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Nursing Students' Moral Courage Development Through Incivility Simulation Education

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NURSING STUDENTS' MORAL COURAGE DEVELOPMENT THROUGH INCIVILITY SIMULATION EDUCATION

by

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Dedication

This is dedicated to my husband John, my children Brett and Hannah, my mother Annette and my students.

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Table of Contents

List of Tables

List of Figures

Abstract

NURSING STUDENTS' MORAL COURAGE DEVELOPMENT THROUGH INCIVILITY SIMULATION EDUCATION
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Nursing students and graduate nurses are among the most vulnerable populations to encounter uncivil behaviors in healthcare. Turnover rates and increased patient safety concerns call for a new approach to solving the issue of incivility within nursing. In order to reduce the harmful effects of incivility, a call to strengthen nursing students' moral courage has been established. Research suggests that students lack the moral courage needed to help them advocate for themselves and their patients. While moral courage can be taught, there is a lack of research on evidence-based interventions that strengthen nursing students' moral courage when faced with behaviors of incivility.

Chapter 2. "Creating a Healthy Work Environment Through Political Activism," provides an overview and example of how nurses can advocate for an anti-bullying healthy workplace bill at the state level.

Chapter 3. "A Time to Speak: Learning from Patients' Experiences Related to Healthcare Worker Incivility," details a case example from a patient's perspective on the phenomena of incivility and highlights the need for nurses to speak up.

Chapter 4. A quasi-experimental non-equivalent pretest-posttest comparison group design was implemented as the primary study to allow the researcher to determine if using an educational module plus incivility simulation intervention increased nursing students' moral

courage more for upper-level nursing students than for lower- level nursing students. A convenience sample of 66 nursing students was utilized across two nursing classes from one university. The Moral Courage Scale for Physicians (MCSP) was administered to all participants before and after the interventions. Quantitative data were analyzed using paired sample *t*-tests and within-between ANOVA to compare pre-and post-test survey results. Finally, a multivariate repeated measures general linear model was employed to compare differences in pre-test to post-test scores across two levels of nursing students the intervention site.

Chapter 1

Overview of the Research

Incivility among healthcare workers is well documented as a persistent problem. If left unchecked, incivility can escalate to acts of bullying. It is symptomatic of conflicting professional relationships that alter the work environment and negatively affect the quality and safety of patient care. Nursing students and graduate nurses are the most vulnerable and are more likely among healthcare workers to encounter environments where uncivil behaviors are common (D'Ambra & Andrew, 2014; Kim, 2017; Palumbo, 2018). Negative effects of incivility for new graduate nurses include job stress, dissatisfaction, cognitive distraction, patient care errors, psychological stress, depression, lost days of work and likeliness to leave the profession (Lim et al., 2009; Palumbo, 2018). Patients' health and well-being are also potentially at risk of suffering collateral damage from healthcare worker incivility.

Confronting behaviors of incivility requires moral courage; however, nursing students and graduate nurses often fear the risks of humiliation, rejection, ridicule, unemployment and loss of social standing (Bickhoff et al., 2016; Bickhoff et al., 2017; Fagan et al., 2016; Lachman, 2010; Oliver et al., 2017). Prior studies support the use of uncivil problem-based learning (PBL) scenarios, video simulations (VS), role-play simulations and active simulations in preparing student nurses for uncivil encounters (Aebersold & Schoville, 2020; Clark & Ahten, 2013; Sharpnack et al., 2013). While the nursing curriculum is ideal for building moral courage values, prior studies have not explored the impact of educational incivility simulation on moral courage development in nursing students.

Purpose

The purpose of this study was to determine if the use of an incivility educational module plus an incivility simulation intervention would increase nursing students' perceived moral courage more than an incivility educational module alone.

Introduction of Articles

Three manuscripts presented in this dissertation portfolio focus on strategies that promote a healthy work environment and mitigate the harmful effects of workplace incivility through: (1) engaging in political activism, (2) exercising moral courage in the workplace through patient advocacy, and (3) practicing moral courage when faced with behaviors of healthcare worker incivility through simulation activities while in nursing school.

The first article provides an example of one nurse's experience of advocating for an anti-bullying healthy workplace at the state level. The article highlights the detrimental impact bullying can have on healthcare workers, patients, and organizations. Another focus of the article details how Christian nurses can approach political activism as another avenue for Godly service. Bullying is not isolated to healthcare alone but is recognized as a global and widespread problem. Namie and Namie (2021) report 30% of Americans suffer abusive conduct at work. All employees, regardless of their profession, have the right to work in a safe and healthy environment. The purpose of the article was to heighten nurses' awareness of bullying in the workplace and encourage their engagement in political activism aimed to promote a healthier work environment. The manuscript is scheduled to be submitted for consideration of publication to the *Journal of Christian Nursing* in April of 2022.

The second manuscript presents a unique case report for viewing the phenomena of incivility. Healthcare worker incivility has not previously been explored in the literature through

the voice of the patient. The purpose of this article was to expand the dialogue regarding the impact of healthcare worker incivility on patient safety and to elaborate on the nurse's duty to intervene through patient advocacy. An episode of incivility witnessed during one couple's labor and delivery experience illustrated the long-term effects on patient outcomes. The article also highlighted the need for Christian nurses to embrace their faith, stand firmly on their spiritual foundation, and "speak up" for those who cannot speak for themselves (Proverbs 31:8, NIV). This manuscript was submitted for consideration for publication to the *Journal of Christian Nursing*. Following peer review, the revised manuscript was accepted. (See Appendix J for notice of acceptance and Appendix L for permission to include the initial version of the manuscript in this portfolio). A 2022 publication date has been targeted by the journal. Dr. McAlister, my Dissertation Chair, served as second author on the manuscript.

Manuscript three is the report of the quantitative study aimed at determining if the use of an educational incivility module plus an incivility simulation intervention would increase nursing students perceived moral courage more than an incivility educational module alone. The study sample size was 66 participants.

Chapter 2

Creating a Healthy Work Environment Through Political Activism

Abstract

Workplace bullying is recognized as a global social injustice, which negatively threatens the health of workers, employers, and society. Current laws fail to provide a preventative and compensatory role in protecting employees. Health effects related to bullying are cause for concern and lend urgency in nurses political advocacy skills. The perceived "self-interest" focus of politics may deter Christian nurses from getting involved. However, political advocacy should be seen as another avenue for Godly service. Experienced and witnessed acts of workplace bullying inspired one Christian nurse to get involved through political activism. The example provided reminds Christian nurses of their power to advocate for the health of the nation by seeking God's direction through scripture and prayer.

Keywords: bullying, healthy workplace bill, policy, advocacy.

Creating a Healthy Work Environment Through Political Activism

If asked, most nurses could probably recall a time when they've experienced or witnessed bullying at work. I once overheard several nurses discussing their desire to quit their jobs due to the incivility and bullying behavior of one surgeon. One nurse expressed her desire to change careers, while another expressed dread of returning to the surgical suite and facing the surgeon again. All agreed there was nothing they could do but to keep tolerating the behavior. Explanations offered for their continued tolerance were based on the collective belief that they were powerless. Essentially, they perceived that nurses were more easily replaced than surgeons, so their circumstance was hopeless. Perhaps the most concerning comment came from a new graduate nurse who claimed she "wasn't doing her job right if the surgeon wasn't verbally abusing her at least twice a week." This example highlights the detrimental impact bullying can have on nurse retention, job satisfaction, and self-esteem. The purpose of this article is to heighten nurses' awareness of bullying in the workplace and to encourage their engagement in political activism aimed at promoting a healthier work environment. My own experience in advocating for an anti-bullying Healthy Workplace Bill (HWB) is shared to encourage other nurses to get involved in the political process. If Christian nurses are not bold and courageous to work for preserving dignity in the workplace, who will take up the cause? For God has not given us a spirit of fear, but of power and of love and of a sound mind (*King James Bible*, 1769/2016, 2 Timothy 1:7).

Background

The American Nurses Association (ANA) defines bullying as "repeated, unwanted, harmful actions intended to humiliate, offend, and cause distress in the recipients" (ANA, 2015a, p. 2). Workplace bullying is recognized as a social injustice which negatively threatens the health

of workers through psychologically abusive, threatening, or intimidating conduct (ANA 2015a; Savrin, 2018). Most existing state laws fail to provide a preventative role in protecting employees against workplace bullying. The absence of a law means employers may tolerate misconduct without legal risks. Evidence regarding the prevalence of workplace bullying and its influence upon the health and job satisfaction of employees magnifies the urgency for nurses to develop political advocacy skills. Nurses, however, may hesitate to pursue political activism (Scott & Scott, 2020). For Christian nurses, politics' focus on "self-interest" may seem in opposition with humble Christian service; however, political advocacy can be seen as another avenue for Godly service. What we are as nurses is God's gift to us, but how we serve as nurses is our gift to God. Not only does God's word instruct us to promote justice and love kindness (King James Bible, 1769/2016, Micah 6:8) but professional nursing organizations also call upon us to promote social justice through participation in political processes (The American Nurses Association [ANA] Code of Ethics (2015b).

Bullying in the workplace is not isolated to healthcare alone but is recognized globally as a widespread problem that negatively affects individuals, employers, and society (ANA, 2015a). Across Northern America workplace bullying affects approximately 79,300,000 U.S. workers and is the second leading cause of absenteeism (Namie & Namie, 2021). Namie and Namie report details about the national prevalence of workplace bullying among adult Americans: 30% suffer abusive conduct at work, 19% witness it, 49% are affected by it, and 66% are aware that workplace bullying happens (2021). Whatever the environment, workers are affected when employees engage in uncivil behavior. Regardless of their profession, all employees have the right to work in a safe and healthy environment, free from detrimental threats to their health. Health effects on employees related to bullying should be cause for concern with reports of

stress-related complications including hypertension, auto-immune disorders, depression, anxiety, and post-traumatic stress disorder (Bickhoff et al., 2016; Green, 2020; Lim et al., 2009). Employers also suffer tangible costs of unwanted turnover of key skilled personnel, absenteeism, higher insurance costs, and litigation expenses (Savrin, 2018). Intangible costs include damage to the institution's reputation and impaired ability to recruit and retain the best talent (Savrin, 2018).

Although the Joint Commission calls for organizations to establish a written code and process for managing behaviors that undermine a culture of safety, leaders in healthcare continue to struggle with curtailing the problem (Blake, 2016; Gillen et al., 2017; Green, 2020). Many bullied nurses leave their positions when their coping attempts prove to be in vain as bullying persists beyond efforts to engage leadership and management (Green, 2020; Karatuna et al., 2020). Gillen et al.'s (2017) systematic review suggests very low quality of evidence for organizational and individual interventions for prevention of bullying in the workplace. Large well-designed controlled trials of bullying prevention interventions operating on the levels of society/policy, organization/employer, job/task and individual/job interface are needed (Gillen et al., 2017). Sanderson (2021) suggests a change from a down-stream approach (individual) to an upstream approach (prevention strategies) for a healthier nation. In this model, preventing the problem saves resources, energy, and lives (Sanderson, 2021). One possible path to preventing the problems of workplace bullying is through enactment of an anti-bullying healthy workplace bill.

The Healthy Workplace Bill

To date, 31 states have introduced the HWB to provide a preventative or compensatory role for victims of workplace bullying. The primary purpose of the HWB is to prohibit and

prevent abusive conduct against employees in the workplace that affects worker performance, alters workplace peace, and threatens the dignity of employees (Namie & Namie, 2021). Some features of the HWB include but are not limited to: (a) employer liability for the actions of their employee's conduct if the employers knew the harassment was taking place and did nothing about it, (b) requirement that the employer adopt and implement internal rules and policies to eliminate or reduce the occurrence of workplace bullying, (c) requirement that the employer establish a procedure to investigate claims of workplace bullying and impose sanctions against those who violate these policies, (d) provide for remedies and damages, and
(e) provide a non-exhaustive list of conduct that can be considered workplace harassment such as injurious, defamatory or damaging expressions about the person with the use of profanity or hostile and humiliating comments about an individual's professional incompetence in the presence of co-workers (Namie & Namie, 2021).

Faith in Action

Personal experiences and witnessed acts of workplace bullying inspired me to pursue a public policy that could help protect all employees from bullying in the workplace. First, I started with prayer, leading me to scripture which reminded me that God has told me what is good and that He requires me to do justice and to love kindness (King James Bible, 1769/2016, Micah 6:8). Workplace bullying is neither good nor kind. Furthermore, justice is sometimes required in order to promote goodness. Claiming this scripture, I began searching for existing policies against workplace harassment, which led me to the Workplace Bullying Institutes' (WBI) online website. Here I found statistics supporting anti-bullying healthy workplace bills, one example of a HWB, and a plea for citizens to speak to their state politicians about sponsoring a bill.

