Using Simulation to Train Nurse Residents on Bedside Legal Ethical Dilemmas

Elisa C. Salas

University of Maryland, Baltimore

June 14, 2017

Abstract

Problem**:* Nurse residents at a medium-size urban medical center reported a gap in knowledge on how to handle legal-ethical issues at the bedside. ***Objective: To develop a sustainable approach to integrate legal-ethical simulations into a nurse residency curriculum. ***Methods:*** In this quality improvement project, classroom content on ethics was replaced by a ten-minute presentation followed by two simulations depicting legal-ethical dilemmas at the bedside. The project leader designed the two legal-ethical simulations using a format consistent with the NLN/Jeffries simulation design. The topics of the simulations were cancer and pneumonia. The simulations for the first nurse resident cohort (N=9) were directed by the project leader; after training, the nursing residency coordinator directed the second cohort (N=19). Targeted training for nurse educators was also developed. Prior to and after the simulation, students completed a ten-item test to measure legal-ethical knowledge. Immediately after the simulation, students also completed the Student Satisfaction and Self-Confidence in Learning questionnaire, a 13 item Likert scale, 1= strongly disagree to 5 =strongly agree. ***Results**:* Comparison of pre and post legal-ethical knowledge scores showed a statistically significant increase in scores (Wilcoxon Signed-Rank Test $p < .001$, effect size medium to strong, $r = .48$). Scores for the *Student Satisfaction and Self-Confidence in Learning* showed consistency. There were no significant differences in scores between cohorts (Mann-Whitney $U = 256$, $z = 1.39$, $p = .1$, two tailed) or between simulations (Mann-Whitney $U = 371$, $z = 0.11$, $p = .9$ two tailed). ***Implications*:** Providing nurse residents with a ten-minute presentation and two simulations appears sufficient to refresh knowledge of basic legal-ethical concepts. Satisfaction and self-confidence scores were high after each of the two simulations, suggesting that their implementation in the residency program could assist in filling the reported knowledge gap.

Using Simulation to Train Nurse Residents on Bedside Legal Ethical Dilemmas

Nurse Residency Programs were created in the early 2000's to address nursing shortages caused by high turnover as well as to enhance the knowledge and expertise of new graduate nurses (University Health System Consortium & American Association of Colleges of Nursing, 2008). The need for a standardized curriculum was identified and a task force that included the leaders of the American Association of Colleges of Nursing (AACN) and the University HealthSystem Consortium (UHC) was formed. The task force implemented a pilot of an evidence-based standardized curriculum in six academic health centers in 2002 (Goode & Williams, 2004). The residency program, now known as the Vizient/AACN Nurse Residency Program™, continued to evolve and in 2016 was implemented in over 200 hospitals in the nation (Vizient, 2016).

In 2013, the Maryland Organization of Nurse Leaders (MONL) partnered with Vizient/AACN to create the Maryland Nurse Residency Collaborative (MNRC). The purpose of this partnership was to provide enhanced support to the twenty participating Nurse Residency Programs and monitor program outcomes, such as new graduate retention, satisfaction, stress and competence (Greene, n. d.). Furthermore, the MNRC has received a grant to develop a process to award credit hours towards a bachelor's degree in nursing (BSN) to associate degree nurses who complete a nurse residency (M. A. Green, personal conversation, December 16, 2016).

One MNRC participant, a medium-sized medical center in a large urban area, has maintained a residency program since 2013. The nurse residency coordinator (NRC) at this medical center identified the need to make the residency program more interactive to increase nurse resident engagement. The integration of active learning strategies in the form of clinical simulations was determined to be one strategy.

Simulation has been shown to be an effective training tool to introduce situations that may not be encountered during a new nurse's training but require immediate action from the nurse. The literature supports the use of simulation to increase satisfaction, confidence, and self-efficacy in graduate nurses (Rhodes et al, 2016; Sturgeon, 2015; Beyea, von Reyn, & Slattery, 2007), all desired traits for novice nurses, who must handle the complexity that the acute care environment brings.

A needs assessment to determine how simulations could be integrated into the program revealed that nurse residents struggled with legal-ethical dilemmas that arose at the bedside. Although they had learned about these issues via case studies during their nursing programs, the case studies had not prepared them to take action at the bedside. Since the use of clinical simulations has also been shown to improve applied knowledge (Everett-Thomas, et al., 2015; Rhodes et al. 2016), the decision to consider developing simulations in the legal-ethical area was made. Furthermore, unresolved legal-ethical dilemmas often result in moral distress and are likely to negatively influence nurse retention since they may be associated with nurse burnout (Ulrich et al., 2007).

The purpose of this Doctor of Nursing Practice (DNP) project was to develop, integrate and evaluate the impact of legal-ethical simulations on the satisfaction and self-confidence of the nurse residents at the medical center. An increased level of satisfaction and self-confidence is expected to increase their likelihood to remain at their current positions. Increased retention will result in a more experienced and capable workforce, which is likely to improve patient outcomes.

Literature Review

The literature review was conducted to find evidence of the use of nursing simulation to address legal and ethical issues involving patient care. The review included the use of

simulations that addressed legal-ethical concepts during nursing school as well as those being used for practicing nurses. The evidence review rating and grading table are found in Appendix A- Evidence Rating Table. An overview of the use of simulations to train nurses in legal and ethical issues in the clinical environment will follow.

When Klaassen, Smith, and Witt (2011) first reported their experience in using simulations to teach students about legal issues, they stated that there were no studies in the literature that addressed the use of simulation to teach legal and ethical issues other than those submitted by their group (Smith, Witt, Klaassen, Zimmerman, & Chen, 2012; Smith, Klaassen, Zimmerman, & Chen, 2013). Smith et al. (2012) studied the effect of high fidelity simulations focusing on legal and ethical issues on undergraduate nursing student learning. They took a convenience sample of sixty students and randomly assigned them the same scenario but used three different learning modalities - an online case study, an in-person case study, or a high fidelity simulation using a mannequin as the patient. The authors reported that students' self-assessed satisfaction with the learning experience was statistically significantly higher in the simulation group when compared to the other two groups (Kruskal–Wallis = 9.712 df = 2, $p < .05$).

Smith et al. (2013) continued to study the effects of simulations and applied the principles of continued quality improvement to their simulations for a period of three years. The subjects for this study were undergraduate nursing students taking the legal-ethical nursing course. During the first year of the study, 67 nursing students were randomly assigned to participate in the simulation either during mid-semester or at the end of the semester after all the content had been presented. Independent t-tests ($p > .05$) yielded data consistent with significantly better perception of the experience when the simulation was given at the end of the

semester. During the second year, 72 nursing students participated in the simulations, which were all carried out at end of the semester. The investigators used paired t-tests to compare before and after test scores for participants. Using an independent t-test, mean differences in learning for students playing nurse roles versus those playing the role of family members were compared. Although the authors reported that those playing family members had a higher pre-post-test mean difference (1.02 vs. 0.78), a p value was not provided to support their conclusion that the difference was not significant. The authors report that during the third year they compared data from 82 participants to determine if learning was affected by participating versus observing a simulation and reported that there was no significant difference; however, they did not provide statistics to support this statement.

The findings from the studies described above support that nursing students benefit from participating in simulations that address legal-ethical issues. They also suggest that playing the role of the nurse during these simulations may not be essential for the student to benefit. Although nursing students and nurse residents practice in different roles, nurse residents are continuing their education through a standardized curriculum, so their learning may be similar to that of a nursing student.

There is evidence that supports the use of simulations to train nurses in legal-ethical aspects of care. Shapira-Lishchinsky (2014) conducted a qualitative study on how ethical decision-making during team-based simulations could enhance the nurses' leadership abilities. The study sample included 50 nurses employed in 10 medical sites in Israel with an average 13.8 years of nursing experience. The aim of the study was to train nurses in effective leadership by allowing them to work through ethical dilemmas in the supportive and non-punitive environment that the simulations offered. Nurses were randomly assigned in groups of five to participate in

the simulation and then view and discuss the video recording of the simulation sessions. Analysis of the data was performed using ATLAS ti 5.0 software for qualitative data and followed an open coding, axial coding, and selective coding process. The investigator reported that participants' benefits included an increase in their self-awareness, improved communication with colleagues, enhanced ability to consider other options and better management of internal conflicts related to their moral and religious standards. Study findings support that simulations that focus on ethical dilemmas may enhance nurses' leadership and decision making abilities.

Legal-ethical simulations have been used as part of more comprehensive programs. A 10-month Clinical Ethics Nurse Residency Program integrating didactics, a mentored clinical experience and simulations was developed to increase nurse retention. The goals were to increase participating nurses' self-confidence, decrease their moral distress and develop these nurses to act as resources within their units. The simulations were reportedly based on real cases that reflected either common or difficult situations that nurses may face (Grace, Robinson, Jurchak, Zollfrank, & Lee 2014). Program outcomes included decreased moral distress, increased knowledge and increased self-efficacy in clinical ethics (Robinson et al., 2014). Although findings reflect the effects of a residency program which also included didactic content and mentorship, it is likely that simulations contributed to the results.

In summary, although the evidence for using simulations to train nursing students and nurses in the legal-ethical aspects of care is limited in quantity and quality, there is evidence to support positive effects in the participants' willingness to discuss ethical issues (Klaassen, Smith, &Witt, 2011; Shapira-Lishchinsky, 2014). Furthermore, nursing students reported increased or enhanced learning (Smith, Klaassen, Zimmerman, & Chen, 2013). Finally, after simulation,

experienced nurses report that they are better able to deal with legal-ethical dilemmas (Grace et al., 2014; Robinson et al., 2014; Shapira-Lishchinsky, 2014).

Theoretical Framework

Jeffries (2005) created a framework for the development of simulations with five different components: student factors, teacher factors, educational practices, simulation design and outcomes. These components were grouped as interrelated domains; student factors, teacher factors, and educational practices encompassed the participant variables, while the simulation design represented the independent variable or intervention, and the outcomes represented the dependent variable. Each domain was separate but interrelated; outcomes were the result of an intervention (the simulation design) as applied to the participants. In time, the framework was tested and refined and became known as the NLN/Jeffries simulation theory (Jeffries, Rodgers, & Adamson, 2015).

The NLN/Jeffries simulation theory has been used extensively to develop simulations (Adamson, 2015). While the theory still includes some of the same components (participant factors, simulation design and outcomes), the process is no longer represented as the original linear process, which suggested a cause and effect relationship between the domains. New components have been identified in the theory, such as *context* and *background*. The *context* surrounds all the other elements, and must be the acknowledged even before the simulation is designed. The context includes the setting where the simulation will take place, and its purpose, i.e. whether it is used to evaluate or to train. The *background* implies that the simulation must be fitted within the curriculum and that as such, it should have a goal, an integrated theoretical perspective and include the available resources.

In the theory the simulation is viewed as a phenomenon composed of the interactions as they occur the time of the simulation. It is labeled as the *simulation experience* and it is driven by the dynamic interaction between the participants and the facilitator (who incorporates the educational strategies). The optimal *simulation experience* should incorporate other elements known to enhance its effectiveness, such as an environment of trust and objectives that are learner centered. Participants should have the opportunity to experience the situation as well as opportunities to interact and collaborate with other participants.

The last component, *outcomes*, also transformed as the framework developed into a theory. Originally, all the outcomes were specific to the participant (student), but this component has expanded to include outcomes in two additional areas: care receiver outcomes, and system (institution) outcomes. For a visual representation of the model, please refer to Figure 1. For permission to use, refer to Appendix B-Permission to Use.

Method

Design, sample, and setting

In this quality improvement project, two different nurse resident cohorts participated in two legal-ethical simulations. Using the findings from the literature and applying the NLN/Jeffries simulation theory, two parallel content simulations that addressed legal-ethical dilemmas that nurse residents may encounter during their daily activities were developed. To conform to the elements of this theory, ten possible scenarios based on anecdotal experiences from project team members' experiences were developed. The NRC reviewed the scenarios and chose the two that were most likely to address the issues that the NRC had observed since the start of the residency program in 2013. Additionally, a nursing clinical ethics expert with a PhD in nursing with a concentration in ethics reviewed both simulations. This expert concurred that

the scenarios were both realistic and presented legal-ethical issues encountered during nursing care, which added validity to the simulation scenarios.

Prior to implementation, the two completed simulations were reviewed by three nursing faculty who are also simulations experts. These experts provided feedback and validated consistency of their structure with the NLN/ Jeffries simulation theory. Additionally, these experts also validated that the scenario content was consistent with situations that nurses encounter while providing routine care and concurred that the selected debriefing method was a good fit for the target participants.

The project's sample consisted of nurse residents from two cohorts (identified as 12 and 13) who were employed in the medical center on the day of simulation. Cohort 12 had nine residents and cohort 13 had 19 residents. All the actively employed nurse residents were present on the day their cohort's simulation was scheduled.

