obtain BP

Scenario Conclusion

Primary nurse enters and receives report from students and tells them she will assume care and they can leave.

Appendix J
Revised Assessment Scenario Storyboard

General Scenario Summary:

- Native female arrives by EMS to the ED c/o abdominal pain, nausea and vomiting. Patient is MRSA positive and has a long history of substance abuse problems but currently sober. EMS provides a report that minimizes patients current presentation senior staff nurse challenges students on need for narcotics.

Overall Goal:

- Primary goal is to have students perform a complete admission assessment on an ED patient. They should be able to identify priorities and initiate appropriate care based on patient presentation. The secondary goal is to have students reflect on the challenges around assumptions and bias in practice and how these can influence their practice.

Anticipated Learner Responses:

- Thorough assessment identifying key symptoms that require intervention using appropriate isolation precautions.
- Initiate appropriate ED protocols for treatment
- Consult and communicate appropriately regarding patients acuity
- Affective communication with patient during assessment and treatment

Scenario Introduction: 0200 patient called EMS for c/o abdominal pain, N+V since 2400h. EMS appear to be frustrated with patient as they have brought her in a few times this week with similar complaints and she has LWBS. Identify she has a long history of alcohol abuse and the last time they brought her in they were told she was MRSA positive.

Phase 1: Receive unkempt patient supine in bed, moaning and retching. Introduce self and identify patient and attach armband. Determine chief complaint, medications and allergies. Using appropriate isolation precautions complete A-I assessment and appropriate focused assessment on abdomen. Patient is abrupt with students in answering questions, c/o 10/10 epigastric pain radiating to back. BP 110/60 P110 RR 26 T 38.0. Abdomen tender on palpation, bluish discoloration around umbilicus. Has old wound to leg, dirty dressing.

Phase 2: Initiate appropriate ED treatment protocols. Start IV NS infusion, Order labs to be drawn. Identify patient's need for analgesic and/or antiemetic. Contact MD to consult re: Fentanyl protocol. Staff RN comes into challenge students on patients need for narcotics. Identifies that had patient last week as an OD and she was combative and needed to be restrained

Scenario Conclusion: Give report to nurse coming in to take report. Instructor comes in to take students to conference room.

Appendix K
Revised Arrest Scenario Storyboard

General Scenario Summary

- While assessing a patient in the ED with chest pain he arrests and students are expected to manage his care making use of both BLS and ACLS protocols. The additional complexity will be that the wife is sitting at the bedside.

Overall Goal

- Expose students to a critical incident that they could experience in the ED and enable them to reflect on their own assumptions and learning needs as they plan for how they may choose to act in similar situations in practice.

Anticipated Learner Responses

- Recognize STEMI on 12 lead ECG and contact MD
- Identify seriousness of patient condition
- Respond appropriately using BLS and ALS guidelines
- Use affective communication with team members including SBAR
- Advocate for wife's right to remain with patient

Scenario Introduction: Report given at bedside by ED nurse going for break. Patient just arrived by EMS to ED c/o chest pain. IV's have been started and labs drawn. ASA given on route by EMS. ECG tech just completed a 12 lead ECG but it has not been reviewed and sitting at the bedside. Wife is at the bedside with the patient.

Phase 1: Receive patient lying in bed attached to cardiac monitor and 2 IV's in place and O2 at 2L/NP. Wife is sitting at his bedside. Students should communicate the delegation of tasks and priority should be given to interpreting the 12 lead and reporting to MD (via phone) as well as doing an initial assessment.

Phase 2: V/S RR 24 HR 102 with PVC's BP 92/50 Plan for patient to go to the cath lab. Orders for Plavix 300mg and continue with Nitro.

Phase 3: Patient is still c/o chest pain. Patient has feelings of impeding doom. Cardiac monitor shows NSR with frequent multi-focal PVC's. BP 88/46 weak radial pulses. Wife is at patient side and expressing concern.

Phase 4: Patient goes into VFib arrest. Initiate BLS protocols and call for help. Communicate as a team to ensure high quality CPR. Wife is still at bedside and not wanting to leave.

Phase 5: 2 persons respond to call for help (RT and PCA) and bring crash cart. Take over airway and compressions. Defibrillator attached and patient shocked at 200J- continue CPR. Wife is still at bedside, not disruptive but visibly upset- expected that one student takes on role of caring for the wife.

Phase 6: MD arrives after 2 mins of CPR- rhythm check is still VFib. Orders Epi 1mg IVP. MD requests that wife be escorted out of the room.

Phase 7: After 2 min of CPR, check rhythm and find NSR. HR of 88 and BP 102/76. Patient breathing on own but RT continues to supplement with BVM.

Scenario Conclusion: On return of pulse MD directs to prep patient to get him to cath lab and leaves to go talk to wife. Nurse returns from break and takes over care and will take patient to the cath lab.