Next, I searched the internet and prayed for God's direction in finding a state politician whom I could collaborate with based on their personal platform/convictions and their past voting history. Upon discovering a local state Senator whose voting record appeared to be in alignment with my personal concerns, I called his office and requested an appointment. To my surprise, the Senator was willing to meet with me. Next, I began praying for the Senator's receptiveness to my concerns as well as for God's strength to pour from my efforts at promoting justice in the workplace. Knowing I had a limited amount of time to share my concerns with the Senator, I carefully planned a one-page flyer highlighting important bullying statistics to discuss with him. I also obtained an example of a neighboring state's HWB that I could leave with the Senator. My prayers and efforts were fruitful; upon meeting with the Senator, my planning proved successful. The Senator recalled a personal experience with workplace bullying and agreed to sponsor the bill in the next legislative session, only five months away. As the months progressed, the Senator kept in contact with me and even asked me to review his proposed bill. As the legislative session rolled out, I was again contacted by the Senator and asked to speak in favor of the bill in the Senate Labor and Industrial Relations committee. All the while, I remained in prayer for the committee members and for God's strength to be able to articulate and express my concerns during my testimony. Although, many of the committee members were ready to vote on the bill, the bill was deferred for further review. The bill did not progress out of the committee during the legislative session; however, my efforts planted the seeds for future advocacy for the HWB in my home state.

This personal example outlines some important points regarding the need for nurses to get involved in political advocacy. First, nurses need to recognize they have power to advocate for a healthy work environment and workforce. When nurses think they have no power, they've

already given it up. Important steps for Christian nurses to remember when taking part in political advocacy is to base action on faith, pray for God's direction, and seek scripture for guidance. Next, Christian nurses need to search the existing laws regarding the topic of concern, then pray for and seek out policy makers whose voting record aligns with their own personal values. If and when a meeting is established with a politician, it is extremely important for the Christian nurse to be well-informed, present facts about their concerns, and to provide an example of a solution to the problem. Finally, Christian nurses should remain in prayer for the policy makers and for God's provision in their own personal efforts of service through political advocacy.

Conclusion

The social and economic well-being of a state is dependent upon a healthy and productive workforce. Workplace bullying may affect at least one-third of employees, endangering their health, career, and livelihood (Namie & Namie, 2021). Christian nurses should recognize the detrimental effects bullying has on their work environment and realize their power to make a difference through Godly service and political activism. Christian nurses can also follow Biblical examples of others who made a difference through their position and personal conviction. One example to follow is that of Queen Esther, whom God positioned to advocate for the lives of her people. Christian nurses are also well positioned to advocate for the health of the nation and safety of their patients through political engagement aimed at promoting justice and loving kindness.

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Chapter 3

A Time to Speak: Learning from Patients' Experiences Related to Healthcare Worker Incivility

Abstract

A spouse's recollection of physician to nurse incivility, as witnessed during his wife's hospitalization for childbirth, provides a rare angle for viewing the phenomena and highlights the need for nurses to speak up. Research indicates an association between the ethical dilemma of healthcare worker incivility and poor patient outcomes, yet incivility has not been explored through the voice of the patient. Fears of retaliation or insubordination claims, and lack of confidence have contributed to nurses' reluctance to advocate for themselves and their patients. This unique case report offers insights worthy of reflection and should embolden Christian nurses to seek, discern, and deliver a spiritual response to co-worker incivility.

Keywords: incivility, bullying, patient safety, patient perspective's, patient outcomes, speak up.

A Time to Speak: Learning from Patients' Experiences Related to Healthcare Worker Incivility

A seasoned nurse faculty co-worker once advised me to stop focusing on the concept of incivility, because "incivility is just part of the job." Left to ponder the advice, I realized I could not recall one nursing job in my thirty years of experience, where I had not encountered co-worker incivility. Unfortunately, my experience is not unique; incivility remains a pervasive societal challenge and the health care professions are not immune to its deleterious effects. Decades of research on workplace incivility have produced few evidence-based interventions to curtail the rampant problem (Gillen et al., 2017). The issue has become dire enough for professional organizations to call for evidenced-based teaching strategies that prepare nurses to speak up when faced with behaviors of incivility (ANA, 2015); however, research suggests that new nurses are more likely to leave their position than to exercise their right to express their viewpoint (Caylak & Altuntas, 2017).

The third chapter of Ecclesiastes serves as a reminder that "for everything there is a season, and a time for every matter under heaven," (New International Version [NIV]) and "…there is a time to keep silent and a time to speak" (NIV). But when does the Christian nurse recognize the time to speak up in relation to co-worker incivility? The purpose of this article is to expand the dialogue regarding the impact of healthcare worker incivility on patient safety and to elaborate on the nurses' duty to intervene through patient advocacy. An episode of incivility witnessed during one couple's labor and delivery experience illustrates the long-term effects on patient outcomes. Their heartbreaking case highlights the need for Christian nurses to embrace their faith, stand firmly on their spiritual foundations and "speak up for those who cannot speak for themselves" (Proverbs 31:8, NIV).

Background

According to Dang et al. (2016), workplace incivility can be defined as "low intensity deviant behavior that violates workplace norms of mutual respect" (p. 115). Clark (2017) describes incivility as the display of "a range of rude or disruptive behaviors and failing to take action when action is warranted or justified" (p. 60). Incivility in healthcare is symptomatic of conflicting professional relationships that alter the work environment and affect the quality and safety of patient care. While physician perspectives of healthcare worker incivility suggest a linkage between unprofessional clinician interactions and diagnostic errors (Giardina et al., 2018), nursing perspectives suggest the potential for unfavorable outcomes, such as patient harm and near misses (Dang et al., 2016). These views merely relate to the perceived immediate ramifications of incivility, however, and do not consider the weeks, months, or even years that follow.

What is known, is that for health care systems that foster a culture of safety and promote teamwork, there are associated decreases in patient harm and hospital mortality (Berry et al., 2020). To date, research has focused primarily on healthcare team members' perceptions of co-worker incivility, however, this approach seems myopic. Patients are the reason the healthcare industry exists. Thus, their impressions after having witnessed healthcare workplace incivility provide a unique perspective upon which nurses may reflect.

Review of Literature

Throughout the literature, numerous studies explore factors associated with barriers and predictors for the nurse's ability to speak up. Barriers to speaking up include nurses' reports of insubordination, fear, anger, and lack of confidence (Fagan et al., 2016; Kirrane et al., 2017). Power differentials can lead nurses to remain silent as they conform to practices in the clinical

environment which could negatively impact quality of patient care (Bickhoff et al., 2015; Houck & Colbert, 2017). This type of silence is considered "defensive silence" as the nurse is "protecting self" and is associated with the emotion of fear (Kirrane et al., 2017, p. 355). The role and position of subservience also influences the nurse's self-perception and value of their contribution and their confidence to assertively speak up (Fagan et al., 2016). Kirrane et al. (2017) identify this as a form of "acquiescence silence" in which the individual becomes resigned and disengaged believing their opinion is not valued (p. 356). Additionally, nurses report concern for looking foolish as a barrier to speaking up (Bickhoff et al., 2105). This lack of confidence is related to generational differences and lack of knowledge concerning regulations, policies and organizational systems (Bickhoff et al., 2015).

Common to all themes identified in the literature is the role of emotions as a primary factor for nurses choosing not to speak up (Bickhoff et al., 2015; Fagan et al., 2016; Kirrane et al., 2017; Law & Chan, 2015). Emotions act as the motivational conduit between thoughts and actions, and different emotions lead to different types of action tendencies (Kirrane et al., 2017). Edwards et al. (2009) suggest that anger and guilt predict speaking up following an observed transgression while anticipatory fear and shame predict decisions to remain silent. Kirrane et al. (2017) suggest "fostering approaches that eliminate fear are key to improving constructive voice and engagement" (p. 373).

The following case interview will demonstrate the barriers to speaking up as identified in this review. Following the example, a discussion of scripture will be offered to help direct Christian nurses' decisional process of knowing to whom and when they should speak up.

Methods

Institutional Review Board approval was obtained from the researcher's doctoral university, and written informed consent was provided by the participant. The participant was known to the researcher through a previous professional affiliation. The participant was purposefully chosen because he had previously offered to share his experience of the phenomena of interest to promote awareness and education for nurses.

The story was recounted in an audio-taped interview that lasted approximately 90 minutes and a private follow-up clarification phone call that lasted approximately 20 minutes. The interview was conducted solely between the researcher and the participant during nonbusiness hours at a private location. Interviews were transcribed verbatim immediately following the interview appointment. The participants' story was analyzed for themes and implications for educating nurses on the impact of healthcare worker incivility and their duty to speak up.

Case Report

Mr. and Mrs. Adams (pseudonym) never thought their pregnancy would be any different than their prior ones. They were told nothing was wrong and everything was going well, but Mrs. Adams had been having some high blood pressure issues and wanted to have it checked out. So she went in for her 38 -week prenatal visit and was immediately admitted to the hospital where labor was induced. As the night progressed Mrs. Adams blood pressure dropped and she turned "white as a sheet". Mrs. Adams called the nurse, who then called the healthcare provider to check her.

Several hours passed as Mrs. Adams' blood pressure continued to drop. Then finally, the fetal heart monitor began alarming, marking a defining moment that would change their life

forever. The Adams "trusted their nurses and still do, but it was obvious something disturbed the nurse about the alarm". So finally, the nurse brought in the bedside ultrasound "on her own gumption".

After five hours of labor, the ultrasound revealed a fetal heart rate of 50 beats per minute, matching Mrs. Adams own heart rate. Later, it was discovered that the internal fetal monitor had been misplaced. This is when the Adams had an "oh my gosh moment" and immediately began to pray.

An emergency C-section quickly ensued leading to the delivery of a neonate with poor Apgar scores and severe brain damage. In the following hours, days, weeks, months and years, the Adams' experienced the effects of healthcare worker incivility as they traced their labor and delivery events and learned to care for their special needs' child.

Analysis

Identified Themes

Based on Mr. Adams perception of healthcare worker incivility, four themes emerged. Three of the four themes, have previously been discussed in the literature through nurse and physician perceptions of co-worker incivility including: defining incivility, power differentials, and fear to speak up. The fourth theme of "long-term consequences" is unique to the patients' perspective and emphasizes the nurse's duty to speak up.

The following statements demonstrate Mr. Adams' definition of healthcare worker incivility, which aligns with Dr. Clark's (2017) description of rude, disruptive behavior "failing to take appropriate action when action is justified" (p.60). Although the nurse took initial action by notifying the healthcare provider of her concerns when Mrs. Adams turned "white as a sheet",

the physician discredited her in the presence of the patient. This led to defensive acquiescent silence and further inaction by the nurse.

> I think incivility is just open unprofessionalism and really using power to manipulate a standard of care. It is the opposite of collaboration. Creativity is stifled. It really has to do with a cruel unprofessional act that everyone in the room knows what it is when they see it. This is when I first saw the incivility. The Dr. literally stiff armed the nurse. He said there's nothing wrong, the nurse was completely discredited.

Power differentials may alter ones' ability to make ethical decisions. "Those in lower roles within organizational hierarchies are often those who experience the negative effects of power relationships such as bullying and oppressiveness" (Gibson et al., 2014, p. 2). The second theme of "power differential" can be seen through the following statements provided by Mr. Adam's observation of the uncivil encounter between the nurse and the physician.

> It was like the Dr. was saying "I know this; who are you to tell me what to do?". But what I think that stood out that night was that in all the stuff going on, was that the Dr. would not listen to the nurse and he was disrespectful. Had the Dr. listened to the nurse, we wouldn't be talking right now.

The third theme of "fear to speak up" can also be seen through Mr. Adams' perspective of the uncivil encounter. The Adamses realized "the nurse knew something was wrong", and that she chose not to not engage in conflict with the healthcare provider nor take further action through the proper channels.

> But I think she knew that something was wrong. In retrospect, we realized this was the moment we were in trouble, and the fetal monitor strip later confirmed our thoughts. I think she knew hours before that the cuff reading and the internal

> monitor should never match. It was like there was no collaboration; it seemed like the nurse was having to work against the doctor. If the nurse had spoken-up the chain of command earlier, our child would be 12 years old now.