The simulations were implemented in the hospital's simulation laboratory using hospital equipment and props, ensuring that the simulation background fit the reality of the nurse residents. The project leader had met and interacted with the new residents in several active learning activities, including an asthma simulation, which created an environment of trust. Groups were limited in size, with most groups having six participants (one group had four, one group had five, and another had seven). During pre-briefing, emphasis was placed on the ground rules, which focused on confidentiality and respect, and it was emphasized that the simulations were not meant to evaluate or grade the participants' performance. These practices were included to make the environment learner centered. Participants were allowed choice of roles played, and all interacted with their peers either during the simulation interaction or the debriefing, which made the experience learner centered. To enhance educational strategies, a structured theory-

based debriefing method that fit the nurse residency delivery format was used, namely *Debriefing for Good Judgment* (Rudolph, Simon, Rivard, Dufresne, & Raemer, 2007). This method has been extensively used to debrief after health care simulations and is effective at eliciting self-reflection as well as changes in practice (Rudolph et al, 2013; Szyld & Rudolph, 2013). The advantage of this debriefing method lies in its flexibility and simplicity, making it ideal for the fast-paced and time-limited NRP seminars.

Procedures

The project ran over eight non-consecutive weeks and each phase of the project was roughly four weeks. During the first phase, the project leader implemented the simulations with the nurse educators assisting and observing. After the first phase was completed, the project leader began the second phase of the project by training the nurse educators to implement clinical simulations using the NLN/Jeffries theory.

Phase one.

During the first week, the project leader worked with the NRC to adapt the asthma simulation currently used in the NRP to a format consistent with the NLN/Jeffries simulation design. Although the simulation was already in use, a simulation kit with simple directions for conducting the simulation added structure and consistency. The kit included a set of suggested questions that followed the *Debriefing with Good Judgment* method.

Two weeks prior to the scheduled simulations with the first cohort (cohort 12), the project leader met individually with medical center educators to inform them of the plan to implement simulations. During these meetings, the project leader provided a brief explanation of the simulation implementation plan and discussed how the NRP curriculum objectives were expected to be met during the simulations. These meetings provided an opportunity for the

project leader to address questions and concerns from the educators. While meeting with the nurse educators, a change in the simulation template format from the NLN format to the one that the medical center already used was discussed. The medical center template contains the same information as the NLN template, but the information is arranged differently. Since using the Medical Center's template would not have a negative impact on its content but rather was likely to have a positive impact, the simulation content was placed in the new format and shared via email with all the nurse educators prior to the first simulation. Please refer to Appendix C-Simulations in Medical Center Format.

Each nurse educator also received a packet with relevant simulation information. Those educators that the project leader was not able to reach face to face had the information packet placed in their mailboxes with a letter encouraging educators to contact the project leader for any questions or concerns. For the introductory information packet, please refer to Appendix D-Nurse Educator Initial meeting.

The following week, one week prior to the first scheduled simulations, the project leader met with NRC, the simulation lab coordinator (SLC) and a few nurse educators and performed a "dry run" of each of the two planned parallel simulations. Laminated sheets with instructions for each of the simulation phases (pre-brief, interactions and de-brief) were created and shared with the group. The SLC, who had agreed to play the role of the standardized family member for both simulations, practiced the roles using the scripts and cues as support. Group members took turns acting as either new residents or facilitators. The mannequins, rooms, props and moulage were tested and small changes were made according to group members' input. The project leader presented the 10-minute content on legal-ethical concepts to practice timing and to elicit feedback.

On the week of the scheduled simulations, the team set up the simulation environment the day before the simulation. A table and four chairs were placed in front of the simulated patient's room so that the participants playing the charge nurse and staff nurses could hear the interactions between the patient's relative and nurses caring for the patient. In both scenarios, the standardized family member requested to speak outside the hearing range of the patient.

Residents were divided into two groups of four and five residents per group. According to Adamson and Rodgers (2016), the ideal group size for a simulation is four to six participants, since larger groups may negatively affect participant satisfaction. While one group completed one of the simulations, the other group completed another training assignment that did not relate to the legal-ethical content. The cancer simulation was implemented with the first group and then with the second group. Then the pneumonia simulation implemented in the same manner, with one group completing the simulation while the other group completed other training assignments. The group that completed the training assignments went to a different room to prevent them from hearing the simulation interactions.

The project leader facilitated all four simulations and the SLC played the standardized family member in all the interactions. The SLC changed clothing and hair to look different in each of the two roles. The NRC coordinated resident flow, observed the interactions and assisted with group logistics details. Nurse educators who were available came in to observe the simulation interactions and debriefing sessions.

The seminar simulation started with the administration of a ten-item test to measure basic legal-ethical knowledge needed to meet the simulation objectives (see Appendix E- Legal Ethical Test). This pre-test was developed by the project leader and it evaluates the basic concepts included in the nurse resident program seminar that were needed to complete the simulation. Test

content validity was established by developing a test blueprint that evaluated readability and content objective fit. Three nurse educators with doctoral degrees reviewed the presentation and each test item for readability and fit. Item content was modified following their feedback. For the final test blueprint, please refer to Appendix F- Legal-Ethical Test Blueprint.

All instruments were administered with paper and pen. Residents were asked to identify a random non-sequential six-digit number that they could remember and entered it on the pre and post tests. After the 10 minutes to complete the test, each resident placed their completed pre-test in a locked box. The legal-ethical concepts were presented immediately after the pre-test and were followed by an identical post-test (Appendix G- Legal Ethical Decision Making Presentation). Residents placed the same six-digit number in their post-test to allow for a paired samples comparison after the simulation. The project leader gathered the post-tests and results were immediately reviewed. Any item that was missed by more than two participants in the post-test, as well as items that were missed by any resident who scored less than 70% were noted. The concepts tested on these items were reinforced prior to the simulation to make sure that participants had the needed knowledge to meet the outcomes.

Immediately after each simulation debriefing, students completed the *Student Satisfaction and Self-Confidence in Learning* questionnaire and placed it in the locked box (Appendix H). Questionnaires to evaluate the cancer patient simulation had a pink mark on the top to differentiate them from those addressing the pneumonia simulation. There was no differentiation made between the questionnaires filled by each group.

When the simulations ended, the project leader, NRC, SLC and one of the nurse educators discussed impressions and observations. There was consensus that all residents actively participated in the discussion and that most simulation objectives had been fully met

during the simulation interactions. Those objectives that were only partially met were addressed during debriefing.

Phase two.

Phase two started with a formal session for the nurse educators at the medical center. The previously planned goals and objectives were maintained, but the content delivery was adjusted to be delivered in a one-hour session to allow a greater number of nurse educators to participate. The project leader adjusted the presentation by minimizing content that the nurse educators had already mastered and focusing on meeting the specific learning objectives. The session consisted of a PowerPoint presentation addressing the NLN/Jeffries Simulation Theory and how this theory can be applied as framework for the design and implementation of simulations. The presentation also addressed some of the best practices identified by Adamson and Rogers systematic review (2016). An interactive activity to guide the process for integrating simulation into the nurse residency curriculum was included in the presentation. The final part of the presentation focused on structured debriefing. Three different methods were presented, *Promoting Excellence and Reflective Learning in Simulation* (PEARLS) (Eppich and Cheng, 2015), *Debriefing for Meaningful Learning* (DML) (Dreifurts, 2012) and *Debriefing for Good Judgement* (Rudolph et al., 2007). The recommendation was to use Debriefing for Good Judgement since it is simple and allows time flexibility. Nurse educators received a packet containing the PowerPoint outline, a copy of the NLN/Jeffries simulation theory diagram, a handout for the interactive activities, content references and a list of selected simulation resources. This packet is included in Appendix I.

The planning for the implementation of the simulations with the next group of residents (cohort 13) began three weeks after the training session. Since this cohort of 19 residents was

larger, additional logistical planning was needed. However, the NRC coordinated all the activities with minimal feedback from the project leader. The NRC arranged for four rooms: one for each simulation, one for an alternate activity addressing conflict management and a separate room to keep policies and the locked box to collect the questionnaires. The NRC also arranged for nurse educators to both facilitate and play standardized patients since the simulations would run simultaneously and the SLC could only assume one role.

On the day of simulation, the project leader delivered the presentation. The legal-ethical pre and post-tests were administered following the same sequence that used with cohort 12 residents. Prior to the simulation, the concepts associated with missed items were reinforced with the entire group.

Residents were divided into two teams of six and a team of seven students. The NRC rounded in all four rooms and directed resident traffic while making sure that simulation content was not overheard by those residents not involved in the simulation at the time. Simulation implementation went over the time allotted, but the NRC was able to adjust the content that followed the simulations. The *Student Satisfaction and Self-Confidence in Learning* questionnaires were completed by the residents immediately after each group completed each simulation and placed in the locked box. The questionnaires for the cancer simulations were marked to differentiate them from the pneumonia questionnaires. All 19 questionnaires from the pneumonia simulations but only 18 from the cancer simulations were returned.

Data Collection

The NRC provided nurse residents' demographic data – age, gender, ethnicity, type of nursing program, unit of hire, date of hire and nursing program name, which is standard collected data in all NRP cohorts. No personal identifiers were attached to the data.

After the simulation, residents completed the National League for Nursing *Student Satisfaction and Self-Confidence in Learning*. This tool is available for use by the nursing community (National League for Nursing, n. d.). The instrument developers, Jeffries and Rizzolo (2006), reported that nine clinical experts validated the two scales and that reliability for the satisfaction scale and the self-confidence scale had been established by Cronbach's alpha and was 0.94 and 0.87 respectively. Adamson (2012) reported Cronbach alpha for satisfaction scale of 0.94 and Cronbach alpha for the self-confidence in learning scale of 0.85. Franklin, Burns, and Lee (2014), also reported Cronbach alpha level consistent with those cited above.

Data Analysis

The demographic information for each of the cohorts was described and presented in table format. Legal-Ethical pre-test scores were analyzed after the simulation to assess nurse resident knowledge prior to the simulation. Though the study was structured so that a paired-samples t-test would have been appropriate, a parametric test would only be appropriate if the underlying data was normally distributed, since this is an assumption of such parametric analyses. Using the Shapiro-Wilks test, it was determined that the pre-intervention subscale and composite scores were not normally distributed, so a parametric test was ruled out. Instead, a non-parametric test was used, namely the Wilcoxon Signed-Rank Test for Paired Samples.

The National League for *Nursing Student Satisfaction and Self-Confidence in Learning Questionnaire,* a 13 item tool measured by a 5 point Likert scale (from 1= s*trongly disagree*, to 5= *strongly agree*) was scored by totaling each subscale separately and then obtaining a total score by adding both subscales. Item number 13 was reverse coded since this is appropriate procedure for a negative item (Franklin, Burns, & Lee, 2014). According to one of the instrument developers, the higher the score in any item, the more concept is being achieved,

therefore scores between 4 and 5 are desirable (M. A. Rizzolo, personal communication, October 13, 2016).

Total scores as well as scores for each subscale were averaged for each individual resident, each cohort, each simulation and for the sample total. This analysis is consistent with what other researchers who have used this instrument have published (Horsley & Wambach 2014; Lubbers & Rossman, 2017; Scherer, Foltz-Ramos, Fabry, & Chao, 2016; Smith & Roehrs, 2009). Group comparisons were analyzed using the Mann-Whitney U non-parametric test.

Human Subjects Protection

The medical center has determined that this is a quality improvement project and has waived the need for an institutional review board (IRB) presentation (see Appendix J). The University of Maryland IRB made a "Not Human Research" determination regarding this project (See Appendix K). All demographic data were obtained from the NRC without personal identifiers. Neither of the two instruments that the residents completed contained any identifying information. The legal ethical-tests had student-generated six-digit numbers so that pre-tests and post-tests could be paired for analysis, but additional measures were taken to maintain confidentiality. Pre-tests were placed by the residents in a locked box, and post-test were folded in half when they were given to the project leader to keep the six-digit number not visible. Residents used the same brand black pens to complete both instruments. Instruments required circling or checking choices, so no handwriting samples were inadvertently collected.

Results

A total of 28 nurse residents participated in both simulations, with 9 residents in cohort 12 and 19 residents in cohort 13. The majority of residents were female (N=26, 96 %) and had graduated from an associate degree program (N=22, 86%); the remaining six nurses graduated

from a bachelor's degree program. Ages ranged from 22 to 45, with mean age was 30.5 years. Over half the residents self-identified as white (54%), while 29% identified as Black or African American. Most of the residents worked in the emergency room (N=9, 32%) or in medical-surgical units (N= 6, 29%). The rest worked in maternal-child services, critical care and operating room services. Refer to Table 1 for nurse resident demographics.

Scores of the legal-ethical pre-tests were assessed for normality using the Shapiro Wilkes test, but the distribution of scores was not normal; therefore, a non-parametric test, namely the Wilcoxon Signed-Rank Test for Paired Samples, was used to compare pre-test scores to post-test scores . For the combined cohorts, test scores improved significantly from a pretest mean of 7.6 to a posttest mean of 9.0 (Wilcoxon P<.001). This represented a strong effect size (r=.49). When the cohorts were examined separately, only cohort 13 showed a significant increase from a pretest mean of 7.6 to a post test mean of 9.4 (Wilcoxon p<.001). In cohort 12, more than two residents missed items number 2 and 5 and two residents obtained a 70% in the post-test. For cohort 13, only one of the 19 residents scored below 80% in the post-test. The items that were missed by more than 2 residents were the same as those missed in cohort 12, items 2 and 5. For results, please refer to Table 2.

Total scores for the Satisfaction and Self-Confidence in Learning Questionnaires were consistent between simulations and cohorts. The cancer patient simulation had total composite score mean of 4.4 (SD=0.4) (N= 27). For cohort 12 the mean was 4.3 (SD=0.4) (N=9); for cohort 13, the mean was 4.4 (SD=0.4) (N=18). There was no significant difference for the cancer patient simulation mean scores between the two cohorts (Mann-Whitney U=68, z=0.6, p= 0.49 two tail). The pneumonia patient simulation had total composite score mean of 0.4 with SD 0.4 (N= 28). For cohort 12, the mean was 4.2 and SD 0.4 (N=9); for cohort 13, the mean was 4.4

and the SD was 0.4 (N=19). Again, there was no statistically significant difference for the pneumonia patient simulation mean scores between the two cohorts (Mann-Whitney U=60, z= 1.2, p= .2 two tail).

Composite scores for both simulations in each cohort were not different. The mean for composite scores for both simulations in cohort 12 was 4.3, SD 0.4 (N=9). The mean for composite scores for both simulations in cohort 13 was 4.4, SD 0.4 (N=19). There was no significant difference when comparing cohort scores for combined simulations (Mann-Whitney U=256, z =1.39, p= .1 two tail). Table 3 contains the comparisons between cohorts and simulations.

Comparison of mean scores in each subscale of the *Satisfaction and Self-Confidence in Learning* instrument was analyzed using Spearman's Rho correlation coefficients. For cohort 12, the relationship between the satisfaction and self-confidence scores were strong (rs=0.73, p=0.01, two tail); however, this same correlation was weak for cohort 13 (rs=0.38, p=0.01, two tail). When comparing the subscales from both cohorts together, the relationship was moderate (rs=0.52, p= 0.01, two tail). Refer to Table 4 for results.

Discussion

The ten-minute presentation of legal-ethical concepts was effective. Post-test scores were statistically significantly higher than the pre-test scores, which suggests that a brief review of basic content may be sufficient for residents to recall basic concepts that presented during nursing school. Therefore, substituting detailed classroom presentations with brief reviews followed by a well-designed simulation may be appropriate for some of the content areas in the nurse residency curriculum.

All residents but two had mean scores equal or greater than 4 (agree) in the satisfaction subscale. None of the residents had a mean score of less than 3.4 (3=neutral) in either subscale or in the composite score. There was no statistically significant difference in mean total scores between cohorts or between simulations, which suggests that all the facilitators were effective and that there was fidelity of the intervention. It also suggests that the simulations were parallel in content.

Scores on item 13, which were reverse coded since it was a negative item, were not consistent with the rest of the scores in the self-confidence scale. Franklin et al. (2014) reported similar findings when analyzing the psychometrics for this tool. Franklin et al. stated that eliminating item 13 would increase reliability. Nevertheless, this may not explain the different relationship strengths between the mean scores for the satisfaction subscale and the self-confidence subscale in the two cohorts. However, cohort sample size may have played a role, since cohort 12 had less than half the number of cohort 13.

Nurse educators who were involved in the implementation of these simulations observed that residents who rarely participated in prior seminars readily interacted during debriefing. The debriefing method elicited information from the participants that was instrumental to the facilitator in order to clarify content or provide meaningful feedback. Most residents were able to reflect on the reasoning that drove their actions, and often the residents themselves were able to identify the reasons why their actions had not yielded their desired outcome.

Most participants fully met all the simulation objectives, though it became clear that when faced with legal-ethical dilemmas, residents seldom tried to identify all the options before deciding on a course of action. On the other hand, residents consistently consulted the policy and procedures and followed them during the simulation. Debriefing sessions provided NRP

educators with valuable insight regarding the nurse residents' competence and decision making processes.

Limitations

The main limitation of this project was a lack of similar data on satisfaction and self-confidence in learning from prior nurse resident cohorts specific to the legal-ethical content that could be used to compare outcome data obtained after the simulation. Although the Vizient/ AACN programs collect outcome data from each of the residents in the Maryland Collaborative, any differences in outcomes from that data could not be attributed to the integration of simulations. Dividing the residents' cohorts and using a part of the group as a control group would have required IRB review from the medical center and would have changed the nature of this project.

Another limitation was the unavailability of tools to measure basic legal-ethical knowledge. Although the Legal-Ethical test was validated by test blueprint and expert opinion for readability and objective fit prior to administration, the need to revise two of the test items became apparent after the test was administered to the first cohort. This finding was confirmed after administering the test to the cohort 13, since it showed the same items needed revision. . Furthermore, administering the post-test so close to the pre-test may have resulted in instrumentation bias, since participants might had already been sensitized to the questions asked.

Although the sample size was small, which limited the validity of the statistics obtained, the group sizes were realistic, therefore the intervention could be implemented using group sizes that were typical to the medical center's Nurse Residency Program. Although findings from this project may not be generalizable to the entire population of nurse residents, they might be useful to medical centers with similar nurse resident populations that follow the same curriculum.

There appeared to be an issue with item 13 of the Student Satisfaction and Self-Confidence in Learning Questionnaire. It is the only negative item of the instrument and it is also placed last in the scale. For most of the questionnaires, the item did not appear to be consistent with the others. Nevertheless, in a few of the questionnaires that returned after cohort 13's simulations, scores in item 13 were consistent with the rest of the items. This might have accounted for the result disparity when comparing correlations between the subscales between the cohorts.

Translation Plans

These legal-ethical simulations may be implemented in nurse residency programs that have similar nurse resident populations and the resources available in this medical center. Simulations could also be developed and integrated to address other NRP topics or to fill other identified knowledge gaps.

Tailoring simulation training to the specific needs of those educators involved in the implementation of simulations was beneficial for all those involved. It not only minimized the time and the effort needed to plan the training session, but it also allowed a larger number of nurse educators to attend. The flexibility to accommodate institutional needs, preferences and constraints was paramount to the success of the simulation implementation.

Sustainability

There are some factors that give this project a high chance for sustainability. First, the project was planned and designed from an identified need and a desire to improve. Second, efforts were made to involve the stakeholders in every step of the process, and third, the project was implemented using resources that were already available within the medical center. One last

factor that may also contribute to sustainability is that the SLC recently became certified in healthcare simulation.

Dissemination

Project findings may be disseminated by a podium or poster presentations during professional meetings or similar forums. However, publication in a professional peer-reviewed nursing journal might be the best way to reach a larger audience. The creation of a tool kit that is made available to other NRP would assist others into implementing similar quality improvement projects.

Implications for Clinical Practice

Legal-ethical simulations could be implemented outside NRP and integrated as part of nursing orientation. Since legal-ethical issues often involve members from other health care disciplines, these simulations could be expanded into multidisciplinary simulations, particularly since these simulations do not require high fidelity mannequins or other expensive equipment.

These legal-ethical simulations allowed NRP educators to discover some issues regarding the nurse residents' competencies and thought processes. Some of the residents reasoned that their legal duty was limited to the actual patient and were ready to exclude the family members from having any input into patient care decisions. A few residents failed to make any effort to communicate therapeutically with the family member, which increased the likelihood of the ethical issue remaining unresolved. This failure to communicate therapeutically with family members could not only affect patient satisfaction scores, but also- and more importantly- affect the effectiveness of discharge teaching and planning, and might result in less than optimal patient outcomes.

Debriefing after the legal-ethical simulations not only brought up relevant issues related to the issue addressed during simulation, but it also allowed nurse residents to bring up other difficult issues that they had encountered during practice but that they had been unwilling to bring up before. Providing a safe forum for novice nurses to share their perceptions on these issues allows NRP educators to address them efficiently.

Conclusions

The integration of simulations in a Nurse Residency Programs is feasible. Like any other evidence translation effort, a supportive and committed team who has bought into the plan is the most important element. Simulations should be designed and implemented following an evidence-based framework for design and implementation. A suitable debriefing method that is a good fit for the participants and time constraints should be selected.

The use of simulations in a Nurse Residency Programs may be instrumental in increasing satisfaction as well as self-confidence in learning. This is significant not only because it may improve job satisfaction and performance, but also because nursing is a life-long learning discipline. Nurses must continuously apply new learning to be effective at caring for their patients. Implementing learning modalities that are effective and increase nurses' self-confidence is essential to the advancement of nursing as a discipline.

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Tables

Table 1

Nurse Resident Demographics for Cohort 12 and Cohort 13

	Cohort 12	Cohort 13	Sample Total	Percentage of Total
Gender				
Female	8	18	26	93%
Male	1	1	2	7%
Degree				
ADN	7	16	23	82%
BSN	2	3	5	18%
Ethnicity				
White	5	10	15	54%
Black /AA	2	6	8	29%
Asian	1	2	3	11%
Hispanic/Latino	1	0	1	4%
Two or more	0	1	1	4%
Age range				
22-25 years	3	5	8	29%
26-30	4	5	9	32%
31-35	0	1	1	4%
36-40	1	7	8	29%
40-45	1	1	2	7%
Unit				
Emergency	5	4	9	32%
Med-Surg	2	4	6	21%
Intermediate	1	4	5	18%
Perioperative	0	3	3	11%
Telemetry	0	2	2	7%
Labor & Delivery	0	2	2	7%
Mother-Baby	0	1	1	4%

Note: *Demographic data collected by the medical center for every NRP cohort*

Table 2

Legal-Ethical Concepts Pre and Post test results.

	Cohort 12	Cohort 13	Both Cohorts
Pre-test	N 9 Mean 7.6 SD 1.77	N 19 Mean 7.6 SD 1.02	N 28 Mean 7.6 SD 1.08
Post test	N 9 Mean 8.3 SD 0.75	N 19 Mean 9.4 SD 0.59	N 28 Mean 9.0 SD 0.92
Wilcoxon Signed-Rank Test for Paired Samples (two-tail)	p value 0.29 effect r 0.28	p value < 0.00 effect r 0.57	p value <0.00 effect r 0.49

Table 3

Satisfaction and Self-Confidence in Learning Composite Scores

	Cohort 12	Cohort 13	Sample Total	Mann-Whitney (two tail)
Cancer Patient Simulation	N 9 Mean 4.3 SD 0.4	N 18 Mean 4.4 SD 0.4	N 27 Mean 4.4 SD 0.4	U 68 z 0.6 p 0.49
Pneumonia Patient Simulation	N 9 Mean 4.2 SD 0.4	N 19 Mean 4.4 SD 0.4	N 28 Mean 4.4 SD 0.4	U 60 z 1.2 p 0.2
Both Simulations	N 18 Mean 4.3 SD 0.4	N 37 Mean 4.4 SD 0.4	N 55 Mean 4.4 SD 0.4	U 256 z 1.39 p 0.1

Note: *Items are scored using Likert-like scale that ranges from 1= strongly disagree to 5 strongly agree. One questionnaire for the Cancer Patient Simulation was not returned*

Table 4

Satisfaction and Self- Confidence Subscales

Spearman's Coefficient	Cohort 12		Cohort 13		Both Cohorts	
Both Simulations	N	18	N	37	N	55
Spearman's Rho		0.73		0.38		0.52
p value		0. 00		0.01		0.00

Figure 1

The NLN/Jeffries Simulation Theory

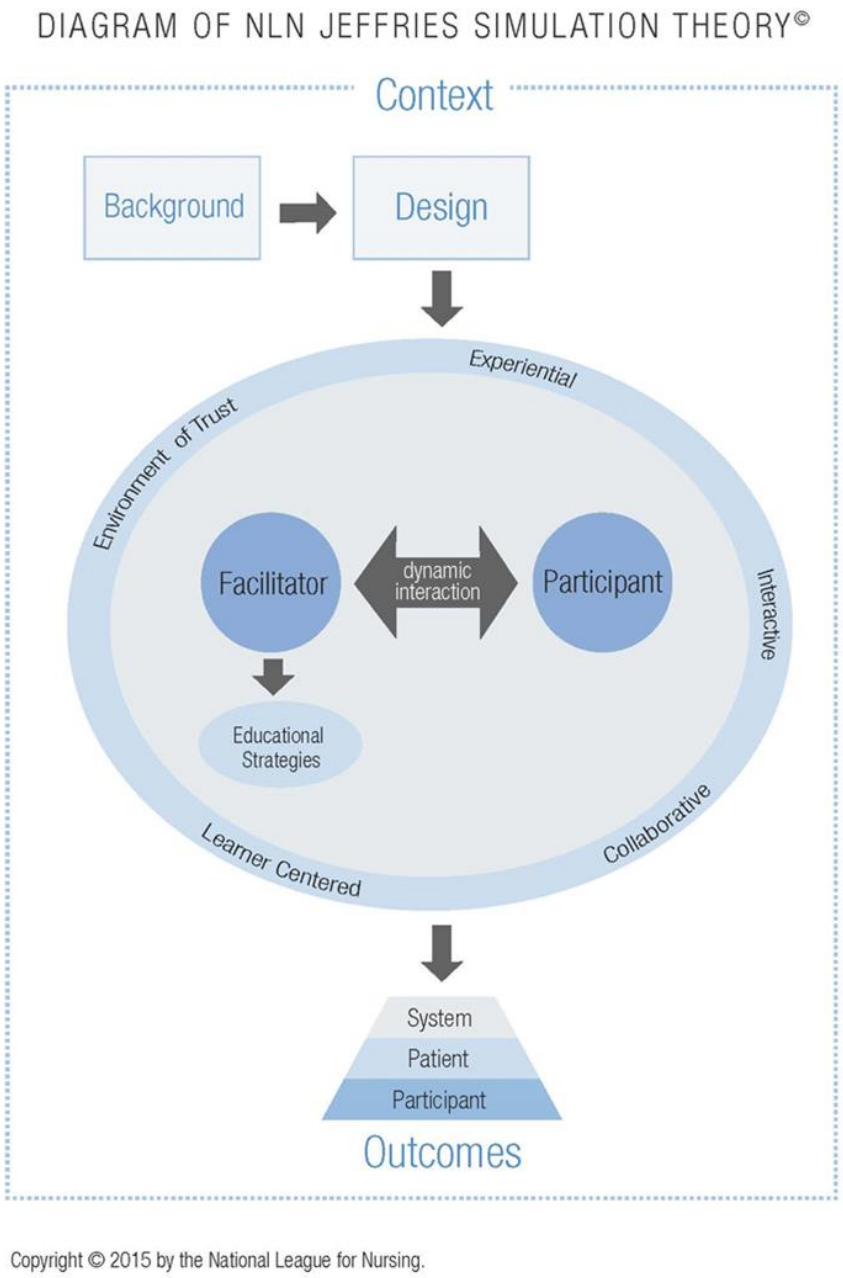

Figure 1. The NLN Jeffries Simulation Theory. Used with permission. See Appendix B