The fourth theme identified from the interview with Mr. Adams emphasizes the importance of including the patients' perspective of healthcare worker incivility and serves as a reminder that nurses need to consider the long-term consequences of their silence. Currently, there are no policy or practice initiatives to supplement patient safety data using patient reported experiences or feedback that capture long-term effects of hospital experiences (Giardina et al., 2018). The following statements identify long-term effects felt by the Adamses due to healthcare worker incivility behaviors' that occurred during their labor and delivery experience.

> So, our child lived for a little over 10 years as a spastic quadriplegic with optic nerve blindness and seizure disorder. There was never any sign of a connection or communication. We just want other nurses to learn from this. We love and forgive those involved, but just want others to learn to speak up and to follow the chain of command with the power given them through Christ.

Discussion

This case report demonstrates the associated barriers to speaking up as identified in the literature, including power differentials and fear. Although the nurse attempted to speak up to the physician at the first sign of trouble, the power-differential was clearly observed by the patient. According to scripture, the nurse can find strength when faced with the issue of power differentials by remembering for whom they are working. The Christian nurse knows that their work is a labor of love for the Lord, as Colossians 3:23 reminds us "Whatever you do, work heartily as for the Lord and not for men, knowing that from the Lord you will receive the

inheritance as your reward" (NIV). New nurses often view their role as following physicians' orders. Certainly, that is their role in part, but it is also to have their own assessment, communication, and advocacy skills. Christian nurses know through God's word who their ultimate boss is, as they find strength to intervene on behalf of their patients. The Apostle Paul also reminds us "Therefore, my beloved brothers, be steadfast, immovable, always abounding in the work of the Lord, knowing that in the Lord your labor is not in vain (1Corintihians 15:58, NIV). Remembering that the true power differential is between God and the perpetrator of incivility, the nurse can pray for the individual, while advocating for the patient.

Facing fear to invoke the chain of command in response to a healthcare providers' actions or behaviors takes moral courage. God's word is steeped with the concept of moral courage through examples of His people facing fear and acting through the strength given them through His power. Christian nurses can draw on scripture to inform their need to intervene on behalf of their patients as they follow through with the Godly principles of moral courage. Although Christian nurses may fear repercussions, they should not conform to poor practices that may affect the safety of the patient.

In this case example, the nurse did not take her concerns through the proper channels when she knew something was wrong. Instead hours passed before she took the ultrasound to the bedside of her own accord. Learning from this example, Christian nurses should remember they are not alone by recalling countless scriptures that begin with the words "fear not" and many that follow with the command to "take courage." One such scripture can be found in Joshua 1:9,"Have I not commanded you? Be strong and courageous. Do not be frightened, and do not be dismayed, for the LORD your God is with you wherever you go" (NIV). Another personal favorite can be found in Isaiah 41:10, "Fear not, for I am with you; be not dismayed, for I am

your God; I will strengthen you, I will help you, I will uphold you with my righteous right hand (NIV). When Christian nurses fear the consequences of their actions to speak up, it is helpful to remember that fear is not derived from the Lord as 2 Timothy 1:7 reminds us, "the Lord does not give us a spirit of fear, but of power, love and a sound mind" (NIV). This spirit is the same spirit given to Moses, Joshua, the disciples, and many others that serve as examples of moral courage for Christian nurses to follow. Christian nurses faced with power differentials and fear in times of healthcare worker incivility need to recall scripture to help them communicate and advocate for their patients. In doing so, Christian nurses exercise moral courage to speak up in love, while following the Lord's command to be fearless and courageous, knowing that the Lord is with them, strengthens them, and upholds them through the power of the sound mind that He has given them.

Conclusion

Although the outcomes of this case study had negative long-term consequences, the participant felt his family's loss should not be in vain. This family's Christian love is evidenced by their passion to help current and future nurses overcome the barriers to speaking up. As the book of Ecclesiastes reminds us, there is a time for every matter under heaven. The painful and potentially convicting insights gleaned from this case study remind us that the right time to speak up is most often at the moment of initial concern or shortly thereafter. A family member's vivid memories of having witnessed healthcare worker incivility reminds us that incivility can cause more than embarrassment and hurt feelings. Patients' health and well-being are at risk of suffering collateral damage. In some instances, patients' lives hang in the balance.

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Chapter 4

Nursing Students' Moral Courage Development Through Incivility Simulation Education

Abstract

Objectives: The purpose of this study was to determine if the use of an incivility simulation intervention and incivility educational module would increase nursing students' perceived moral courage more than an incivility educational module alone.

Hypotheses**:** Nursing students' moral courage scores would increase more in response to an incivility simulation intervention and educational module than for those who received the incivility educational module intervention alone.

Methods: The NLN Jeffries Simulation Theory framed the proposed intervention using a quasi-experimental pre-test-post-test comparison group design. A convenience sample of 66 students was utilized from one university across two classes. The Moral Courage Scale for Physicians was administered to all participants before and after the interventions.

Results: Students that participated in an online educational module plus a simulation activity had a significant increase in pretest/post-test moral courage scores. An insufficient sample for the comparison group prohibited the ability to compare outcome measures for the intervention vs comparison groups.

Conclusion: Uncivil simulation interventions combined with an incivility educational module are useful for developing nursing students' moral courage when faced with uncivil behaviors in the clinical environment.

Keywords: moral courage; simulation; incivility; NLN Jeffries Simulation Theory; patient outcomes; problem-based learning

Nursing Students' Moral Courage Development Through Incivility Simulation Education

Nursing continues to be rated the highest among various professions for honesty and ethical standards (Saad, 2020). So, it is especially concerning that nursing students and graduate nurses are the most vulnerable and are more likely among healthcare workers to encounter environments where uncivil behaviors are common (D'Ambra & Andrew, 2014; Kim, 2017; Palumbo, 2018). Incivility in healthcare is symptomatic of conflicting professional relationships that alter the work environment and negatively affect the quality and safety of patient care. Workplace incivility can be defined as "low intensity deviant behavior that violates workplace norms of mutual respect" (Dang et al., 2016, p. 115). Clark and Kenski (2017) describe incivility as the display of "a range of rude or disruptive behaviors and failing to take action when action is warranted or justified" (p. 60). In order to reduce the harmful effects of incivility, a call to strengthen nursing students' moral courage has been established (American Nurses Association [ANA], 2015; Fitzpatrick, 2018). Acting with moral courage in times of incivility is challenging for nursing students and new graduates (Bickhoff et al., 2016; Bickhoff et al., 2017; Fagan et al., 2016; Oliver et al., 2017). A study to examine the effects of incivility simulation education to strengthen moral courage in nursing students is important for several reasons. First, prior studies have not explored the impact of an educational incivility simulation on moral courage development in nursing students. Second, the student nurse's sense of well-being should improve through active rehearsal of integrity-promoting activities which support advocating for themselves and others. Next, new graduate nurse turnover rates may improve as workforce teamwork and collaboration strengthen. Finally, patient outcomes may improve as graduate nurses enter the workforce with an increased ability to advocate for the safety of their patients.

Problem and Significance

Effects of incivility in the workforce are extensive, especially for new graduate nurses (D'Ambra & Andrews, 2014; Palumbo, 2018; Yang-Heui & Choi, 2019). Uncivil behaviors discourage newly licensed nurses from asking questions and seeking validation, thus diminishing their self-perceptions of assimilation into the profession (Anderson, 2014). Negative effects of incivility for new graduate nurses include job stress, dissatisfaction, cognitive distraction, patient care errors, psychological stress, depression, lost days of work, and likeliness to leave the profession (Lim et al., 2009; Palumbo, 2018). Patients' health and well-being are also potentially at risk of suffering collateral damage from healthcare worker incivility. Students and new graduate nurses may not always understand the impact incivility has on patient safety. While physician perspectives suggest a linkage between incivility, diagnostic errors, and patient harm (Giardina et al., 2018; Porath et al., 2015), nursing perspectives suggest the potential for unfavorable outcomes, such as patient harm, near misses, and potential death (Dang et al., 2016; Porath et al., 2015). Recent studies, however, indicate that for health care systems that foster a culture of safety and promote teamwork, there are associated decreases in patient harm and hospital mortality rates (Berry et al., 2020).

While there are multiple predictors of turnover and intent to leave nursing, incivility has demonstrated a significant influence. New nurses are more likely to leave their position than to exercise their right to express their viewpoint (Caylak & Altuntas, 2017). Lashcinger (2009) reports that incivility has a negative correlation with both job satisfaction and retention ($p < .01$). If left unchecked, incivility may progress to bullying or threatening situations (Schoville & Aebersold, 2020) and has been cited by nurses to have more influence over intent to leave a position than any other factor (Flateau-Lux & Gravel, 2014). Bullying is described as repeated,

unwanted harmful actions intended to humiliate, offend, and cause distress in the recipient (ANA, 2015). An estimated 1.2 million vacancies will emerge for registered nurses between 2014 and 2022 (Grant, 2016). By 2025, the shortfall is expected to be the largest experienced since the introduction of Medicare and Medicaid (Grant, 2016). With this impending shortage, efforts to improve new graduate nurses' retention is needed through civility promoting strategies that may co-create a healthy place of employment.

Decades of research on workplace incivility have produced few evidence-based interventions to curtail the rampant problem (Gillen et al., 2017). Professional nursing organizations are now calling on academia for evidenced-based teaching strategies that will curtail incivility and foster moral courage in nursing students (ANA, 2015); however, a review of the literature provided no studies that measure moral courage development in response to incivility education. Fostering moral courage through clinical simulation may be one way for educators to teach nursing students how to engage in difficult conversations surrounding uncivil encounters. The purpose of this quasi-experimental study was to determine if an educational module on incivility plus an active, realistic, simulation involving an uncivil encounter would increase student nurses' self-perceptions of moral courage to confront uncivil behaviors in the workplace more than an educational module on incivility alone.

Review of Literature

Incivility among nurses is well documented as a persistent problem. Presumed root causes for incivility among nurses include longstanding paternalism in healthcare, learned behavior (enculturation), lack of assertiveness, and workplace stress in a predominantly female profession (Szutenbach, 2013). Common examples of incivility include verbal assaults such as persistent criticism, belittling, or swearing (Sanner-Stiehr & Ward-Smith, 2017). Non-verbal

innuendo's include eye rolling, sighing, or ignoring another individual (Sanner-Stiehr & Ward-Smith, 2017). Other forms of incivility include undermining and sabotaging through withholding information or refusing to help another individual in need (Sanner-Stiehr & Ward-Smith, 2017).

Among the many consequences of healthcare co-worker incivility is the depletion of the nursing workforce, as many nurses report decreased job satisfaction and reduced organizational commitment (D'Ambra & Andrews, 2014; Laschinger, 2009). Financial ramifications of an increased turnover rate in nursing have been estimated at $11,581 per nurse annually (ANA, 2015). Negative intrinsic consequences to nurses include reports of decreased self-worth, headaches, interrupted sleep, intestinal problems, psychological stress, anxiety, irritability and depression (Palumbo, 2018). Reports of shame and loss of empowerment are also voiced by nursing students when faced with incivility (Aebersold & Schoville, 2020). Lapses in patient safety are another undesired consequence resulting from a disrespectful work environment, as breakdowns in communication have been identified as a significant factor in the majority of sentinel events (Sauer et al., 2018).

In response to the mounting evidence for the negative effects of incivility, the Joint Commission appealed to all health care organizations to take measures to decrease behaviors that undermine a culture of safety (The Joint Commission, 2017). Research on incivility began over three decades ago; however, the search for prevention interventions continues to date. One systematic review of literature examined over 19,000 research articles on the topic but found only one quantitative study reporting a 5% increase in civility utilizing the Civility, Respect and Engagement in the Workforce (Crew) intervention (Gillen et al., 2017). The remaining studies reported no increase in civility in the workplace (Gillen et al., 2017).

The search for incivility prevention interventions has also led experts and professional organizations to call on Academia to strengthen the moral courage values of nursing students when faced with behaviors of incivility (ANA, 2015; Fitzpatrick, 2018). Confronting behaviors of incivility requires moral courage; however, graduate nurses often fear risks of humiliation, rejection, ridicule, unemployment, and loss of social standing (Lachman, 2010). Moral courage can be thought of as acting according to one's convictions and doing what one thinks is right despite adverse consequences (Eby et al., 2013; Kritek, 2017; Numminen et al., 2017; Sadooghiasi et al., 2016). While the nursing curriculum is ideal for building moral courage values, few studies describe how these values are embedded in any nursing curriculum through the use of simulation.