Appendix A

Evidence Rating Table

Author, year	**Study objective/ intervention or exposure**	**Design**	**Sample**	**Outcomes studied**	**Results**	***Level and quality rating**
Rhodes et al.(2016)	Effect of nurse specific vs. multi-disciplinary Simulations	Prospective Cohort	Newly licensed registered nurses at large urban hospital (N=93)	Knowledge Satisfaction Confidence	Knowledge and confidence increased in both simulations modes. Satisfaction was higher with multidisciplinary.	IV B
Adamson (2015)	Simulation effectiveness	Systematic review	Studies that used the NLN/ Jeffries framework (N= 93)	Simulation studies from 2000 to 2014	Simulation produces better outcomes, improved performance, and increased confidence. 2. Medium fidelity was found to be very cost effective. 3. Debriefing is the most important aspect, though there is no consensus of whether video assisted debriefing is superior to debriefing w/o video	I A
Everett-Thomas et al. (2015)	Effect of simulation on applied knowledge	Retrospective	Twenty cohorts of graduate nurse residents	Clinical performance	Improvement in applied knowledge	IV B

Author, year	**Study objective/ intervention or exposure**	**Design**	**Sample**	**Outcomes studied**	**Results**	***Level and quality rating**
Sturgeon (2015)	Simulation to improve confidence and competence	Before and after	Convenience. All staff nurses in one unit for a year period.	Confidence Communication Response time Participation	Improvement in all measured outcomes	IV B
Grace et al. (2014)	Effect of clinical ethical residency on nurses' moral distress levels. Included simulations in curriculum	Descriptive	Convenience Nurses applied to be part of the ethics residency (N=93)	Transformative learning. (Quantitative data in Robinson et. Al)	Needs assessment findings prior to program revealed that the majority of RN's at one Academic Medical Center in New England had reported at least one ethical event the prior year that they felt they were unprepared to face	VI A
Robinson et al. (2014)	Effect of clinical ethical residency on nurses' moral distress levels. Included simulations in curriculum	Before and after	Convenience Nurses applied to be part of the ethics residency (N=93)	Moral Distress Knowledge Self-efficacy	Findings were statistically significant at Decreased moral distress $p < .000$ Slight increase in knowledge $p < .005$ Increase in self-efficacy $p < .000$	IV A
Shapira-Lishchinsky (2014)	Benefits of ethical simulations on nurses' leadership abilities	Before and after	Stratified from 10 medical centers in Israel (N=50)	Benefits attained by the participants after simulation sessions.	Increased levels of: Self-awareness of strengths and weaknesses; Relational transparency (open and honest communication with colleagues); Balanced processing (considering options); Internalized moral perspective own religious and traditional values and more modern institutional values)	IV B

Author, year	**Study objective/ intervention or exposure**	**Design**	**Sample**	**Outcomes studied**	**Results**	***Level and quality rating**
Smith et al. (2013)	Application of quality improvement to legal ethical simulations	Descriptive.	Convenience Nursing students in legal-ethical class	Goals of each specific simulation (met vs. not met)	Simulations should be implemented after content is presented. Role fulfilled in simulation did not affect learning	VI B
Smith et al. (2012)	Legal-ethical content comparison of simulations, online case studies, or in person case studies	Descriptive	Convenience Nursing students in legal-ethical class	Student perceptions of the different teaching modalities	Simulations were perceived as being more effective than in person case studies and online case studies	VI B
Klaassen et al. (2011)	Integration of legal-ethical simulations	Expert opinion.	Convenience Nursing students in legal-ethical class	N/A	The literature supports the use of active learning to engage students. After integrating simulations, students demonstrated higher levels of engagement	VII B
Beyea et al. (2007)	Simulations during nursing orientation	Weekly assessments	New nurses recruited into residency program (N=42)	Clinical skills: initiating nursing interventions, synthesizing clinical data, and making decisions	Decreased orientation time, increased readiness for independent practice, and better predictability regarding mastery of skills. Over 95% of participating nurses reported enjoying the simulations and finding them helpful.	IV B

Note: Level of evidence based on Melnyk & Fineout-Overholt (2011); quality rating based on Newhouse, (2007)

Appendix B

Permission to Use

Recently you requested personal assistance from our on-line support center. Below is a summary of your request and our response.
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To access your question from our support site, click here.
Subject

Doctor of Nursing Practice (DNP) student seeks permission to reproduce graphic in DNP project proposal.

Discussion Thread

Response Via Email (Chandreyi Das) 10/04/2016 01:46 PM

Dear Elisa,
Thank you for contacting Wolters Kluwer. Your request to use Figure 3.1 in your thesis has been approved by NLN and Wolters Kluwer as gratis.
If you are posting your thesis/dissertation electronically on a website, the website must be password protected. Posting of our content to commercial/social media websites, such as ProQuest, YouTube, ResearchGate, Facebook is not permitted. Please see below for the link to our Terms and Conditions. Please consider those, and this email, your official grant of permission.
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Customer By Email (Elisa Salas) 09/30/2016 08:16 PM

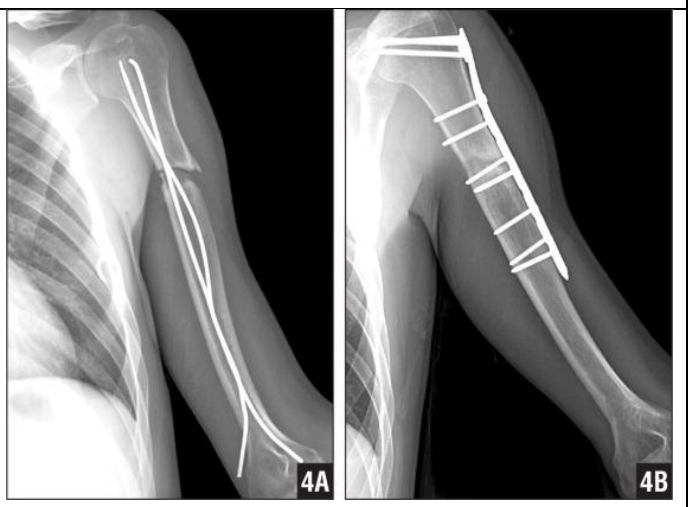
Dear Sir or Madam,

My name is Elisa Salas and I am a Doctor of Nursing Practice (DNP) student at the University of Maryland School of Nursing.
I am currently working on my DNP project proposal and I will be using the NLN/ Jeffries simulation theory for my project (both the proposal and if accepted the actual project). I would like to have permission to use the Diagram of the NLN Jeffries Simulation Theory.
This diagram is found as "FIGURE 3.1" on page 40 of the publication entitled "The NLN Jeffries Simulation Theory" which I purchased via Amazon this month. Pamela Jeffries is the book editor.
The ISBN number of the publication is as follows: 978-1-934758-24-3
Thank you for your consideration,
Elisa C. Salas, MSN, RN
University of Maryland School of Nursing.

Appendix C

Simulations in Medical Center Template

<table>
<tr><td>Title of Core Course
Nurse Residency Program:
Legal- Ethical Simulation
CANCER PATIENT ORIF of the right humerus</td><td>Created on: 10/06/ 2016
Revised on: 2/23/2017</td></tr>
<tr><td> 

http://www.irbsearchblog.com/ethics-vs-the-law-a-p-is-perspective/</td><td> 

Rosenbaum A, Uhl R. Nonunion of Humeral Shaft Fractures Following Flexible Nailing Fixation. ORTHOPEDICS. 2012; 35: 512-515. doi: 10.3928/01477447-20120525-08</td></tr>
<tr><td>Concepts: Nursing ethics code, ethical principles, laws, policies and procedures.</td><td>Patient Name: Jessica Ann Gardiano</td></tr>
<tr><td colspan="2">Nurse Residency Seminar Objectives:
Provide ethical care while adhering to the ethical principles stated in the ANA Code of Ethics
Demonstrate use of an ethical framework to facilitate decision making
Utilize institutional policies, procedures, and resources for handling complex ethical dilemmas.
Simulation Objectives:
Recognize the ethical issue or dilemma
Follow ethical principles when caring for the patient and their family
Use Chally and Loriz's (1998) framework to solve ethical issues at the bedside
Adhere to institutional policies</td></tr>
<tr><td colspan="2">Brief Overview: Patient's best friend brought her to the ER after the patient sustained a fall. Patient had a right humerus fracture that required surgical repair. The patient's only daughter, a college student, just arrived from Boston to be with her mother. The patient's best friend alerts the nursing staff that the patient, who recently had a lumpectomy and has started radiation therapy, has not told her family members that she has breast cancer. The patient does not want her daughter to know of this diagnosis.</td></tr>
<tr><td>Pre –simulation work:
Presentation on legal ethical content</td><td>Required skills needed:</td></tr>
<tr><td>QSEN Graduate Competencies
Analyze ethical and legal implications of patient-centered care.
Describe the limits and boundaries of therapeutic patient-centered care. Respect the boundaries of therapeutic relationships.
Acknowledge the tension that may exist between patient preferences and organizational and professional responsibilities for ethical care.
Facilitate informed patient consent for care.
Value shared decision-making with empowered patients and families, even when conflicts occur</td><td>Equipment needed:
Patient bed
Low fidelity mannequin
Moulage (arm bandages, radiation markings)
IV PCA (box only- can be turned off)
Smart phone
File folder with selected polices</td></tr>
</table>

American Academy of Colleges of Nursing/QSEN Education Consortium (2012). Graduate-Level QSEN Competencies Knowledge, Skills and Attitudes. Retrieved from: http://www.aacn.nche.edu/faculty/qsen/competencies.pdf	

Brief description of client

Name: Jessica Ann Gardiano

Gender: F **Age**: 48 **Race**: W **Weight**: 150 lbs **Height**: 168 cm.

Religion: Methodist

Major Support: Best friend - Anita Maddox (46), daughter Kelly (22). Parents and brother live out of state

Allergies: **NKDA** **Immunizations:** up to date

Primary Care Provider/Team: Orthopedics

Past Medical History: Anxiety, Breast CA, Lumpectomy of right breast.

History of Present Illness: Patient was recently diagnosed with Breast Cancer, undergoing radiation therapy. Patient became dizzy, fell, and tumbled down a flight of stairs. Patient suffered a fracture of the right humerus. Brought by ambulance accompanied by best friend.

Social History: Divorced. Currently head of Human Resources at large corporation. Has one daughter in College (out of State). Daughter drove from college when she heard of her mother's impending surgery. Patient and patient's friend reported to the nursing staff that the patient has not shared CA diagnosis with family members yet since patient wanted to wait until daughter had finished current semester in College.

Primary Medical Diagnosis: Fracture of right humerus.

Surgeries/Procedures & Dates: ORIF of right humerus- to PACU 4 hours ago, to floor 2 hours ago.

Pre-brief:

1. Ground rules/ confidentiality
2. Explain process (pre-brief, interact, debrief) NO RECORDING
3. Orientation to the simulation environment
4. Share simulation objectives
5. Provide nurses with simulation objectives
6. Allow nurses to ask questions regarding objectives and expectations

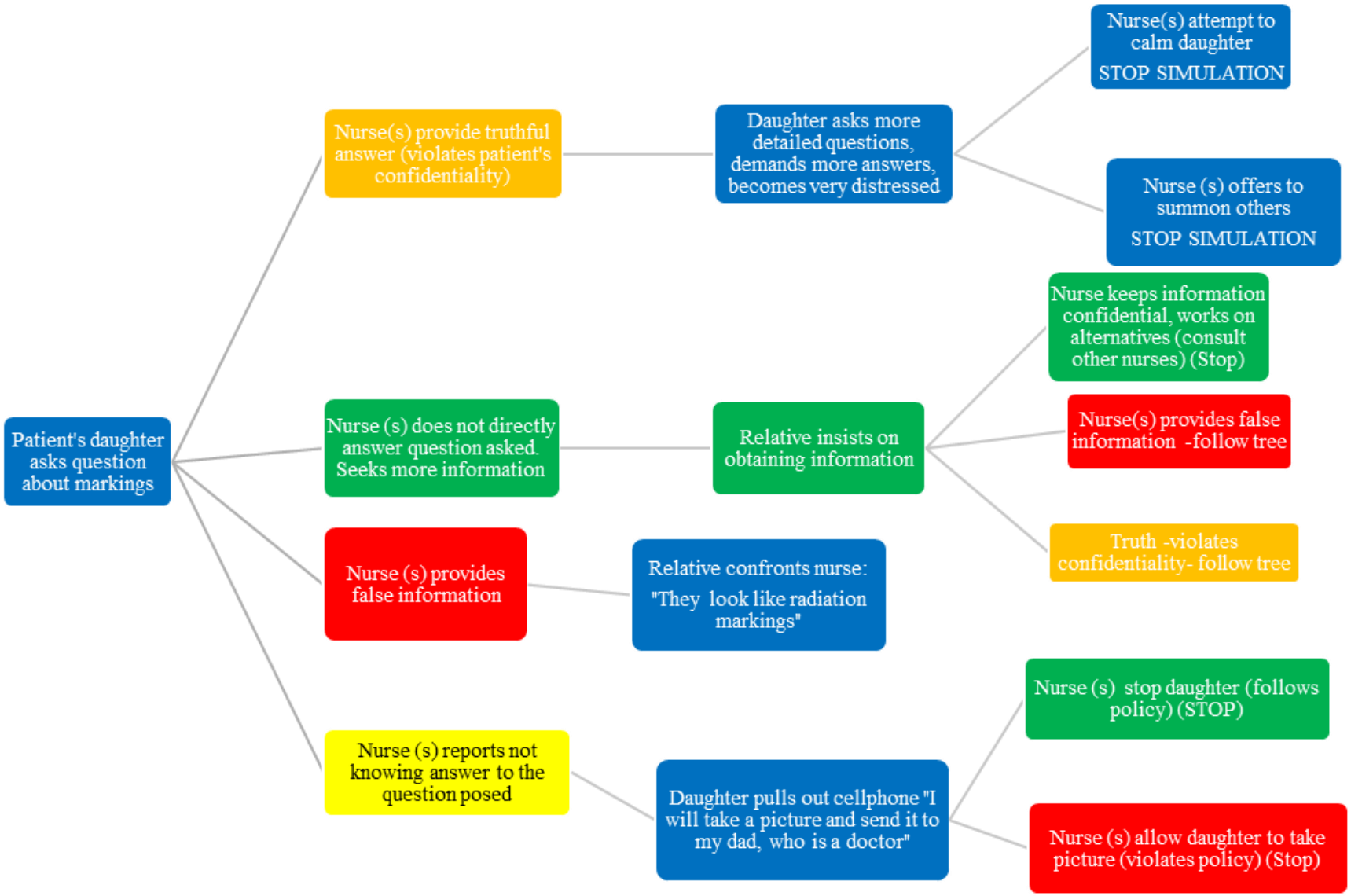
Interaction:

1. Distribute roles, tags, and cue cards
2. Honor role preference if possible
3. Read this information to all participants (also found in facilitator's handout.
   "Jessica Ann Gardiano is a 48-year-old divorced Caucasian female who works at a large corporation as the head of Human Resources. Mrs. Gardiano was recently diagnosed with breast cancer, had a lumpectomy of the right breast, and had just begun radiation therapy. This morning the patient tripped, fell, and tumbled down a flight of stairs at her home. Her best friend brought her to the hospital where she was diagnosed with a fracture of the right humerus. She had an ORIF of the right humerus at noon, came to the unit at 1700 (two hours ago). She is currently stable and her pain is controlled with an IV PCA. The patient's daughter, Kelly (22), just arrived from Boston, where she attends school, so the patient's best friend, Anita (46), just left.
   Although the patient's best friend knows that the patient had a lumpectomy and is receiving radiation for breast CA, the patient has NOT YET shared her CA diagnosis with any of her family members."
4. Answer questions
5. Allow participants a few minutes to plan their actions

Debrief:

1. Stop simulation when participants meet or attempt to meet objectives (see algorithm)
2. Take students to classroom
3. Reinstate ground rules and expectations (respect, confidentiality)
4. Use Szyld and Rudolph's (2013) "Debriefing for good judgment framework"
5. Debrief in order: reaction phase, analysis phase, and summary phase

Suggested Algorithm



PRE- BRIEFING

Legal-ethical Simulation- Medical Center Hospital

1. Ground rules/ confidentiality
2. Explain process (pre-brief, interact, debrief) NO RECORDING
3. Orientation to the simulation environment
4. Orient to room:
    a. If manikin present- describe level of fidelity (ei, chest movement can be observed/ injection can be administered in pad)
    b. Describe roles and availability: ("The charge nurse may be consulted, summoned to come to the room, asked to look up policies).
5. Answer questions

Simulation Objectives:

1. Recognize the ethical issue or dilemma
2. Follow ethical principles when caring for the patient and their family
3. Use Chally and Loriz's (1998) framework:
    a. Clarify the issue
    b. Seek more information
    c. Identify options
    d. Decide/ Act
    e. Evaluate
4. Adhere to institutional policies

Chally, P. S., & Loriz, L. (1998). Decision making in practice. *American Journal Of Nursing*, *98*(6), 17

INTERACTION

Legal-ethical Simulation- Medical Center Hospital

Jessica Gardiano

Distribute roles- be flexible and allow participants to volunteer.

Jessica: (standardized patient- if not available, facilitator can voice manikin)

Kelly: (standardized participant- daughter)

Incoming nurse

Outgoing nurse

Charge nurse

Staff nurses (observers)

Read this report to the entire group.

Jessica Ann Gardiano is a 48-year-old divorced Caucasian female who works at a large corporation as the head of Human Resources. Mrs. Gardiano was recently diagnosed with breast cancer, had a lumpectomy of the right breast, and had

just begun radiation therapy. This morning the patient tripped, fell, and tumbled down a flight of stairs at her home. Her best friend brought her to the hospital where she was diagnosed with a fracture of the right humerus. She had an ORIF of the right humerus at noon, came to the unit at 1700 (two hours ago). She is currently stable and her pain is controlled with an IV PCA.

The patient's daughter, Kelly (22), just arrived from Boston, where she attends school, so the patient's best friend, Anita (46), just left.

Although the patient's best friend knows that the patient had a lumpectomy and is receiving radiation for breast CA, the patient has NOT YET shared her CA diagnosis with any of her family members.

- Answer questions or clarify doubts
- Allow a few minutes for participants to read cards and prepare.

DEBRIEFING

Legal-ethical Simulation- Medical Center Hospital

Jessica Ann Gardiano

1. Take students to classroom. Emphasize respect and confidentiality
2. Be curious, give feedback, but do not try to "fix" the participants

Reaction phase.

How did the situation made you feel?
What is one word that could describe your feelings?
What was Kelly's story?
How would you explain this experience to others?

Analysis phase

I noticed that you (point out participant action). Can you explain your thinking?
What went well during this experience?
What did not seem to work as well as expected?
What could be done differently?"

Summary-

- Option one- open discussion to share insights: *How about each of you share with the group something you learned, realized, or applied today*
- Option two- solicit and reinforce "take away" points: *Let's take a moment to write down one 'take away' from this experience and then share it with the group*

Adapted from: Szyld, D., & Rudolph, J. W. (2013). Debriefing with good judgment. In A. I. Levine et al. (Eds.), *The Comprehensive Textbook of Healthcare Simulation* (pp 85-93). New York, NY: Spring Science+ Business Media.

Outgoing Nurse	Your job is to give patient hand off report outside the room. Then you come into the room to introduce patient and family to incoming nurse. **Read the script provided for your report** Do not leave the unit until simulation is completed
Incoming Nurse	Listen to report and take notes. If you face an ethical issue, follow the framework as indicated. 1. Clarify the dilemma 2. Gather additional information 3. Identify options 4. Make a decision 5. Act 6. Evaluate Remember to ask for help as needed
Staff Nurse	You are sitting at the nurse's station. Pay attention to the interactions. If you are asked for help, get involved. If you think you can help, get involved
Charge Nurse	You are sitting at the nurse's station. You can "look up" hospital policies (you will have them in a folder available to you). You may assist and/or get involved as indicated
Staff Nurse	You are sitting at the nurse's station. Pay attention to the interactions. If you are asked for help, get involved. If you think you can help, get involved.

(Expand and laminate as desired)

OUTGOING NURSE REPORT

Legal-ethical Simulation- Medical Center Hospital

Nurse caring for: Jessica Ann Gardiano

Let's do hand off away from the door- I don't want the patient's daughter to hear us. Mrs. Gardiano, had an ORIF of the right humerus today. She is 48, divorced, and recently diagnosed with breast cancer, had a right breast lumpectomy a few weeks ago and either just started – or she is about to start radiation therapy. The report was not very clear and I have not been able to ask the patient. Her best friend just left but told me- this is very important- that her daughter was about to come in and that the daughter has not been told of the mother's diagnosis of breast cancer. Apparently the daughter is a college student in Boston and the mother did not want to give her the news until she finished the semester. Well, the daughter arrived about 20 minutes ago.

At any rate, the story is that she tripped this morning at the top of the stairs and tumbled all the way down, fracturing her right arm. Her friend brought her over and they decided to do the ORIF. When she came in she was a bit groggy, but complaining of arm pain (about 4 to 5). I did some more PCA education and last time I checked she said pain was down to a 2. Her right arm is wrapped, bandages no drainage on the bandages. . Vital stable, breath sounds clear. I just updated the PCA documentation and did a neurovascular check. Right hand and fingers are warm, have sensation, not swollen, pink and with good capillary refill. Let's go in.

NURSING SHIFT REPORT

Acct# 0000013884 MR# SA00001176 F Room/ Bed:S5504-1 DOB:01/27/1969 Admit Date: 2/27/2017 Printed: 2/28/2017

Name: **Gardiano, Jessica A** (Simulation)**F 48** Attending (Flannery- Ortho) Code Status Full Weight (kg): 58 Height (in): 69

Diagnosis: ORIF right Humerus **Marital Status:** D Diet: NPO

Restraints: N Fall score: Nutr. Score: Pain Score **Braden Score: 23**

Isolation/ Reason: **Activity: BR** **Ability:**

History of Violent Incident by:

PAST MEDICAL HISTORY

Cardiac -
GU-
Resp-
Seizure-
Communicable Dx-
Surgery-Y
Smoker-Y

Endo-
GI-
Neuro-
Cancer- Y
Blood disorder-
Other Hx-

HEENT-
Mus/Skel-
Psych-
Sleep Dx-
GYN-

History of falls this admission: Y
ALLERGIES AND REACTIONS: NKDA

IV Access: 1) Type/ Size PIV 18g Site LUE Fluids D5LR 100 ml/hr 2) Type/ Size_____ Site_____ Fluids_____

Intake Total: _____ Output total: _____ Drains_____

VITALS: Frequency **Q4.** Time 1600 Temp (F)- 98.1 oral Pulse- 90 Resp- 20 BP- 130/82 P.Ox-98% R/A

TESTS, TREATMENTS & LABS:

MEDS NOT ADMINISTERED:

ASSESSMENT

NEURO:

RESP:

CARDIAC:

GI/GU/GYN:

SKIN/WOUND:

MUS/SKEL:

PAIN:

HEENT:

NEUROMUSCULAR:

PYCH:

OTHER:
EDUCATION/DISCHARGE PLANNING:

Medical Center Hospital- Department of Education and Research

Participant directions
Legal-ethical Simulation- Medical Center Hospital

Jessica Gardiano

Patient- *Jessica Gardiano: Manikin- low fidelity. Pain under control, finally sleeping.*

Daughter*- Kelly Ann Allen: 22, single, Junior at Boston College.*

Jessica Ann's only child. Father, Brad Allen, is plastic surgeon who is remarried, has two young sons, lives out of state, but is very involved in Kelly's life. Kelly does not have a romantic relationship at the moment.
Concerns: Has applied to top graduate school programs seeking a professional degree.

Demeanor: Worried about her mother's accident and subsequent surgery. Mother has been in great health and is physically fit, so the news of a fall and a fracture were surprising and unexpected. Kelly is very intelligent. Very respectful and polite, but able to read people well. Although not confrontational, Kelly expects others to treat her with respect.

Although both parents have doted on Kelly, Kelly is realistic, self-sufficient, and independent. Kelly has been traveling on her own to see her father since her parents divorced when she was 12 years old.
Kelly does not have any health care background and has never had any surgeries, other than having her wisdom teeth extracted when she was 16 years old. As far as she knows, her mother has never had surgery before and since all her grandparents live out of state, she only visited a hospital when her stepmother had the twins. However, Kelly is well read and has a wide network of friends.