Qualitative studies identifying barriers to exercising moral courage indicate a need to implement teaching strategies directed toward contextual and individual factors that influence student nurses' decisions to respond to incivility (Bickhoff et al., 2016; Edwards et al., 2009; Fagan et al., 2016; Gillespie et al., 2015; Schoville & Aebersold, 2020). Recent studies support the use of uncivil problem-based-learning (PBL) scenarios, video simulations (VS), role-play simulations, and active simulations in preparing student nurses for uncivil encounters (Aebersold & Schoville, 2020; Clark & Ahten, 2013; Sharpnack et al., 2013). Problem-based-learning is an instructional strategy in which students confront contextualized, ill- structured problems and strive to find meaningful solutions (Clark & Ahten., 2013). Video simulations incorporate faculty recorded scenarios to promote student collaboration concerning an incivility encounter (Sharpnack et al., 2013). Role-play simulation involves role-play scenarios to raise awareness and understanding of strategies that address incivility (Aebersold & Schoville, 2020; Gillespie et al., 2015). Active simulations utilize anticipated uncivil healthcare scenarios as a teaching

strategy to guide collaboration among students in identifying solutions and priority courses of action to take (Sauer et al., 2018). The use of simulation-based education to develop moral courage to respond to incivility in nursing students is underexplored. By placing students in a simulated uncivil encounter, and relating its potential negative impact to patient outcomes, it is anticipated that students' moral courage to advocate for patient safety will increase.

This review of literature identifies barriers and predictors associated with moral courage responses in healthcare and explores studies that support moral courage development through various teaching strategies. The review also examines the concept of simulation as an intervention technique to foster moral courage in nursing students when faced with behaviors of incivility. Last, the review will provide an overview of previous studies incorporating the measurement of moral courage.

Moral Courage

Kidder (2005) describes moral courage as "the courage to be moral" and the ability to persist in being true to one's principles or values regardless of danger to self and relationships (p.10). According to Kidder (2005) moral courage is a core virtue of humanity and an intersection of action based on core values, awareness of risks, and a willingness to endure necessary hardship. It is driven by principles and manifested in the service of the five core values of honesty, respect, responsibility, fairness and compassion (Kidder, 2005). Moral courage differs from physical courage, in that it is also about-facing mental challenges that could risk one's reputation, well-being, self-esteem, or financial status (Kidder, 2005). Moral courage requires consideration of various actions, other's viewpoints and one's own decisional processes (Koskinen et al., 2020). Nurses often find themselves in ethically questionable situations that conflict with their personal or professional morals. These situations often require instinctual

responses that allow the nurse to quickly arrive at the right course of action. Healthcare worker incivility is an example of a moral dilemma requiring a quick response by the nurse in order to deter the potential negative effects on patient outcomes. Nursing students, however, are often unaware of the impact co-worker incivility can have on patient outcomes and find it difficult to exercise moral courage when faced with these encounters (Spruce, 2016). **"**Most have never been taught to address these types of situations, and many will leave a facility rather than endure the treatment or attempt to remedy it" (Spruce, 2016, p. 20). Koskinen et al. (2020) claim moral courage can be developed but advise educators to appraise whether their teaching enhances their students' ability to put their moral courage into action in ethically demanding situations. Some examples of morally courageous actions taken in ethically demanding situations of incivility may include: (a) speaking to a colleague, (b) speaking to the transgressor, or (c) speaking to a manager (Kirrane et al., 2017). Throughout the literature, numerous studies explore factors associated with barriers and predictors for the student's ability to act in moral courage in general; however, little research has attempted to measure nursing students' moral courage development.

Moral Courage Barriers

When faced with incivility, "the majority of millennial students (aged 22-37) are reluctant to advocate for their patients or assert themselves during morally stressful situations" (DeSimone, 2019, p. 2). Barriers to responding in moral courage include student reports of fear, anger, subordination and lack of confidence (Bickhoff et al., 2017; Fagan et al., 2016; Kirrane et al., 2017). Themes identified as contributing to these barriers include: (a) "being just a student, (b) not rocking the boat, (c) fear of consequences, (d) mentor-student relationships, and (e) lack of knowledge" (Bickhoff et al., 2017, p. 71).

According to Bickhoff et al. (2017) being “just a student” (p. 74) leads students to believe they have no voice or right to question a licensed nurse. This power differential leads the student to conforming to practices in the clinical environment which could negatively impact quality of patient care (Bickhoff et al., 2016; Christensen et al., 2007; Kent et al., 2015). This type of silence is considered “defensive silence” as the student is “protecting self” and is associated with the emotion of fear (Kirrane et al., 2017). Facing fear involves experiencing emotions such as anxiety and doubt that can lead to a first response of not getting involved in a risky encounter; however, morally courageous individuals regularly exercise self-regulation of a moral response despite fear (Eby et al., 2013; Edwards et al., 2009; Fagan et al., 2016; Kent et al., 2015; Kritek, 2017; Lachman 2010; Law & Chan, 2015; Murray, 2010; Martinez et al., 2016; Sekerka et al., 2009). Mentor-student relationships further contribute to the student’s choice to remain silent (Bickhoff et al., 2016; Christensen et al., 2007; Kim, 2017; Lachman, 2010). If students observe other nurses, not morally speaking up, they are more likely to replicate this behavior (Bickhoff et al., 2016; Christensen et al., 2007; Kim, 2017; Lachman, 2010). Christensen et al. (2007) explain that most adults operate at the conventional level of cognitive moral development where moral decisions are based on the larger society expectations. “People look up and around to see what their peers are doing to guide their actions” (Christensen et al., 2007, p. 80). The role and position of subservience also influences the student’s self-perception and value of their contribution and their confidence to assertively speak up (Fagan et al., 2016). Kirrane et al. (2017) identifies this as a form of “acquiescence silence” in which the individual becomes resigned and disengaged believing their opinion is not valued (Kirrane et al., 2017). Additionally, students report concern for looking foolish as a barrier to putting their moral courage to action (Bickhoff et al., 2016). This lack of confidence extends from generational

differences and lack of knowledge concerning regulations, policies, and organizational systems (Bickhoff et al., 2016; Fagan et al., 2016; Lachman, 2010).

Moral Courage Predictors

Qualitative studies exploring moral courage support education focused on motivators and predictors associated with decisional processes for speaking up (Bickhoff et al., 2016; Christensen et al., 2007; Fagan et al., 2016; Gillespie et al., 2015; Kent et al., 2015; Sauer et al., 2018). The goal of such education is to improve teamwork and communication and thereby prevent patient harm (ANA, 2015; Bickhoff et al., 2016; Clark & Ahten, 2013; Eby et al., 2013; Fagan et al., 2016; Gillen et al, 2017; Keller et al., 2018; Lachman, 2010). Motivators to voicing concerns include moral and ethical beliefs, willingness, and self-confidence (Fagan et al., 2016; Kidder, 2005; Lachman, 2010). Defining attributes making one more likely to speak up include advocacy and agency (Christensen et al., 2007; Fagan et al., 2016). Advocacy involves interceding through thoughtful communication on behalf of oneself and others (Christensen et al., 2007; Fagan et al., 2016). Student nurses strongly identify with their role as a patient advocate and are more willing to challenge practices detrimental to patient safety (Bickhoff et al., 2017). Agency involves a student's willingness to engage in conflict through moral action (Bickhoff et al., 2016; Christensen et al., 2007). Some authors claim that moral agency can be taught (Christensen et al., 2007; DeSimone, 2019; Sekerka et al., 2009; Spruce, 2016). Bickhoff et al. (2017) suggest nursing students' moral agency develops over the course of their degree and moral courage is greatly enhanced when students strongly identify as patient advocates.

Teaching Moral Courage

Disciplines including business and sociology lend insight into the concept of teaching moral courage in times of ethical decision making. Christensen et al. (2007) compared several

methods for developing resolve to have moral courage in accounting students (traditional vignettes, guided reflection, moral exemplars, and exhortation) based on Rest's piloted four-component-model of moral courage. The piloted model included comparisons of moral sensitivity, moral judgment, moral motivation, and moral action. Gain scores, defined as differences between post-test and pre-test observations for each student, were averaged for each group. Questions from the Moral Competency Inventory were utilized to reveal personal commitment to an attribute of moral competency. Differences were tested across the four methods using one-way analysis of variance at an alpha level of .05. Traditional methods of teaching ethical principles promote moral sensitivity and judgement; however, moral sensitivity and moral judgment are insufficient conditions for moral behavior, moral motivation is also needed (Christensen et al., 2007). The main gain scores of the reflection and exemplar methods were significantly greater than the mean gain score of the traditional and exhortation methods, suggesting that the reflection and exemplar methods were more effective in creating resolve to have moral courage than the traditional and exhortation methods (Christensen et al., 2007).

Oliver et al.'s (2017) pilot study explored the SPEAKER model's effect on teaching moral courage to speak up in social work students. Drawing on lived experience and review of relevant literature, the authors collaborated with 10 social work students to develop 'Difficult Conversations' learning activities for an undergraduate social work practicum seminar course. One premise of the education drew on creating a safe place to discuss real-life difficult conversations. The quantitative portion was analyzed using descriptive statistics and the qualitative data were analyzed using a process of coding and constant comparative analysis based on grounded theory. A practice model was adapted from Rushton's moral distress model to guide students through the steps of engaging in difficult conversations. The students utilized

reflective journaling and role-playing to guide them in difficult conversations. Indications from the study suggest the relationships between the desire to speak up, the decision to speak up, and the act of speaking up are influenced by context and pre-conscious responses (Oliver et al., 2017); however, they are regulated by conscious choices over which educators have some influence (Sekerka et al., 2009). The authors suggest that teaching moral courage is best done through: "(a) discourse and discussion; (b) modelling and mentoring; and (c) practice and persistence" (Oliver et al., 2017, p. 709).

Simulation to Teach Moral Courage

Simulation is a dynamic pedagogical strategy which enables students to relate theory and practice in a wide range of professional contexts (Guimaraes et al., 2018). Jeffries (2005) defined simulation as "activities that mimic the reality of a clinical environment and are designed to demonstrate procedures, decision-making, and critical thinking" (p. 97). At the academic level, descriptive studies involving the student nurse's response to uncivil problem-based-learning (PBL) scenarios, video simulations (VS), role-play incivility simulations and active incivility simulations suggest usefulness in bridging new graduate nurses into the workforce. Problem based-learning (Clark et al., 2014), video simulation (Sharpnack et al., 2013), role play simulation (Aebersold & Schoville, 2020), and active incivility simulation (Sauer et al., 2018) had the effect of guiding students to recognize uncivil encounters, but the effect remains unclear for the graduate nurse's ability to exercise moral courage in the workplace.

Clark and Ahten (2013) explored the use of PBL in nursing students by using Kirkpatrick's model to evaluate students' perceived ability to address incivility in the work environment. Problem-based-learning requires the student to consider a potential solution to relevant scenarios. This teaching method engages students to identify what they know, what they

don’t know, what they need to know, and how to communicate with others (Clark & Ahten, 2013). Results of the study suggest student reports of heightened awareness of incivility in the practice environment and an increased level of confidence in their ability to address uncivil behaviors in their future workplace (Clark & Ahten, 2013).

Sharpnack et al. (2013) utilized a quasi-experimental pretest-posttest design to evaluate the effectiveness of video simulations to rehearse professional practice in nursing students. Faculty recorded video simulations, including incivility scenarios based on real-life occurrences, were used to evaluate learning at the end of a twelve-month period. During video presentations, students were able to collaborate and decide courses of action, prioritize concerns, choose communication techniques, and identify patient safety concerns (Sharpnack et al., 2013). Paired sample *t*-tests were conducted for each class to compare the mean pre-test scores with the post-test scores. Results revealed a statistical difference ($N = 54$, $p < .001$) in means for pre-test and post-test scores in assessment, communication, critical thinking, and technical skills (Sharpnack et al., 2013). The post-test results demonstrated deeper learning and understanding that led to selecting appropriate nursing actions for each video simulation.