<table>
<tr><td>Title of Core Course
Nurse Residency Program:
Legal- Ethical Simulation
Pneumonia Patient</td><td>Created on: 10/06/ 2016
Revised on: 2/21/2017</td></tr>
<tr><td> 
https://openclipart.org/detail/26849/scales-of-justice</td><td> 
By Jtechr - Own work, CC BY-SA 3.0, https://commons.wikimedia.org/w/index.php?curid=17385153</td></tr>
<tr><td>Concepts: Nursing ethics code, ethical principles, laws, policies and procedures</td><td>Patient Name: Dorothy Elizabeth Woodford</td></tr>
<tr><td colspan="2">Nurse Residency Seminar Objectives:
Provide ethical care while adhering to the ethical principles stated in the ANA Code of Ethics
Demonstrate use of an ethical framework to facilitate decision making
Utilize institutional policies, procedures, and resources for handling complex ethical dilemmas.
Simulation Objectives:
Recognize the ethical issue or dilemma
Follow ethical principles when caring for the patient and their family
Use Chally and Loriz’s (1998) framework to solve ethical issues at the bedsie
Adhere to institutional policies</td></tr>
<tr><td colspan="2">Brief Overview: Admitted to the hospital with CAP. This patient had a negative experience with anticoagulants in the distant past, so she refuses to take them. However, the patient’s daughter has been authorizing the subcutaneous injections since the patient has been too sick to be fully aware of her surroundings. The patient’s condition is improving and the patient is becoming more aware. Right before the anticoagulant is going to be injected, the patient’s daughter request that her mother NOT be told that the injection is an anticoagulant. The daughter explains that her mother will refuse the medication if she knows what it is, but if the patient is not told, the patient will not refuse it. The records reflect that the patient has received the injection since she was admitted.</td></tr>
<tr><td>Pre –simulation work:
Attendance to the legal ethical presentation</td><td>Required skills needed:
Subcutaneous injection</td></tr>
<tr><td>QSEN Graduate Competencies
Analyze ethical and legal implications of patient-centered care.
Describe the limits and boundaries of therapeutic patient-centered care.
Respect the boundaries of therapeutic relationships.
Acknowledge the tension that may exist between patient preferences and organizational and professional responsibilities for ethical care. Facilitate informed patient consent for care.
Value shared decision-making with empowered patients and families, even when conflicts occur.

American Academy of Colleges of Nursing/QSEN Education Consortium (2012). Graduate-Level QSEN Competencies Knowledge, Skills and Attitudes. Retrieved from: http://www.aacn.nche.edu/faculty/qsen/competencies.pdf</td><td>Equipment needed:
• Low fidelity manikin
• Injection pad
• Syringe, alcohol, and hypodermic needle
• MAR prop
• Heparin vial
• Nasal cannula
• Saline lock
• File folder with selected policies</td></tr>
</table>

Brief description of client: Dorothy "Dot" Elizabeth Woodford

Gender: F **Age**: 68 **Race**: W **Weight**: 161 lbs **Height**: 160 cm.

Religion: Catholic

Major Support: Children: Brandon (42), Adam (40), David (36), Arthur (34), and Daniella "Dani" (31)

Allergies: **PCN** **Immunizations:** up to date

Primary Care Provider/Team: Hospitalist

Past Medical History: Hypercholesteremia, hypothyroidism, Type 2 NIDD, hypertension, complicated septic pelvic thrombophlebitis after last vaginal delivery (31 years ago). **Past surgical history:** Tibia and fibula compound fracture (from motorcycle accident) 50 years ago, Total abdominal hysterectomy 20 years ago, open cholecystectomy 10 years ago.

History of Present Illness: Brought in by ambulance two days ago when son went to mother's house to check on her because she had called complaining of cough and not feeling well for the prior two days. Chest x-ray on admission revealed bilateral lung infiltrates.

Social History: Widower- husband died 3 years ago due to massive stroke. Patient teaches history at local community college. Lives at home alone. Son David and daughter Dani live in the area.

Primary Diagnosis: Bacterial pneumonia **Surgeries/Procedures & Dates:** Peripheral IV on admission.

Pre-brief:

7. Ground rules/ confidentiality
8. Explain process (pre-brief, interact, debrief) NO RECORDING
9. Orientation to the simulation environment
10. Share simulation objectives
11. Provide nurses with simulation objectives
12. Allow nurses to ask questions regarding objectives and expectations

Interaction:

6. Distribute roles, tags, and cue cards
7. Honor role preference if possible
8. Read this information to all participants (also found in facilitator's handout)
   "Mrs. Dorothy Woodford is a 68 year old widower who was BIBA in the afternoon two days ago. Her son went to check on the Ms. Woodford after talking to her on the phone. At the time the patient reported persistent cough, difficulty breathing, and being so tired that she felt she could not walk up the stairs. When her son came in he found her pale, lethargic, and complaining of feeling extremely weak.
   Chest ray on admission revealed bilateral lung infiltrates. She has diagnosed with bacterial pneumonia and was admitted for IV ABX, IV fluids, and oxygen therapy. Mrs. Woodford has a past medical history of hypothyroidism, Type 2 NIDD, HTN, hypercholesteremia, and a leg fracture in her youth. Surgical history includes a total abdominal hysterectomy and an open cholecystectomy.
   Her overall condition has improved: her breathing is less labored, her oxygen saturation is stable on 3 LPM via NC, her lungs still have some scattered crackles, and she still complains of feeling very tired. She is groggy but she is A and O x 4. She is a widower, teaches at the local community college, and lives alone at home. Two of her five children live locally and have been taking turns to stay with her. The patient's son just left and her daughter just arrived and plans to stay overnight.
   (Note to facilitator: hospital personnel were not told about the history of septic thrombophlebitis- those caring for the patient do not have this information- Do not share with nurse residents)
9. Answer questions
10. Allow participants a few minutes to plan their actions

Debrief:

6. Stop simulation when participants meet or attempt to meet objectives (see algorithm)
7. Take students to classroom
8. Reinstate ground rules and expectations (respect, confidentiality)
9. Use Szyld and Rudolph's (2013) "Debriefing for good judgment framework"
10. Debrief in order: reaction phase, analysis phase, and summary phase

Suggested Algorithm

PRE- BRIEFING

Legal-ethical Simulation- Medical Center Hospital

6. Ground rules/ confidentiality
7. Explain process (pre-brief, interact, debrief) NO RECORDING
8. Orientation to the simulation environment
9. Orient to room:
    a. If manikin present- describe level of fidelity (ei, chest movement can be observed/ injection can be administered in pad)
    b. Describe roles and availability: ("The charge nurse may be consulted, summoned to come to the room, asked to look up policies).
10. Answer questions

Simulation Objectives:

5. Recognize the ethical issue or dilemma
6. Follow ethical principles when caring for the patient and their family
7. Use Chally and Loriz's (1998) framework:
    f. Clarify the issue
    g. Seek more information
    h. Identify options
    i. Decide/ Act
    j. Evaluate
8. Adhere to institutional policies

Chally, P. S., & Loriz, L. (1998). Decision making in practice. *American Journal Of Nursing*, *98*(6), 17

INTERACTION

Legal-ethical Simulation- Medical Center Hospital

Dorothy Woodford

Distribute roles- be flexible and allow for participants to volunteer.

Dot: (standardized patient- if not available, facilitator can voice manikin)

Dani: (standardized participant- daughter)

Incoming nurse

Outgoing nurse

Charge nurse

Staff nurses (observers)

Read this report to the entire group.

Mrs. Dorothy Woodford is a 68 year old widower who was BIBA in the afternoon two days ago. Her son went to check on the Ms. Woodford after talking to her on the phone. At the time the patient reported persistent cough, difficulty breathing, and being so tired that she felt she could not walk up the stairs. When her son came in he found her pale, lethargic, and complaining of feeling extremely weak.
Chest ray on admission revealed bilateral lung infiltrates. She has diagnosed with bacterial pneumonia and was admitted for IV ABX, IV fluids, and oxygen therapy. Mrs. Woodford has a past medical history of hypothyroidism, Type 2 NIDD, HTN, hypercholesteremia, and a leg fracture in her youth. Surgical history includes a total abdominal hysterectomy and an open cholecystectomy.
Her overall condition has improved: her breathing is less labored, her oxygen saturation is stable on 3 LPM via NC, her lungs still have some scattered crackles, and she still complains of feeling very tired. She is groggy but she is A and O x 4. She is a widower, teaches at the local community college, and lives alone at home. Two of her five children live locally and have been taking turns to stay with her. The patient's son just left and her daughter just arrived and plans to stay overnight.
(Note to facilitator: hospital personnel were not told about the history of septic thrombophlebitis- those caring for the patient do not have this information- Do not share with nurse residents)

Answer questions or clarify doubts

Allow a few minutes for participants to read cards and prepare.

DEBRIEFING

Legal-ethical Simulation- Medical Center Hospital

Dorothy E. Woodford

1. Take students to classroom. Emphasize respect and confidentiality
2. Be curious, give feedback, but do not try to "fix" the learners

Reaction phase.

How did the situation made you feel?
What is one word that could describe your feelings?
What was Dani's story?
How would you explain this experience to others?

Analysis phase

I noticed that you …… Can you explain your thinking?
What went well during this experience?
What did not seem to work as well as expected?
What could be done differently?"

Summary-

- Option one- open discussion to share insights: *How about each of you share with the group something you learned, realized, or applied today*

- Option two- solicit and reinforce "take away" points: *Let's take a moment to write down one 'take away' from this experience and then share it with the group*

Adapted from: Szyld, D., & Rudolph, J. W. (2013). Debriefing with good judgment. In A. I. Levine et al. (Eds.), *The Comprehensive Textbook of Healthcare Simulation* (pp 85-93). New York, NY: Spring Science+ Business Media.

Outgoing Nurse	Your job is to give patient hand off report outside the room. Then you come into the room to introduce patient and family to incoming nurse. **Read the script provided for your report** Do not leave the unit until simulation is completed
Incoming Nurse	Listen to report and take notes. If you face an ethical issue, follow the framework as indicated. 7. Clarify the dilemma 8. Gather additional information 9. Identify options 10. Make a decision 11. Act 12. Evaluate Remember to ask for help as needed
Staff Nurse	You are sitting at the nurse's station. Pay attention to the interactions. If you are asked for help, get involved. If you think you can help, get involved
Charge Nurse	You are sitting at the nurse's station. You can "look up" hospital policies (you will have them in a folder available to you). You may assist and/or get involved as indicated
Staff Nurse	You are sitting at the nurse's station. Pay attention to the interactions. If you are asked for help, get involved. If you think you can help, get involved.

(Expand and laminate as desired)

OUTGOING NURSE REPORT

Legal-ethical Simulation- Medical CenterHospital

Nurse caring for: Dorothy E. Woodford

Mrs. Woodford, 68, pneumonia. Admitted evening before yesterday. On IV ABX. Hx. of HTN, hypothyroidism, type 2 DM. Alert and oriented, still very weak. Her breathing is still a bit labored, but her breath sounds have improved compared to this morning. She had a neb treatment one hour ago, but she still had some scattered crackles throughout. Oxygen saturation has remained 92 to 94 on 3 LPM via nasal cannula. Her vital signs have been within acceptable limits today, except for her respiratory rate, which remains 20-24. Last temperature spike was last night at midnight, but she has been afebrile all day for me. She has only eaten about 30% of her meals, has not had a BM during this admission. Her glucose levels have been normal, she has not required any sliding scale insulin. She has not had difficulty urinating, but she has been using the bedpan (she has a BSC but refuses to get out of bed). She has a 20 gauge in her right arm. She is receiving NS at 100 cc/hr., no swelling or redness. Next dose of Levaquin is due at 2100. She was due for SQ heparin one hour ago but pharmacy just sent it up. I got tied up with my last admission so I have not given it. I got it right here- Can you please administer it?

NURSING SHIFT REPORT

Acct# 0000013290 MR# SA 00001191 F Room/ Bed:S5505-1 DOB: 02/01/1949 Admit Date: 2/27/2017 Printed: 2/28/2017

Name: **Woodford, Dorothy E.** (Simulation)**F 68** Attending: Grossman Code Status Full Weight (kg):73 Height (in): 64

Diagnosis: Pneumonia (CAP) **Marital Status:** W **Diet:** Controlled CHO

Restraints: N Fall score: Nutr. Score: Pain Score **Braden Score: 21**

Isolation/ Reason: **Activity: BSC** **Ability:**

History of Violent Incident by:

PAST MEDICAL HISTORY

Cardiac – HTN, Hyperlipedemia
GU-
Resp-
Seizure-
Communicable Dx-
Surgery-Y
Smoker-Y

Endo- T2DM, Hypothyroidism
GI- Cholecystectomy
Neuro-
Cancer-
Blood disorder-
Other Hx-

HEENT-
Mus/Skel-
Psych-
Sleep Dx-
GYN- Total ABD Hysterectomy

History of falls this admission: N
ALLERGIES AND REACTIONS: PCN

IV Access: 1) Type/ Size: PIV 20g lock Site: RUE Fluids: saline lock 2) Type/ Size_____ Site_____ Fluids_____

Intake Total: _____ Output total: _____ Drains_____

VITALS: Frequency **Q4.** Time 1600 Temp (F)- 99.1 oral Pulse- 99 Resp- 20 BP- 130/82 P.Ox-92% 3L NC

TESTS, TREATMENTS & LABS:

MEDS NOT ADMINISTERED:

ASSESSMENT

NEURO:

RESP:

CARDIAC:

GI/GU/GYN:

SKIN/WOUND:

MUS/SKEL:

PAIN:

HEENT:

NEUROMUSCULAR:

PYCH:

OTHER:
EDUCATION/DISCHARGE PLANNING:

Participant directions
Legal-ethical Simulation- Medical Center Hospital

Dorothy Woodford

Patient- Dorothy Woodford: The last time you felt this terrible was after delivering Dani, when you had an infection and a blood clot. You are sure that back then, someone in the hospital gave you an overdose of blood thinners and you started to bleed profusely. Even though this happened 31 year ago, you still remember this experience as the most terrifying in your life. **You will NOT allow anyone to give you anticoagulants**. You have limited trust in hospitals, doctors, and nurses.

Daughter- Dani: 31 year-old. Owns local floral shop. Catholic, married lives with husband. Ready to have a family.

Demeanor: Dani is very pleasant and as the family's only daughter, very close to her mother. Despite being the youngest, she believes that because of her gender and because she lives locally, she will be the major decision maker regarding her mother's health. During this hospitalization, she has assumed the role of the decision maker even though her mother is not incapacitated or confused, just extremely fatigued.

Dani remembers that after her mother's last surgery (a scheduled laparoscopic cholecystectomy that turned into an open cholecystectomy 10 years ago) her mother adamantly refused to receive injectable anticoagulants. At the time, Dot related the "ordeal" that she had endured the day after Dot gave birth to Dani. Dot had been diagnosed with pelvic septic thrombophlebitis and given antibiotics and intravenous heparin. There had been a medication administration error and Dot had experienced severe hemorrhage as a result. Dot had to be transferred to the intensive care unit where she remained for a few days.

Dani has heard that blood clots can kill someone. Although she understands her mother's fears, she also knows that the mother will not change her mind on the anticoagulant. Dani believes that the best course of action is to have the nurses administer the anticoagulant without letting her mother know. So far, her mother has received the injections twice.

Appendix D

Initial Meeting with Educators

Seminar Objectives*	**Presentation Objectives**	**Simulation objectives**
1. Adhere to the ethical principles stated in the ANA Code of ethics when providing care and making ethical decisions in the clinical setting	Define concepts surrounding legal and ethical issues in nursing Identify ethical principles that guide nursing practice	Recognize the ethical issue or dilemma
2. Use a model framework to facilitate ethical decision making in dilemmas that may be encountered in the clinical setting	Recognize steps used in the Chally and Loriz's (1998) framework for everyday ethical decision making at the bedside	Clarify the issue Seek more information from patient and/or family as needed Consult with other nurses as needed /Identify options Make a decision / Act (Chally & Loriz,1998)
3. Analyze and implement approaches to resolving selected ethical problems		
4. Utilize institutional policies, procedures, and resources for handling complex ethical dilemmas	Locate resources that may be utilized for ethical decision making	Adhere to institutional policies
5. Take action to prevent or limit unsafe or unethical health and nursing care practices by self or others		Follow ethical principles when caring for the patient and their family

*Seminar objectives are from UHC/ AACN (2015) p. 6.

References

Chally, P. S., & Loriz, L. (1998). Ethics in the trenches: Decision making in practice. *American Journal Of Nursing*, *98*(6), 17

University HealthSystem Consortium [UHC] & American Association of Colleges of Nursing. (2008). Nurse Residency program executive summary. Retrieved from http://www.aacn.nche.edu/leading-initiatives/education-resources/NurseResidencyProgramExecSumm.pd

(Letter for Nurse Educators if unable to meet one on one)

February 14, 2017

Good morning,

My name is Elisa Salas and I am a University of Maryland DNP student. As you may already know, I have been working with (Name, NRC) since June 2016. I will be implementing my DNP project at St. Agnes in the following months, so I wanted to keep you informed on the project implementation process.

First, I wanted to assure you that this project is being conducted with the required permission. Dr. (Name, director), who is a member of my project committee, has approved the project implementation proposal. I will be working very closely with (Name, NRC) and (Name, SLC), both of whom are part of my implementation team. Since the project will be implemented as part of the nurse residency program, other educators in the department may be involved.

The project consists of two simulations that address legal ethical issues that nurses may face during daily care. These simulations will be preceded by a brief presentation on legal-ethical content to review the concepts that students will need to successfully complete the simulation. I will present the framework to solve ethical issues in practice that was developed by Chally and Loriz (1998) because of its simplicity and applicability to bedside issues. The presentation and the simulations are designed to address the objectives from the Vizient/AACN seminar. The table attached shows how the objectives inter-relate.

This week we will be doing a practice run of the simulations and making the last few changes as needed. I will send the content of the presentation and the simulation templates via email to all the members of the Department of Education and Research at (Medical Center). On February 28, cohort 12 will participate in the simulations. On Friday March 10, I will hold a training session for all the nurse educators. If you are not able to attend, I will provide you with all the supporting material. On April 26, (NRC and SLC) will run the simulations with cohort 13 while I assist as needed.

Residents on both cohorts will take a test on legal and ethical issues and complete a satisfaction and self-confidence in learning questionnaire. The questionnaires will not contain any identifying information and will be kept in a locked box to protect participant confidentiality. Once all the data is analyzed, results will be shared with (NRC and Director).

Please do not hesitate to contact me if you have any questions or concerns. My contact information is below.

Elisa C. Salas, UMB DNP student
elisa.salas@umaryland.edu
(859) 420-4274

Thank you,

Elisa S.

Appendix E

Legal-Ethical Test Pre and Post Test Key

Instructions: Please enter a random six-digit number. Numbers should not all be the same digit (555555) or sequential (123456). *Example: 324100*

Number: _____

Please circle the correct answer. Example: ©

1. A federal law must be observed:

    a. Only in hospitals that receive state assistance
    b. **In every hospital**
    c. Only in federal institutions
    d. Only in public hospitals

2. An ethical dilemma occurs when:

    a. A law and a personal belief are opposed
    b. There is a conflict involving ethical principles
    c. The ethical issue is difficult for the nurse
    d. An issue involves ethics

3. When a patient refuses care and the nurse respects the decision, the nurse adheres to the principle of:

    a. Beneficence
    b. Autonomy
    c. Veracity
    d. Nonmaleficence

4. When the nurse takes steps to avoid causing harm to a patient, the nurse adheres to the principle of:

    a. Beneficence
    b. Veracity
    c. Nonmaleficence
    d. Fidelity

5. When a nurse refrains from sharing information with a patient's family member at the patient's request, the nurse adheres to the principle of:

a. Fidelity
b. Autonomy
c. Veracity
d. Beneficence

6. To facilitate ethical decision making while providing care, the nurse starts by:

a. Clarifying the issue
b. Consulting the hospital chaplain
c. Recalling past personal experiences
d. Evaluating the decision

7. After identifying possible options for resolving an ethical issue the nurse:

a. Reports the issue to the charge nurse
b. Clarifies the issue
c. Makes a decision
d. Gathers more data

8. When faced with a complex ethical dilemma involving a patient, the nurse:

a. Finds the hospital mission
b. Contacts social services
c. Refers to Case Management
d. Considers consulting the ethics committee

9. The nurse can learn about the law that regulates nursing practice in Maryland in the:

a. ANA code of ethics
b. Maryland Nurse Practice Act
c. Hospital policies and procedures
d. Employee handbook

10. The nurse needs to review a specific hospital policy. The nurse:

a. Calls the physician
b. Checks the hospital website
c. Calls human resources
d. Consults their manager

Appendix F

Legal-Ethical Test Blue Print

Objective	Content	Time spent (min)	# of items	Questions	Readable	Fit
Define concepts surrounding legal and ethical issues in nursing	**Ethical** Issues Problems • Distress • Dilemma **Legal** Federal State Institutional	2	2	An ethical dilemma occurs when: a. A law and a belief are opposed **b. There is a conflict involving ethical principles** c. The ethical issue is difficult for the nurse d. An issue involves ethics A federal law must be observed: a. Only in hospitals that receive state assistance **b. In every hospital** c. Only in federal institutions d. Only in public hospitals		
Identify ethical principles that guide nursing practice	**Respect for persons** • Autonomy • Beneficence • Nonmaleficence • Fidelity • Veracity	3	3	When a patient refuses care and the nurse respects the decision, the nurse adheres to the principle of: a. Beneficence **b. Autonomy** c. Veracity d. Nonmaleficence When the nurse takes steps to avoid causing harm to a patient, the nurse adheres to the principle of: a. Beneficence b. Veracity **c. Nonmaleficence** d. Fidelity When a nurse refrains from sharing information with a patient's family member at the patient's request, the nurse adheres to the principle of: **a. Fidelity** b. Autonomy c. Veracity d. Beneficence		

Recognize steps used in the Challis & Loriz's (1998) framework for everyday ethical decision making at the bedside	• Clarify the issue • Gather additional data • Identify options • Make a decision • Act • Evaluate	2	2	To facilitate ethical decision making while providing care, the nurse starts by: **a. Clarifying the issue** b. Consulting the hospital chaplain c. Recalling past personal experiences d. Evaluating the decision After identifying possible options for resolving an ethical issue the nurse: a. Reports the issue to the charge nurse b. Clarifies the issue **c. Makes a decision** **d.** Gathers more data		
Locate resources that may be utilized for ethical decision making	**ANA Code of Ethics** **Maryland Nurse Practice Act** **Hospital website** **Ethics committee**	3	3	When faced with a complex ethical dilemma involving a patient, the nurse: a. Finds the hospital mission b. Contacts social services c. Refers to Case Management **d. Considers consulting the ethics committee** The nurse can learn about the law that regulates nursing practice in Maryland in the: a. ANA code of ethics **b. Maryland Nurse Practice Act** c. Hospital policies and procedures d. Employee handbook The nurse needs to review a specific hospital policy. The nurse: a. Calls the physician **b. Checks the hospital website** c. Calls human resources d. Consults their manager		

Note: Earlier versions of the test blue print where experts assessed readability and fit are not included. Questions included in this blue have feedback and suggestions integrated. Edited questions above were deemed readable and a good fit by all three experts

Appendix G

Legal Ethical Decision Making Presentation

Presentation objectives

- Define concepts surrounding legal and ethical issues in nursing
- Identify ethical principles that guide nursing practice
- Recognize steps used in the Challis & Lauris (1998) framework for everyday ethical decision making at the bedside
- Locate resources that may be utilized for ethical decision making

Legal and Ethical Concepts

- Laws
  - Federal
  - State
  - Institutional
    - Policies
    - Procedures
- Ethical Issue
- Ethical problem
  - Distress
  - Dilemma

Ethical Principles in Nursing

- Respect for human persons
  - Autonomy
  - Beneficence
  - Non-maleficence
  - Veracity
  - Fidelity

Ethical Decision Making Framework*

- Clarify the issue or dilemma
- Gather additional data
- Identify options
- Make a decision
- Act
- Evaluate

* Chally & Lorlz, 1998

Resources

- American Nurses Association (ANA) Code of ethics http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html
- Maryland Nurse Practice Act http://mbon.maryland.gov/Pages/nurse-practice-act.aspx
- Hospital website
  - Policies
  - Procedures
- Ethics committee

Appendix H

Student Satisfaction and Self-Confidence in Learning

Instructions: This questionnaire is a series of statements about your personal attitudes about the instruction you receive during your simulation activity. Each item represents a statement about your attitude toward your satisfaction with learning and self-confidence in obtaining the instruction you need. There are no right or wrong answers. You will probably agree with some of the statements and disagree with others. Please indicate your own personal feelings about each statement below by marking the numbers that best describe your attitude or beliefs. Please be truthful and describe your attitude as it really is, not what you would like for it to be. This is anonymous with the results being compiled as a group, not individually.

Mark:

1 = STRONGLY DISAGREE with the statement
2 = DISAGREE with the statement
3 = UNDECIDED - you neither agree or disagree with the statement
4 = AGREE with the statement
5 = STRONGLY AGREE with the statement

Satisfaction with Current Learning	**SD**	**D**	**UN**	**A**	**SA**
1. The teaching methods used in this simulation were helpful and effective.	1	2	3	4	5
2. The simulation provided me with a variety of learning materials and activities to promote my learning the medical surgical curriculum.	1	2	3	4	5
3. I enjoyed how my instructor taught the simulation.	1	2	3	4	5
4. The teaching materials used in this simulation were motivating and helped me to learn.	1	2	3	4	5
5. The way my instructor(s) taught the simulation was suitable to the way I learn.	1	2	3	4	5
Self-confidence in Learning	**SD**	**D**	**UN**	**A**	**SA**
6. I am confident that I am mastering the content of the simulation activity that my instructors presented to me.	1	2	3	4	5
7. I am confident that this simulation covered critical content necessary for the mastery of medical surgical curriculum.	1	2	3	4	5
8. I am confident that I am developing the skills and obtaining the required knowledge from this simulation to perform necessary tasks in a clinical setting	1 ○	2	3	4	5
9. My instructors used helpful resources to teach the simulation.	1	2	3	4	5
10. It is my responsibility as the student to learn what I need to know from this simulation activity.	1	2	3	4	5
11. I know how to get help when I do not understand the concepts covered in the simulation.	1	2	3	4	5
12. I know how to use simulation activities to learn critical aspects of these skills.	1	2	3	4	5
13. It is the instructor's responsibility to tell me what I need to learn of the simulation activity content during class time.	1	2	3	4	5

Appendix I

Integrating Simulation: *Medical Center* Nurse Residency Program

Elisa C. Salas, DNP Student
University of Maryland, Baltimore

Introduction

- THANK YOU!
- Objectives:

By the end of this session participating nurse educators will:

1. Discuss ways to integrate simulation in the curriculum
2. Describe best practices when designing simulations
3. Identify resources to support simulation design & implementation

The "Problem"→ Improve Quality

"Need more nurse resident engagement"

Simulations? What, why, how, and where to start?