Schoville and Aebersold’s (2020) qualitative descriptive study explored senior-level BSN nursing students’ ($N= 169$) understanding and awareness of bullying and strategies to use when it occurs through a 2-hour role-play simulation followed by a reflection survey. The simulation consisted of a nurse bully and several nurses who conspired against a new nurse during shift report, medication administration, or throughout patient care. Students prepared for the simulation by reading seven journal articles that spanned the concepts of bullying prevalence and behaviors, victims, the impact on the individual experiencing bullying, and the costs to the institution. All sessions began with pre-briefing followed by role assignments for the students as

patient, family member, staff nurse, clerk, charge nurse, or conspiring nurse. A simulated actor played the bully nurse. Incivility simulation instructions were given to each participant individually followed by a thirty-minute simultaneous incivility event at one of the designated locations. Participants then went to a conference room for a 60-minute debriefing where students explored their feelings of being bullied or witnessing the bullying and identified interventions to use with bullying. The students then completed a post-evaluation survey. Students expressed appreciation for practicing the experience in simulation prior to experiencing it in real life. Students identified the importance of supportive teams, asking for help, standing up for themselves and for speaking up. Students reported feelings of fear, shame, hurt, and a sense of empowerment to advocate for themselves. Student observers commented on the quickness of nurses aligning with the bully and how they witnessed incivility behaviors in action. This sparked reflection within the students to consider how they could respond in the future. Students admitted that their decision making was altered as they felt overwhelmed by the bully. One observer commented on their admiration for the 'courage' of the charge nurse who stood up to the bully. Another student realized they had already witnessed some of the bullying behaviors in their clinical placements.

Measuring Moral Courage

Psychometrically sound tools for measuring nursing students' moral courage are not found in the literature; however, Martinez et al. (2016) provided psychometrically validated properties for the Moral Courage Scale for Physicians (MCSP). The MCSP scale was based on the professional moral courage scale developed by Sekerka et al. in 2009 to measure moral courage for physicians in the context of patient care through five themes: "moral agency, multiple values, endurance of threats, measures beyond compliance, and moral goals" (Martinez

et al., 2016, p. 1431). Participants (*N= 352*) were taken from two large academic medical centers located in the northeastern United States. The moral courage questionnaire was embedded within a larger survey of patient safety culture and speaking-up. Principal component analysis with orthogonal varimax rotation on 12 preliminary MCSP items was undertaken and demonstrated a single, meaningful nine-item factor labeled the Moral Courage Scale for Physicians (MCSP) (Martinez et al., 2016). All item-total score correlations were significant ($p < .001$) and ranged from 0.57 to 0.76. A Cronbach's alpha of .90 suggested excellent internal consistency based on theory. MCSP scores were negatively associated with being an intern versus resident ($B = -4.17$, $p < .001$) suggesting discriminant validity. MCSP scores were positively associated with respondents' Jefferson Scale of Physician Empathy perspective-taking score ($B = 0.53$, $p < .001$), a construct conceptually relevant to moral courage, suggesting convergent validity. Finally, MCSP scores were positively correlated with self-reported speaking up about patient safety ($r= 0.19$, $p = .008$), an action that involves moral courage, suggesting concurrent validity. Construct validity was established theoretically. Recommendations for further research identified the need for use of the MCSP to be utilized in other healthcare disciplines to measure moral courage (Martinez et al., 2016).

Theoretical Framework

The National League of Nursing (NLN) Jeffries Simulation Theory served as the theory for framing this study. The NLN Jeffries Simulation Theory evolved from the NLN Jeffries Framework, developed in 2005, to guide educators in implementing, developing, and evaluating the use of simulated learning experiences (Jeffries, 2005). It was informed by three theories of learning including: (a) constructivist, or the acquisition of new knowledge through experience, (b) sociocultural, which asserts that learning is interactive, and (c) and learner centered theory,

which involves learning through guidance of the instructor (LaFond & Van Hulle Vincent, 2012). The basic assertion of the framework was that four interrelated concepts of teacher, student, educational best-practices, and simulation design characteristics, influenced the fifth the component of student-learning outcomes (Jeffries, 2005; LaFond & Van Hulle Vincent, 2012).

In response to an increased growth in simulation research, the International Nursing Association for Clinical Simulation and Learning (INACSL) saw the need to review the framework in 2011 (Lafond & Van Hulle Vincent, 2012). The findings from the systematic review largely supported the NLN Jeffries Simulation Framework but suggested modifications or additions to the existing variables (Adamson, 2015). As a result, new concepts were formulated, added to the NLN Jefferies Framework, and currently serve as the NLN Jeffries Simulation Theory (Jeffries et al., 2015; Jeffries & Rodgers, 2021). The major concepts included in the NLN Jeffries simulation theory are: (a) context, (b) background, (c) design, (d) simulation experiences, (e) facilitator and educational strategies, (f) participants, and (g) outcomes.

The NLN Jeffries Simulation Theory identifies *context* as foundational for understanding real-life situations through simulation research and provides an avenue to study participant responses in a way that would not be possible during actual patient encounters (Jeffries & Rodgers, 2021). The concept of *context* involves identifying what the simulation is being designed for, including the overarching purpose, the usage, the circumstances, and setting where the simulation will take place (Jeffries & Rodgers, 2021). Sullivan et al. (2019) note in their side-by-side comparison study that more clinical reasoning opportunities and activities are accomplished in one-fifth of the time in an academic simulation compared to the traditional clinical experience. Though the simulation-based experience (SBE) is being developed in an

academic setting, the spaces, locations, and resources should mimic realistic patient care (Cowperthwait, 2020).

The concept of *background* is considered a benchmark for planning the goals, expectations, and resources needed for the simulation activity (INACSL, 2016a; Jeffries & Rodgers, 2021; Jeffries et al., 2015). The concept of *background* begins with a needs assessment to provide the foundational evidence for the need of a well-designed SBE (INACSL, 2016a). The needs assessment may include analysis of underlying concerns in patient safety or an identified gap in knowledge through literature review (INACSL, 2016a). Goals of the simulation are formulated based on the needs assessment while considering the desired acquisition of knowledge, skills, attitudes, and/or behaviors for the targeted participants as well as the placement of the simulation pedagogy within the broader curriculum (INACSL, 2016a; Kardong-Edgren, 2021). The success of the simulation requires use of clear evidenced-based guidelines such as the INACSL standards of best practice when planning and preparing SBEs (Jeffries et al., 2015). Additional theoretical perspectives are identified within the concept of *background,* when needed, for the specific simulation experience (Jeffries et al., 2015).

The concept of *design* begins with formulating broad and specific learning objectives that guide the development or selection of activities and scenarios with appropriate problem-solving complexity (Jeffries et al., 2015). Broad objectives reflect the purpose of the SBE and are related to the organizational goals (INACSL, 2016b). Specific objectives are related to participant performance measures (INACSL, 2016b). *Design* elements include: (a) participant/observer roles, (b) progression of activities with predetermined responses by the facilitator to the participants' interventions, and (c) briefing/debriefing strategies (Adamson, 2015; Jeffries & Rodgers, 2021; Jeffries et al., 2015). Formulated guides serve as blueprints for the students and

facilitators to promote the participants' ability to meet the objectives (INACSL, 2016c). These guides allow students to identify the learning objectives, necessary prep work, and patient background information prior to the SBE (INACSL, 2016c). The facilitator guide is an extension of the student guide but also includes a list of needed resources, equipment, pre-briefing points, cues to deliver during the simulation, and debriefing discussion questions (INACSL, 2016c). The scenario case is developed to include the backstory and a realistic starting point with clinical progression and cues that advance the scenario. The case may include embedded elements of patient safety, teamwork, or professionalism within the design (INACSL, 2016c). A script of a scenario is developed for consistency and standardization to increase scenario repeatability/reliability (INACSL, 2016c). Evidenced-based critical actions or performance measures are determined to evaluate achievement of scenario objectives (INACSL, 2016c). Use of subject matter experts strengthen the validity of the simulation scenarios (INACSL, 2016c).

Simulation experience is characterized by an environment that is experiential, interactive, collaborative, trusting, and learner centered. The simulation experience involves execution of the planned activity within a trusting environment to support the psychological safety of the participant (Stephen et al., 2020). A psychologically safe environment is defined as one where individuals feel comfortable to take risks without fear of negative consequences (Stephen et al., 2020). The simulation experience should incorporate the appropriate type of fidelity to create a perception of realism (INACSL, 2016a). Pre-briefing should precede the experience and include orientation to the space, manikin, equipment, roles, and limitations (Stephen et al., 2020). A review of the objectives should be covered and adequate prep-time allowed to prepare for the SBE (Stephen et al., 2020). The SBE should be followed by a debriefing session to allow for reflection and conscious consideration for the meanings and implications of actions (INACSL,

2016a). Reflection can lead to new interpretations and cognitive reframing by the participants (INACSL, 2016a).

The concepts of *facilitator and educational strategies* involve a dynamic interaction between the facilitator and the participants (Jeffries & Rodgers, 2021). Effective facilitation requires a facilitator who has specific skills and knowledge in simulation pedagogy (INACSL, 2016c). Formal preparation for the facilitator role is a priority for faculty. Attributes include skill, educational techniques, and the ability to guide, support, and seek out ways to assist participants in achieving expected outcomes (INACSL, 2016c). The facilitative and educational strategy approach is appropriate to the level of learning, experience, and competency of the participants (INACSL, 2016c). Facilitative educational strategies include preparatory activities and pre-briefing to prepare the participants for the SBE (INACSL, 2016c). During the SBE the facilitator responds to the participants' needs by adjusting educational strategies (INACSL, 2016c). Educational strategies include providing cues during the simulation through a variety of methods such as delivery of laboratory results, phone calls from providers, or embedding actors for events (INACSL, 2016c). Facilitators are competent in the process of debriefing which allows for reflection and interpretation of the SBE (INACSL 2016c). Evidence suggests that essential learning occurs in the debriefing phase of the SBE with heightened *participant* self-awareness and self-efficacy (INACSL 2016c). Use of an identified theoretical debriefing framework such as GAS (gather, analyze, summarize) allows summarization of learning to close the gaps in knowledge and reasoning (INACSL, 2016c). The debriefer is responsible for providing formative feedback based on the scenario objectives, participants' decisions, and misunderstandings (INACSL, 2016d). The debriefer should have specific initial education through a formal course, have worked with an experienced mentor, and actively maintained

debriefing skills as evidenced by an established instrument to ensure the best possible learning outcomes (INACSL, 2016d).

The concept of *participant* is defined as the individual being immersed into the simulation encounter (Jeffries & Rodgers, 2021). Non-modifiable *participant* attributes that affect the SBE include age and gender (Jeffries & Rodgers, 2021). Modifiable attributes include level of anxiety and preparedness (Jeffries & Rodgers, 2021). Individually assigned roles that the participants assume for the simulation can alter their learning (Jeffries & Rodgers, 2021). The role can be an active one, in which the *participant* is immersed into the decision-making aspects of the SBE, or it can be an observer role where participation occurs after the SBE during the debriefing session (Jeffries & Rodgers, 2021).

Simulation based experiences incorporate the development of measurable outcomes and objectives (INACSL, 2016b). Outcome measures determine the impact of the SBE (INACSL, 2016b). The concept of *outcomes* for simulation is divided into three separate areas: (a) participant, (b) patient, and (c) systems outcomes (Jeffries et al., 2015; Jeffries & Rodgers, 2021). Participant outcomes focus on learning behaviors, knowledge, skill acquisition, and attitudes (Jeffries & Rodgers, 2021). Research has primarily focused on participant *attitudes* as measured in areas of satisfaction or self-confidence; whereas, research on participant *behaviors* has focused on how the learning transfers to the clinical environment (Jeffries & Rodgers, 2021). Systems outcome measurements focus on changes implemented on a systems level and include cost effectiveness, throughput of services, identifying gaps in the healthcare system, or the need for practice change (Jeffries & Rodgers, 2021). Jeffries and Rodgers (2021) identify the greatest need for simulation research is in the area of patient outcomes. Once the outcome measures have been determined for the SBE, broad and/or specific objectives are developed that will guide the

achievement of the outcomes (INACSL, 2016b). Bloom's taxonomy provides a framework for developing the objectives to meet the expected outcomes (INACSL, 2016b). The taxonomy classifies three domains of learning: cognitive, psychomotor and affective (INACSL, 2016b). Simulation based activities provide higher levels of Bloom's cognitive, psychomotor and affective learning through behaviors of applying, analyzing, evaluating, and creating (INACSL, 2016b). Sedgwick et al. (2019) suggest that simulation can extend ethics education in undergraduate nursing programs beyond the cognitive domain. However, nurse educators must be moral agents during the simulated learning experience by helping students learn what ethical dilemmas are and what strategies to use to manage them. Ethical dilemmas in nursing are instances of ethical or unethical behaviors as established by nursing codes of conduct (Sedgwick, 2019). This study added to understanding the effect of an uncivil simulated dilemma on moral courage development in nursing students as the outcome variable was measured using the MCSP. (See Appendix A for a visual representation of the NLN Jeffries Simulation Theory as applied to nursing students' moral courage development in response to incivility simulation).