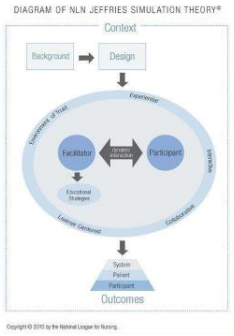
- **What?** Priorities- Is there a gap?
- **Why?** Evidence that it works
- **How?** Using available resources
- **Where to start?** Informal needs assessment

Evidence-Based Practice: Not Just the Latest Phrase

*"Evidence-based practice is the integration of the best available research with clinical expertise in the **context of patient characteristics, culture and preferences**"* (American Psychological Association)

*"A problem solving approach to clinical decision making that incorporates a search for the best and latest evidence, clinical expertise and assessment, **and patient preference values within a context of caring**"* (Mazurek Melnyk et al., 2005 as cited in The International Council of Nurses, 2012)

What is best for ***Medical Center*** **Nursing**?



The NLN/ Jeffries Simulation Theory

Best Practices Systematic Review

(Adamson & Rogers, 2016)

Recurring Themes and Key Issues

- Simulations can improve outcomes
- Fidelity matters
- **Debriefing**
  - Benefits novice nurses
  - Theory based
  - Use of video recording?

Best Practices

- Educational Practices
  - Learner centered
  - Feedback
    - *Immediate*
    - *Opportunity to Apply*
- Simulation Design
  - **Goal directive/ Objective driven**
  - Sequence
  - Complexity
- Participant
  - Group size
  - Role
  - Orientation to environment
- Facilitator
  - "Guide on side"
  - Allows participants to talk
  - Integrates others
  - Provides encouragement

Which Method to Use?

Promoting Excellence and Reflective Learning in Simulation (PEARLS) (Eppich and Cheng, 2015)

- Four phases:
  - *Reactions*
  - *Description*
  - *Analysis*
  - *Summary*

Which Method to Use?

Debriefing for Meaningful Learning (DML) (Dreifurst, 2012)

- Scripted method that focuses on problem solving while reflecting in three areas:
  - *Thinking-in-action*
  - *Thinking-on-action*
  - *Thinking-beyond-action*
- Six phases:
  - *Engage, Explore, Explain, Elaborate, Evaluate, Extend*

Which Method to Use?

- Debriefing with Good Judgement (Rudolph et. al, 2007)
  - Three phases
    - *Reactions*
    - *Analysis*
    - *Summary*

Debriefing with Good Judgment

Key Principles

1. Learning objectives are clearly de fined prior to simulation session.
2. Set expectations clearly for the debriefing session.
3. Be curious, give feedback, but do not try to " fix" your learners.
4. Organize the debriefing session into three phases: reactions, analysis, and summary

Debriefing with Good Judgment

Rationale for its use in *Medical Center* Residency Program

- Formal training for facilitators is not required
- Simple
  - Only 4 key principles
  - Three phases
- Semi-scripted
  - Flexible
  - Allows for facilitator choice and judgment
- Devised to be used with trainees
  - Moves beyond the nursing student role

Key Points to Remember

- Participants need the tools to **succeed**
- Simulation should have a goal and present a challenge
- Respect among all participants is a priority
- Debrief with a plan:
  - Reaction phase-
    - *"Blow off steam" feelings surrounding the interaction, even when things go well emotions can be strong. Provide facts as needed*
  - Analysis phase
    - *Assume participants did their best*
    - *Aim to understand the reasons that drove the action (the frame)*
    - *Follow feedback with learning opportunities*
  - Summary phase

Curriculum Integration of Simulation

Application Exercise- Pairs

1. Identify a recent problem or issue involving nurse residents
2. Follow the example to assess if integrating a simulation in the curriculum is feasible or desired

Problem	Topic	Goal	Applied Objectives	Goal met during orientation?	Could Simulation fill this gap?	Cost? Time? Resources?
Two Heparin errors involving new grads the past year.	Medication Management (Heparin)	Nurse will administer correct dose of heparin	Nurse will locate the heparin policy Nurse will evaluate lab values Nurse will determine correct dosage base on lab values	Not always	Maybe?	+ Cost is minimal Resources are available - No time to develop Not suitable for group simulation Not time efficient

Vizient/ AACN Topics

- Patient Care Delivery
- Resource Management
- Patient Care Coordination
- Cultural Competency
- Conflict Management
- Interprofessional Communication
- Resource Management
- Patient Care Coordination
- Cultural Competency
- Patient and family teaching
- Pain Management
- Ethics
- End of Life Care
- Patient Safety and Accountability
- Professional Development
- Stress Management and Self-Care
- Medication Administration
- Physical Assessment
- Clinical Judgement

Simulation Resources

1. The International Nursing Association for Clinical Simulation and Learning (INACSL).
   Information on membership, conferences, and other resources. Free download of their standards for best practice
   http://www.inacsl.org/i4a/pages/index.cfm?pageid=3407

2. National League for Nursing (NLN) Simulation Innovation Resources Center (SIRC). **Offers free support material, has information on workshops, a simulation leaders directory, and a faculty development toolkit**
   http://sirc.nln.org/mod/page/view.php?id=843

3. Maryland Simulation Resource Consortium (MSRC)
   Offers the "Train the Trainer" series workshops at no cost to participants. Must apply before deadline
   http://cms.montgomerycollege.edu/mcsrc/

4. Society for Simulation in Healthcare (SSIH)
   Certification, accreditation, workshops, webinars, meetings, membership http://ssih.org/

5. Laerdal Simulation Users Network (SUN)
   Information about yearly meeting and other online resources
   http://www.laerdal.com/us/SUN

Integrating Simulation: Medical Center

Nurse Residency Program

Elisa Carola Salas

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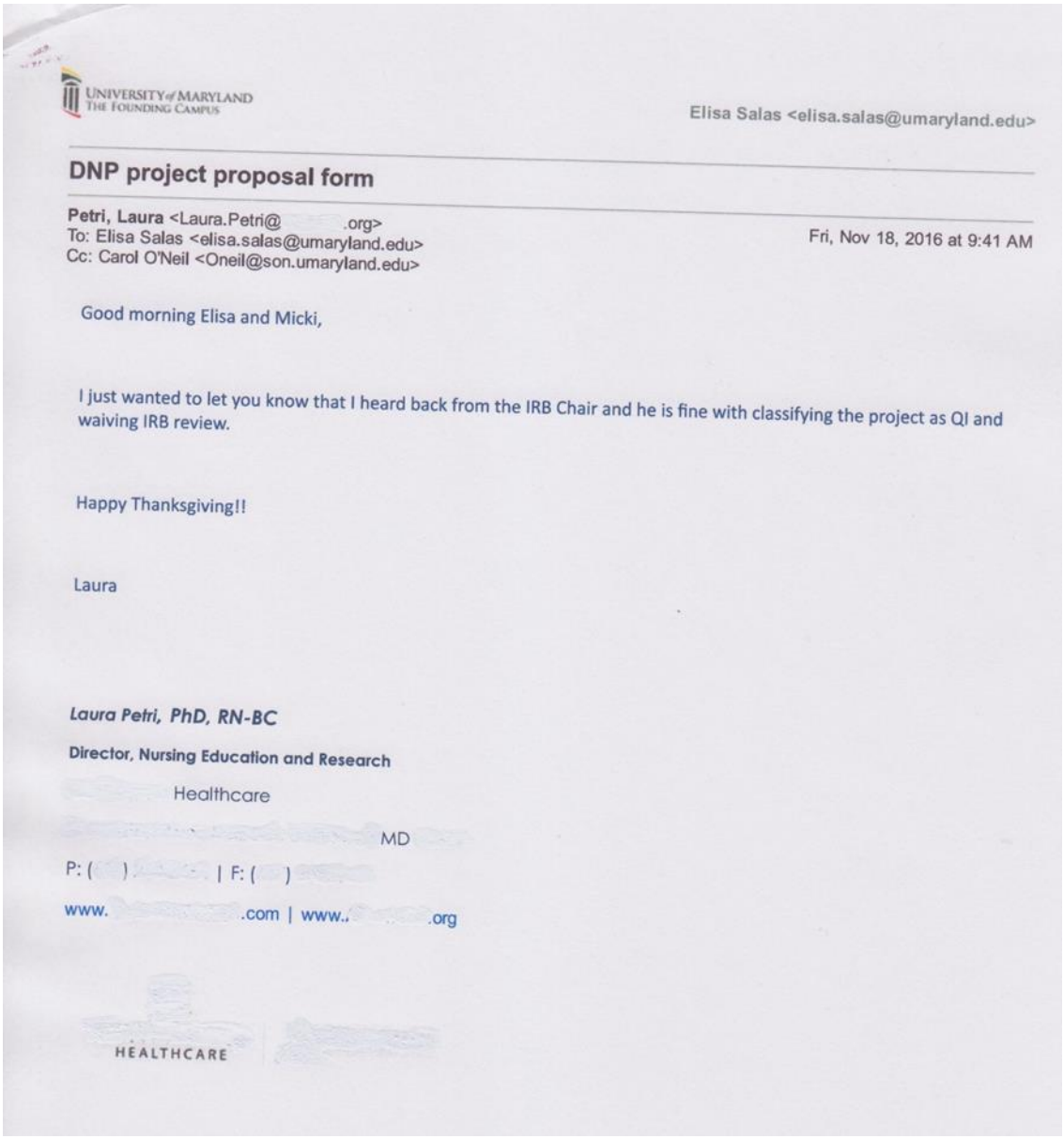
Images

Slide 3: Retrieved from http://www.inloso.com/ (Creative Commons License – may use for non-commercial purposes)

Slide 5: Diagram of the NLN/Jeffries Simulation Theory- Used with permission.

Appendix J

Medical Center Classification of Project as Quality Improvement



UNIVERSITY of MARYLAND
THE FOUNDING CAMPUS

Elisa Salas <elisa.salas@umaryland.edu>

DNP project proposal form

Petri, Laura <Laura.Petri@ .org>
To: Elisa Salas <elisa.salas@umaryland.edu>
Cc: Carol O'Neil <Oneil@son.umaryland.edu>

Fri, Nov 18, 2016 at 9:41 AM

Good morning Elisa and Micki,

I just wanted to let you know that I heard back from the IRB Chair and he is fine with classifying the project as QI and waiving IRB review.

Happy Thanksgiving!!

Laura

Laura Petri, PhD, RN-BC

Director, Nursing Education and Research

Healthcare

MD

P: ( ) | F: ( )

www. .com | www.. .org

HEALTHCARE

Note: the medical center's identifying information was deleted to preserve confidentiallity

Appendix K

UMB IRB Not Human Research Determination

University of Maryland, Baltimore
Institutional Review Board
Phone: (410) 706-5037
Fax: (410) 706-4189
Email: hrpo@umaryland.edu

NOT HUMAN RESEARCH DETERMINATION

Date: February 2, 2017

To: Carol O'Neil
RE: HP-00073635
Name: Using Simulation to Train Nurse Residents on Bedside Legal Ethical Dilimmas

This letter is to acknowledge that the UMB IRB reviewed the information provided and has determined that the submission does not require IRB review. This determination has been made with the understanding that the proposed project does not involve a systematic investigation designed to develop or contribute to generalizable knowledge **OR** a human participant (see definitions below).

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are human subject research in which the organization is engaged, please submit a new request to the IRB for a determination.

Definitions –

Human Research: Any activity that either:
- Is "Research" as defined by DHHS and involves "Human Subjects" as defined by DHHS ("DHHS Human Research"); or
- Is "Research" as defined by FDA and involves "Human Subjects" as defined by FDA ("FDA Human Research").

Research as Defined by DHHS: A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

Research as Defined by FDA: Any experiment that involves a test article and one or more human subjects, and that meets any one of the following:
- Must meet the requirements for prior submission to the Food and Drug Administration under section 505(i) of the Federal Food, Drug, and Cosmetic Act meaning any use of a drug other than the use of an approved drug in the course of medical practice;
- Must meet the requirements for prior submission to the Food and Drug Administration under section 520(g) of the Federal Food, Drug, and Cosmetic Act meaning any activity that evaluates the safety or effectiveness of a device; OR
- Any activity the results of which are intended to be later submitted to, or held for inspection by, the Food and Drug Administration as part of an application for a research or marketing permit.

Human Subject as Defined by DHHS: A living individual about whom an investigator (whether professional or student) conducting research obtains (1) data through Intervention or Interaction with the individual, or (2) information that is both Private Information and Identifiable Information. For the purpose of this definition:

- Intervention means physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.
- Interaction means communication or interpersonal contact between investigator and subject.
- Private Information means information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record).
- Identifiable Information means information that is individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information).

Human Subject as Defined by FDA: An individual who is or becomes a subject in research, either as a recipient of the test article or as a control. A subject may be either a healthy human or a patient. A human subject includes an individual on whose specimen (identified or unidentified) a medical device is used.

Please keep a copy of this letter for future reference. If you have any questions, please do not hesitate to contact the Human Research Protections Office (HRPO) at (410) 706-5037 or HRPO@umaryland.edu.