Conceptual and Operational Definitions

Table 1 provides conceptual and operational definitions for the study variables. Table 2 presents major concepts of the NLN Jeffries Simulation Theory as it relates to this study.

Table 1

Conceptual and Operational Definitions

Variable	Conceptual definition	Operational definition
Simulation Educational Intervention	Pre-planned activity within an experiential, interactive collaborative, trusting, and learner centered environment to support the psychological safety of the participant (Stephen et al., 2020)	The Simulation experience consists of an executed experiential patient care scenario framed by the NLN Jeffries Simulation Theory, with an encounter of unexpected incivility from a healthcare provider targeted at one participant and two bystanders on a Med/Surg unit. The simulation intervention consists of a 15-minute pre-briefing session, plus a 20-minute simulated experience. One of two trained actors play the role of the uncivil healthcare provider. A 25-minute debriefing session follows the simulation activity to allow for cognitive reflection. The ADN university upper-and lower-level interventional group of students are the only participants that will receive the intervention.
Educational Module Intervention	Articulate software system incorporating a pre-packaged pre-developed, researcher designed, interactive online unfolding case-study. Components include: Understanding incivility, Kidder's (2005) five core values of moral courage, Lachman's (2010) *Strategies Necessary for Moral Courage*, CODE, and Keller's (2019) S^4 strategies.	Upon obtaining electronic consent, both the comparison (BSN) and intervention (ADN) groups are automatically re-directed to the interactive online educational module. The module includes an interactive unfolding case-study involving an uncivil encounter between a charge nurse and a new graduate nurse. The participant must select the correct choices to advance through the module.
Demographic factors	Age and identified gender	Demographic factors of age and gender identity included in a demographic survey

Table 1 Continued

Variable	Conceptual Definition	Operational Definition
Worked in healthcare more than 6 months	Prior employment in the healthcare setting for more than 6 months	Question included in survey Has the participant worked in a healthcare setting for more than 6 months?
Prior workplace incivility	Prior experience of incivility while in the workplace.	Question included in survey Has the participant experienced incivility while in the workplace?
Incivility In personal life	Prior experience of incivility in personal life.	Question included in survey Has the participant Experienced incivility in personal life?
Ethical dilemma in need of moral courage	Prior experience of a dilemma in need of personal moral courage	Question included in survey Has the participant encountered an ethical dilemma in need of Moral Courage?
Outcome Moral Courage	The degree of predisposition to voluntarily and willingly act upon ethical convictions despite barriers (Martinez et al., 2016).	Moral Courage Scale for Physicians (MCSP) modified for nursing students. Nine-item factors. Scores range from 9-63. (Martinez et al., 2016)

Table 2

NLN Jeffries Concepts Applied to Moral Courage Educational Simulation

Concept	Description	Application
Context	The setting, circumstances and purpose in which a simulation takes place (Jeffries et al., 2015)	The academic simulation lab, with use of high-fidelity equipment and a standardized actor was used for the purpose of interjecting an uncivil encounter by a healthcare provider during the course level appropriate simulation event.
Background	The goals of the simulation based on a needs assessment and a gap of knowledge through literature review (Jeffries et al., 2015)	The goal of the simulation was informed by an exhaustive literature review by the researcher, to explore the effect of simulation plus an education versus a educational module alone in developing moral courage in nursing students.
Design	Pre-determined broad and specific learning objectives that guide the scenario with appropriate problem-solving complexity (INACSL, 2016b)	The pre-determined broad objective was for the participant to encounter an uncivil event to allow for cognitive reflection upon course of actions to taken. The specific learning objective was for the student to practice decisional processes for engaging in moral courage behaviors during an uncivil encounter.
	Design elements include participant/observer roles, progression of activities with predetermined responses and briefing/debriefing strategies (INACSL, 2016b).	Participant roles included: one student served as the student nurse target of incivility, two students served as nurse peer bystanders to the encounter, and one served as the charge nurse. All participants had the opportunity to engage in moral courage behaviors. Design element included a 15-minute pre-briefing session focused on review of the pre-sim prep work facilitated by the trained INACSL researcher. Design element include a 20-minute progression of activities as developed by the INACSL trained facilitator/researcher with pre-determined responses to the participants' actions as outlined in the facilitator guide. Design element included a pre-planned 25-minute debriefing activity led by the trained INACSL facilitator to allow for cognitive reflection on moral courage behaviors.

Table 2 Continued

Concept	Description	Application
Simulated Experience	Execution of the planned activity within an experiential, interactive collaborative, trusting, and learner centered environment to support the psychological safety of the participant (Stephen et al., 2020)	The Simulation experience of an executed experiential patient care scenario allowed for an encounter of incivility from a healthcare provider targeted at one participant and two bystanders. The simulated experience took place in a trusting, collaborative and safe setting within the academic environment.
Facilitator and Educational Strategies	A facilitator has specific skills and knowledge of simulation pedagogy and debriefing strategy (INACSL, 2016c).	The facilitator is an INACSL fellow who has completed one- year of training in simulation pedagogy and debriefing techniques.
	Educational strategy as appropriate for the level of learning, experience and competency of the participants to include preparatory activities (INACSL, 2016c)	Educational strategy utilized a level of learning consistent with the students' experience and position within the progression of nursing curriculum of courses.
	Educational Strategies to include delivery of cues during the simulation and guided debriefing (INACSL, 2016c).	Educational strategy of cues delivered during the simulation occurred based on pre-planned unfolding case development of an uncivil encounter from a healthcare provider during the course's usual clinical simulation.
		Educational de-briefing strategies included reflection on emotional decisional responses and based on personal/professional values, willingness, self-confidence, and Kidders' five core values of honesty, respect, responsibility, fairness and compassion.
Participant Personal factors	The individual being immersed into the simulation encounter (Jeffries & Rodgers, 2021)	Thirty-four students participated in an upper-level (200) Associate Degree of Nursing Program simulation activity
		Thirty-four students from the same university's lower-level (100) course participated in the simulation activity.

Research Questions and Hypotheses

The following foundational research questions were considered:

1. Is there a significant difference in pre-test/post-test moral courage scores for upper-level students who view an educational incivility module?
2. Is there a significant difference in pre-test/post-test moral courage scores for lower-level students who view an educational incivility module?
3. Is there a significant difference in pre-test/post-test moral courage scores for upper-level students who view an educational incivility module plus experience an episode of incivility during clinical simulation?
4. Is there a significant difference in pre-test/post-test moral courage scores for lower-level students who view an educational incivility module plus experience an episode of incivility during clinical simulation?

The primary research question was:

5. Is there a difference in pre-test/post-test moral courage scores for upper and lower-level nursing students who view an educational incivility module versus upper and lower-level nursing students who view an educational incivility module plus experience an episode of incivility during a clinical simulation?

The hypotheses for the study were:

1. Upper-level nursing students will have higher moral courage pre-test scores than lower-level nursing students across the control and intervention groups.
2. Nursing students who view an educational incivility module plus experience an episode of incivility during a clinical simulation will have a larger increase in moral courage scores compared to nursing students who only view an educational incivility module.

Research Design

A review of literature returned few interventional studies exploring the use of simulation to prepare nursing students for workplace incivility. Additionally, few studies explored measuring moral courage to speak up in times of incivility, particularly in nursing students. Therefore, a quasi-experimental non-equivalent pretest-posttest design was implemented as the subjects were not randomly assigned to groups (Portney & Watkins, 2015). The pretest-posttest design was used to show the effect of the intervention on the scores. The research hypothesis was tested by the chosen design.

Methods

Sample

A convenience sample of 136 nursing students at two universities in the southern region of the United States were sought for recruitment to participate in one of two educational formats. A minimum of 34 upper-level BSN and 34 lower-level BSN students from one university in the southern region of the United States was sought to participate in the online educational module. A minimum of 34 upper-level ADN and 34 lower-level ADN students from a different university in the southern region of the United States was sought to participate in the online educational module plus the simulated incivility encounter intervention. Participants were recruited for participation at the BSN University through email notification. Participants were recruited for the educational module and simulation intervention through email notification at the ADN university. Students willing to participate in the study were offered to voluntarily be placed in a drawing for a chance to win a $100 Amazon gift card. One gift card was awarded for each university.

Eligibility criteria included: (a) enrolled as an undergraduate nursing student in either upper level or lower-level nursing courses at the academic institution, (b) age 18 or older. Exclusion criteria included: (a) not enrolled in chosen academic nursing program. After confirmation of eligibility requirements, all participants at the BSN and ADN institutions electronically consented to participate in the study at their respective university.

To avoid type II error, a power analysis using G*Power was utilized to determine the size of convenience sample needed to detect a significant difference in moral courage scores. G* Power (*d:* .3, α. 05, 1 -β err prob .80) indicated a sample of 128 total participants would be needed for two-tailed *t* tests to compare differences between two independent means. To allow for attrition, a total of 136 participants, 34 per group, were sought for recruitment for participation.

Protection of Human Subjects

The proposal received Institutional Review Board (IRB) approval at two universities in the southern region of the United States prior to data collection (See Appendix B and Appendix C for Human Use Consent and IRB forms). An invitation and statement of purpose allowed potential subjects at both sites to determine if they wanted to participate in the study. To further protect study participants, the following was explained prior to requesting consent: full disclosure of the purpose of the study, data collection procedures, expectations of commitment, potential risks and benefits of the participation, protection of the student's personal identification, right to withdraw from the study at any time without prejudice, and the researcher's contact information. To protect their identity, students created their own codes using unique identifier numbers and letters taken from the first three letters of their maternal parent's maiden name and their two-digit birth month and four-digit birth year. Data were stored within a

password protected computer software system protected further by firewall software. All study data contained within the computer software program were maintained in the researcher's locked office.

Instruments

Requested demographic information included age, gender identity, and current course level in the nursing curriculum. Additional questions included in the demographic section were:

1. Have you worked in healthcare more than six months?
2. Have you experienced incivility while in the workplace?
3. Have you experienced incivility in your personal life?
4. Have you encountered an ethical dilemma in need of moral courage?

This information was useful in comparing generational, gender, and education level differences among the participants and to examine the covariance of prior experience with incivility and moral courage dilemmas (See Appendix D). It was also useful for analyzing and interpreting the generalizability of the study results. Moral courage scores were assessed pre-and post-intervention using the Moral Courage in Physicians (MCSP) Scale. Surveys for the participants and eligibility vetting took place through the online survey site Qualtrics (Qualtrics, Provo, UT) in which only the researcher had password protected access.

Moral courage can be defined as the voluntary willingness to stand-up for and act on one's ethical beliefs despite barriers that may inhibit the ability to proceed toward right action (Martinez et al., 2016). The Moral Courage Scale for Physicians (MCSP) was utilized to measure the following moral courage themes in nursing students: (a) endurance of threats, (b) multiple values, (c) moral agency, (e) moral goals, and (f) measures beyond compliance. Martinez et al. (2016) performed initial psychometric testing utilizing Principal Component Analysis (PCA)

with orthogonal varimax rotation to result in a single, meaningful factor described as *physician moral courage*. Cronbach's coefficient alpha for the MCSP was .90 indicating excellent internal consistency. The scale consists of a 9-item survey which focuses on features of moral courage in context of patient care and is measured on a 7-point Likert scale from strongly disagree = 1 to strongly agree = 7. Summary scores ranged from 9 (lowest) to 63 (highest). Discriminant validity was assessed using the known-groups validation method. Multivariate linear regression tested the relationship among variables. Bonferroni correction was to be applied when interpreting the significance of the results of the multivariate analysis. Components of the MCSP may be found in Appendix E. Permission to utilize and the MCSP scale may be found in Appendix F.

Procedures

Simulation Plus Educational Module

This group was the intervention group and consisted of 34 participants from one upper-level ADN nursing program and 32 participants from one lower-level ADN nursing program. In addition to the online educational module, students participated in a structured simulation developed by the researcher based on INACSL standards of best practice and framed by the NLN Jeffries Simulation Theory. One of two trained standardized actors was utilized for the role of an uncivil physician for all simulations. A facilitator's guide detailed the simulation experience. A debriefing guide served as the basis for education focused on the participants' personal/professional values, willingness, and self-confidence to respond in moral courage. Lachman's (2010) *Strategies Necessary for Moral Courage*, and acronym, *CODE*, developed to guide nurse's advocacy skills, along with Keller et al.'s (2018) concepts of "standing up, supporting, speaking up, and sequestering (S^4)" (p. 1) were also role-played and discussed during the debriefing session. "It is important to role-play what *support* looks like, otherwise the most

common response is to turn the other way" (R. Keller, personal communication, December 3rd, 2019). Components of the simulation intervention procedures may be found in Appendix G.

Educational Module

This comparison group of participants was to consist of a minimum of 34 participants from one upper-level BSN nursing program and a minimum of 34 participants from one lower-level BSN nursing program. However, due to a low response rate per course level, the data were insufficient to incorporate into the study results. Students were to participate in an online educational module developed by the researcher. The module incorporated Articulate Software in which realistic interactive case studies of healthcare worker incivility were presented. Components of the educational module included a historical understanding of incivility in healthcare, its potential negative impact on patient outcomes, implications for the need to exercise moral courage, and example cases of incivility in need of moral courage. The educational module further focused on personal/professional values, willingness, and self-confidence to respond to incivility through moral courage. Kidders' five core values of moral courage and Lachman's (2010) *Strategies Necessary for Moral Courage*, were included in the educational module. These strategies follow the acronym CODE, where C stands for courage, O for obligation, D for danger management, and E for expression through action (Lachman, 2010). Keller et al.'s (2018) S^4 model was another component of the educational module. Students interacted within the module in real-time and decided courses of actions as they worked through an unfolding case study of a new graduate nurse's realistic encounter with healthcare worker incivility.

Data Collection

The study took place at two universities in the southern region of the United States. Once eligible participants from both universities were identified, email notification along with the study recruitment flyer was sent by a designated facilitator at each university. Students who were interested in learning more about the study clicked a link which opened the informed consent document. Those students who chose to provide online anonymous consent were automatically re-directed to the pre-test MCSP survey followed by the educational module. Descriptive demographic information was elicited and the additional questions delineated in Table 1 were deployed. The MCSP survey was utilized pre-and post-intervention. Within two weeks following the online educational presentation at the BSN site, the post-test MCSP was administered to the participants. The simulation educational intervention was held approximately two weeks after ADN participants took the MCSP pre-test and viewed the educational presentation. Once the simulation educational intervention had been completed at the ADN university, the MCSP post-test was administered within two weeks. The PI took sole responsibility for data collection and management to ensure consistent and accurate handling of the information.

Data Analysis

To maintain confidentiality of the participants, collected data were stored on a password-protected database with firewall protection, located on the computer in the researcher's locked office. Participants' self-generated unique identification codes were also stored to facilitate analysis of the paired samples pre-test/post-test responses.

The data were analyzed using IBM SPSS Statistics (Version 26) predictive analytics software. The data analysis plan was conducted in three phases. First, all study variables were presented using descriptive statistics, such as means, standard deviation, and

minimum/maximum values for continuous variables (Interval/Ratio level) and frequencies and percentages for categorical variables (Nominal/Ratio level).

Next, a series of bivariate tests were used to produce inferential findings. First, a paired samples *t*-test analysis was used to determine if pre-test to post-test mean moral courage (MC) scores changed at a statistically significant level ($p < .05$). Next, pre-test to post-test difference scores were computed through subtracting pre-test MC scores from post-test MC scores. Bivariate tests, including independent samples *t*-test analysis and One-Way ANOVA were then used to determine if mean MC difference scores varied at a statistically significant level by all study explanatory variables, including the independent variable intervention, as well as the covariate variables including: (1) gender, (2) age, (3) worked in a healthcare position for $\geq$ 6 months, (4) perceived workplace incivility (items: experienced incivility while in the workplace/experienced incivility in your personal life), and (5) need for moral courage (the item: experienced an ethical dilemma, issue, or situation that required moral courage). All covariate variables that were significantly related to pre-test to post-test difference scores were to be included in the third phase of data analysis, multivariate analysis.

Third, a multivariate model, specifically a repeated measures general linear model, was used to model pre-test to post-test changes in MC scores of Nursing 100 vs. Nursing 200 level students as a function of the independent variable. As no covariate variables significantly related to pre-test to post-test difference scores in bivariate analysis, they were not included in the multivariate analysis. The model was assessed in terms of overall statistical significance and partial eta square (PES) effect size.

Procedures to Enhance Control

Threats to internal validity for the study included history effects, maturation effects, selection, diffusion of treatment, instrumentation, and experimenter effects. To control for history effects, the simulation intervention took place within a two-day time period for all participants. To control for maturation effects, participants were recruited from two distinct levels to allow for consistent and equal comparison. Selection effects were controlled for by non-purposeful group assignments for those who consented to participate. To control for diffusion of treatments, the course faculty scheduled all students for other activities at concurrent times of simulation education. The same instrument was used for pre-and post-test measures in both groups to limit instrumentation threats to validity. To avoid experimenter effects, the primary investigator emailed the same online educational module to a university designated facilitator who then emailed both groups access to the consent, educational module, and MCSP pre-test and post-test. The same standardized incivility scenario was embedded into each class specific simulation activity. Debriefing and teaching methods were standardized utilizing the same simulation facilitator. The role of the hostile physician was played by one of two trained standardized actors, utilizing the same script for each scenario.

Threats to external validity included construct validity. To minimize these threats the researcher acknowledges the multi-dimensional characteristics of the participants' internal personal factors including, personality, attitude, confidence, and emotional intelligence as constructs affecting moral courage.

Results

Data collection efforts at the BSN study site were unexpectedly challenging. The university's IRB does not support linking educational research to coursework for fear of

potential inappropriate coercion. Consequently, initial participants were sent the recruitment flyer through their student cohort group email. Two cohorts were contacted, 187 senior level students and 128 junior level students from each cohort. Initial response rates were disappointing with only10 seniors and 8 junior nursing students who watched the educational module and took the MCSP pre-test resulting in a 5.7% response rate. Post-test data collection was also less than ideal. From the senior cohort, 12 students took the post-test, but only one of them had completed the pre-test. Among the juniors, 11 responded to the follow up email for the post-test, but only one had completed the pre-test. Ultimately there was only one senior student and one junior student from the BSN study site who provided complete datasets. Therefore, the data from the BSN university (educational module comparison group) was insufficient for inclusion in the final analysis. Thirty-two lower-level and 34 upper-level participants completed pre-to-post-test datasets from the ADN university (educational module plus simulation intervention group) and are included in the final analysis of the study.

In terms of statistical power, the G*power software indicated that an approximately medium effect size (*f*=.25) would be detected in a repeated measures general linear model, with power set at .80 and alpha set at .05, with a 2 group by 2 timepoint design, using a sample size of 66 study participants. Thus, the current sample of 66 study participants provided sufficient statistical power for the current analysis.

Prior to and within the final inferential analysis presented, all test assumptions related to parametric testing were examined and revealed no significant problems, including normality, linearity, and homoskedasticity. In terms of assuring that there was no undue influence of outliers scores there were 4 pre-test and 4 post-test outlier scores that were reduced to the next score that was not an outlier toward reducing the undue influence of outlier scores. There were 8

resulting outlier (2 negative and 6 positive) pre-test to post-test difference scores that were reduced to the next score that was not an outlier toward reducing the undue influence of outlier scores. Fields (2018) identifies this method as "winsorizing" by replacing outliers with the next highest score that is not an outlier to reduce bias (p. 198).

There were no missing data values present in the dataset, which facilitated a complete case analysis. In terms of psychometric properties, a reliability analysis was conducted that revealed a sufficient level of internal consistency reliability for the Moral Courage scale both at pre-test (Cronbach's alpha = .97) and post-test (Cronbach's alpha = .99).

Demographic/Descriptive Analysis

Table 3 presents a descriptive analysis of categorical study variables. Data indicated that the sample was approximately evenly distributed by study group with 48.5% (*n*=32) in the ADN (intervention group) of Nursing 100 (lower-level) and 51.5% (*n*=34) in the Nursing 200 (upper-level) groups. Regarding age, the sample was approximately equally divided among the groups: 19-20 (*n*=24, 36.4%), 21 (*n*=20, 30.3%), and 22 or older (*n*=22, 33.3%). The 22 or older category ranged from 22-25 years of age with one participant age 45. The typical study participant was female (*n*=57, 86.4%), had not worked in a healthcare position for $\geq$ 6 Months (*n*=49, 74.2%), but had experienced incivility while in the workplace (*n*=40, 60.6%) and in his/her personal life (*n*=57, 86.4%). About three quarters of study participants (*n*=49, 74.2%) reported having experienced an ethical dilemma, issue, or situation that required moral courage. Students in the intervention group produced a mean MC score of 58.39 (*SD*=4.56) at pre-test.

Table 3

Demographic/Descriptive Analysis of Categorical Study Variables for the Intervention Group

Variable	*n*	%
Study Group		
Nursing 100 (lower-level)	32	48.5
Nursing 200 (upper-level)	34	51.5
Age		
19-20	24	36.4
21	20	30.3
22 or older	22	33.3
Gender		
Male	9	13.6
Female	57	86.4
Worked in a Healthcare Position for $\geq$ 6 Months		
Yes	17	25.8
No	49	74.2
Experienced Incivility while in the Workplace		
Yes	40	60.6
No	26	39.4
Experienced Incivility in Your Personal Life		
Yes	57	86.4
No	9	13.6
Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage		
Yes	49	74.2
No	17	25.8

Data also indicated that the typical comparison group (BSN university) of pre-test students were female (*n*=16, 88.9%) and 22 years of age or older (*n*=10, 55.6%). Half of these students had worked in a healthcare position for $\geq$ 6 Months (*n*=9, 50.0%) and had experienced incivility while in the workplace (*n*=9, 50.0%). The majority had experienced incivility in his/her personal life (*n*=10, 55.6%). About two-thirds of the BSN study participants (*n*=11, 61.1%) reported having experienced an ethical dilemma, issue, or situation that required moral courage. Lastly, comparison group produced a MC mean score of 57.56 (*SD*=4.15) at pre-test.

Bivariate analysis indicated that the intervention (ADN) and comparison (BSN) groups of students did not differ at a statistically significant level by age, $X^2(2)=3.10$, $p=.21$, gender, $X^2(1)=.08$, $p=.78$, experienced incivility while in the workplace, $X^2(1)=.66$, $p=.42$, and experienced an ethical dilemma, issue, or situation that required moral courage, $X^2(1)=1.20$, $p=.27$. Furthermore, bivariate analysis indicated that intervention and comparison groups of students did not generate a significantly different MC mean score at pretest, $t(82)=.71$, $p=.48$. However, chi-square analysis did indicate a higher percentage of BSN students (50%) indicated they had *Worked in a Healthcare Position for $\geq$ 6 Months*, relative to the ADN students (25.8%), $X^2(1)=3.89$, $p<.05$. A significantly lower percentage of BSN students (55.6%) reported they had *Experienced Incivility in Your Personal Life*, relative to the ADN students (86.4%), $X^2(1)=8.32$, $p<.01$. With acknowledgment that the BSN study site did not provide an adequate sample. Table 4 presents analysis of bias between the intervention (ADN) and comparison (BSN) groups at pre-test.

Table 4

Analysis of Bias Between ADN and BSN Students (n=84)

	ADN Intervention group (n=66)		BSN Comparison group (n=18)			
Variable	n	%	n	%	t/X^2(df)	p
Age					X^2(2)=3.10	.21
19-20	24	36.4	5	27.8		
21	20	30.3	3	16.7		
22 or older	22	33.3	10	55.6		
Gender					X^2(1)=.08	.78
Male	9	13.6	2	11.1		
Female	57	86.4	16	88.9		
Worked in a Healthcare Position for ≥ 6 Months					X^2(1)=3.89	.05
Yes	17	25.8	9	50.0		
No	49	74.2	9	50.0		
Experienced Incivility while in the Workplace					X^2(1)=.66	.42
Yes	40	60.6	9	50.0		
No	26	39.4	9	50.0		
Experienced Incivility in Your Personal Life					X^2(1)=8.32	.004
Yes	57	86.4	10	55.6		
No	9	13.6	8	44.4		
Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage					X^2(1)=1.20	.27
Yes	49	74.2	11	61.1		
No	17	25.8	7	38.9		
Pretest Moral Courage Scores	M=58.39 SD=4.56		M=57.56 SD=4.15		t(82)=.71	.48

Table 5 presents descriptive analysis of the continuous study variables for the intervention group. Data indicated that the mean MC pre-test score was 58.39 (*SD*=4.56, MIN/MAX = 48.00-63.00), and mean MC post-test score was 60.24 (*SD*=3.25, MIN/MAX=54.00-63.00), and the mean pre-test/post-test difference score was 1.85 (*SD*=2.95, MIN/MAX = ¨4.00-7.00). The distribution of scores was approximately normal as the skewness and kurtosis were not greater than three times the standard error.

Table 5

Descriptive Analysis Continuous Study Variables for the Intervention Group

Variable	M (SD)	Minimum/Maximum	Skew (SE)	Kurtosis
Pre-test Moral Courage Score	58.39 (4.56)	48.00-63.00	-.93 (.30)	-.07 (,58)
Post-test Moral Courage Scores	60.24 (3.25)	54.00-63.00	-.86 (.30)	-.81 (.54)
Pre to Post-test Moral Courage Difference Scores	1.85 (2.95)	-4.00 - 7.00	.11 (.30)	-.27 (.58)

Research Question One and Two

The first and second research questions asked if there was a significant difference in pre/post-test moral courage scores for upper and lower-level students who viewed an educational incivility module. Due to lack of obtained data from the BSN university, these two research questions could not be answered; however, future research is planned to repeat the study in order to answer these two questions.

Research Question Three and Four

The third research question asked if there was a significant difference in pre-test/post-test moral courage scores for upper-level students who viewed an educational incivility module plus experienced an episode of incivility during clinical simulation.

The fourth research question asked if there was a significant difference in pre-test/post-test moral courage scores for lower-level students who viewed an educational incivility module plus experienced an episode of incivility during clinical simulation.

Table 6 presents paired-sample *t*-test analysis indicating the Nursing 200 (upper-level) mean MC scores changed at a statistically significant level, $t(33)=-3.84$, $p<.001$, from pre-test ($M=56.94$, $SD=5.07$) to post-test ($M=59.21$, SD=3.47), with a medium size effect (Cohen's d =-

.52). The Nursing 100 (lower-level) mean MC scores changed at a statistically significant level, $t(31)=-3.48$, $p<.01$, from pre-test ($M=59.94$, $SD=3.37$) to post-test ($M=61.34$, SD=2.63), with a medium size effect (Cohen's $d=-.46$). The combined groups (entire sample) paired-sample *t*-test analysis also indicated mean MC scores changed at a statistically significant level, $t(65) = -5.10$, p<.001, from pre-test ($M=58.39$, SD=4.56) to post-test ($M=60.24$, SD=3.25), with a medium size effect (Cohen's d= -.47).). Examination of individual questions on the MCSP survey demonstrated increases in the mean responses for all 9 questions from pre-test to post-test. Question 8, "I do what is right for my patient even if it puts me at risk," demonstrated the largest increase. Question 1 had the second largest increase and stated, "I do what is right for my patients, even if I experience opposing social pressures." Question 6 had the third largest increase from pre-test to post-test and stated, "When faced with ethical dilemmas in patient care, I consider how both professional values and my personal values apply to the situation before making decisions".

See Figure 1 for a graph reflecting changes in pre-test to post-test MC scores among the entire sample.

Research Question Five

Research question five asked if there was a difference in pre-test/post-test moral courage scores for upper and lower-level nursing students who viewed an educational incivility module versus upper and lower-level nursing students who viewed an educational incivility module plus experienced an episode of incivility during a clinical simulation. This research question could not be answered due to the insufficient data obtained from the BSN university (educational module group). This question would have compared the educational intervention's effect on the outcome

of mean moral courage score changes. Future research is planned to answer this research question.

Table 6

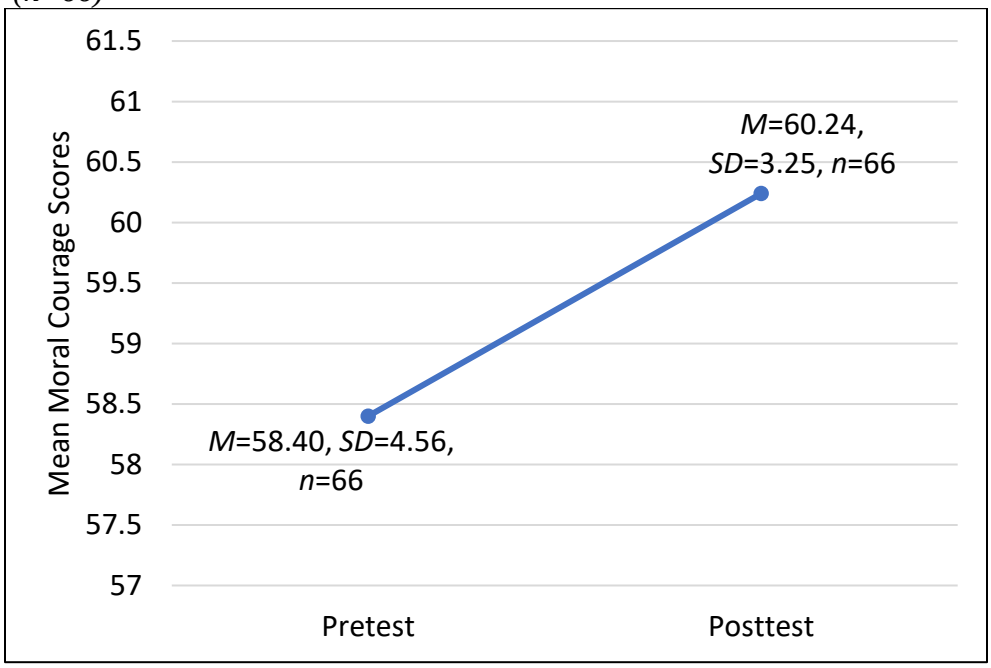
Paired Samples T-Test Analysis of Pre-test to Post-test Change in Moral Courage Scores Among the Intervention Group (n=66)

Timepoint	**n**	**M (SD)**	**t(df)**	**p**	**Cohen's *d***
			-5.10 (65)	**.001**	**-.47[1]**
Pre-test Total Group	66	58.39 (4.56)			
Post-test Total Group	66	60.24 (3.25)			
			-3.48 (31)	**.002**	**-.46[1]**
Pre-test Nursing 100	32	59.94 (3.37)			
Post-test Nursing 100	32	61.34 (2.63)			
			-3.84 (33)	**.001**	**-.52[1]**
Pre-test Nursing 200	34	56.94 (5.07)			
Post-test Nursing 200	34	59.21 (3.47)			

[1]The Cohen's *d* effect size is an approximately medium (medium=.50) effect.

Figure 1

Changes in Pre-test to Post-test Moral Courage Scores Among the Intervention Group (n=66)



Hypothesis Testing

The first hypothesis indicated upper-level nursing students would have higher moral courage pre-test scores than lower-level nursing students. This hypothesis was rejected as the analysis indicated that scores did vary by study group with a significantly higher mean MC pre-test score evidenced by the Nursing 100 (lower-level) students (M=59.94, SD=3.37) relative to the Nursing 200 (upper-level) students group (M=56.94, SD=5.07), $t(57.68)=2.84$, $p<.01$. Possible explanations for this, may be that the Nursing 200 (upper-level) students had more exposure to real-life uncivil experiences in clinical settings than the Nursing 100 (lower-level) students and were therefore more aware of the fear involved in exercising moral courage.

Table 7 presents an independent samples t-test and one way ANOVA analysis of bias regarding pre-test MC scores by study variables. Pre-test MC scores did not vary significantly by gender, $t(64)=.43$, $p=.67$, age, $F(2, 63)=2.50$, $p=.09$, worked in a healthcare position for $\geq$ 6

months, $t(64)=-.47$, $p=.64$, experienced incivility while in the workplace, $t(64)=-.87$, $p=.39$, experienced incivility in your personal life, $t(64)=-.74$, $p=.46$, and experienced an ethical dilemma, issue, or situation that required moral courage, $t(21.63)=1.52$, $p=.14$.

Table 7

Independent Samples T-Test and One-Way ANOVA Analysis of Bias Regarding Pre-test Moral Courage Scores by Study Variables for the Intervention Group

Variable	n	M (SD)	*t/F*(df)	p
			2.84 (57.68)	.006
Nursing 100 (lower-level)	32	59.94 (3.37)		
Nursing 200 (upper-level)	34	56.94 (5.07)		
Gender			.43 (64)	.67
Male	9	59.00 (5.24)		
Female	57	58.30 (4.48)		
Age			2.50 (2.63)	.09
19-20	24	60.00 (2.38)		
21	20	57.25 (5.64)		
22 or older	22	57.68 (4.96)		
Worked in a Healthcare Position for $\geq$ 6 Months			-.47 (64)	.64
Yes	17	57.94 (5.12)		
No	49	58.55 (4.39)		
Experienced Incivility while in the Workplace			-.87 (64)	.39
Yes	40	58.00 (4.94)		
No	26	59.00 (3.91)		
Experienced Incivility in Your Personal Life			-.74 (64)	.46
Yes	57	58.23 (4.45)		
No	9	59.44 (5.34)		
Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage			1.52 (21.63)	.14
Yes	49	58.98 (3.98)		
No	17	56.71 (5.72)		

The second hypothesis stated that nursing students who viewed an educational incivility module plus experienced an episode of incivility during a clinical simulation would have a larger increase in moral courage scores compared to nursing students who only viewed an educational incivility module; however, due to insufficient data, this hypothesis was not tested.

Tables 8a-8f present chi-square analysis of bias regarding study group (Nursing 100 students vs. Nursing 200 students by study variables). Analysis indicated that study group did not vary at a statistically significant level by gender, $X(1)=3.58$, $p=.06$, worked in a healthcare position for $\geq$ 6 months, $X(1)=1.60$, $p=.21$, experienced incivility while in the workplace $X(1)=.49$, $p=.48$, experienced incivility in personal life, $X(1)=1.38$, $p=.24$, and experienced an ethical dilemma, issue, or situation that required moral courage, $X(1)=1.60$, $p=.21$. However, chi-square analysis did indicate that membership in study group (Nursing 100 students vs. Nursing 200 students) did vary significantly by study participant age, $X(2)=21.15$, $p<.001$, with Nursing 100 students containing a higher percentage of 19-20 years old students relative to the Nursing 200 students (n=20, 62.5% vs. n=4, 11.8%, respectively), as well as the Nursing 100 students containing a lower percentage of 21 year old students relative to the Nursing 200 students (n=3, 9.4% vs. n=17, 50.0%, respectively).This is explained by the normal aging process for incoming Freshman students relative to yearly advancement.

Table 8a

Chi-Square Analysis of Bias Regarding Intervention Group by Gender

	Gender			
	Male	Female		
Variable	n (%)	n (%)	X^2(df)	p
Study Group			3.58 (1)	.06
Nursing 100	7 (21.9)	25 (78.1)		
Nursing 200	2 (5.9)	32 (94.1)		

Table 8b

Chi-Square Analysis of Bias Regarding Intervention Group by Age

	Age				
	19-20	21	22 or older		
Variable	n (%)	n (%)	n (%)	X^2(df)	p
Study Group				21.15 (2)	.001
Nursing 100	20 (62.5)	3 (9.4)	9 (28.1)		
Nursing 200	4 (11.8)	17 (50.0)	13 (38.2)		

Table 8c

Chi-Square Analysis of Bias Regarding Intervention Group by Worked in a Healthcare Position for ≥ 6 months

	Worked in a Healthcare Position for > 6 months			
	Yes	No		
Variable	n (%)	n (%)	X^2(df)	p
Study Group			1.60 (1)	.21
Nursing 100	6 (18.8)	26 (81.3)		
Nursing 200	11 (32.4)	23 (67.6)		

Table 8d

Chi-Square Analysis of Bias Regarding Intervention Group by Experienced Incivility while in the Workplace

	Experienced Incivility while in the Workplace			
	Yes	No		
Variable	n (%)	n (%)	X^2(df)	p
Study Group			.49 (1)	.48
Nursing 100	18 (56.3)	14 (43.8)		
Nursing 200	22 (64.7)	12 (35.3)		

Table 8e

Chi-Square Analysis of Bias Regarding Study Group by Study Participant Experienced Incivility in Your Personal Life

	Experienced Incivility in Your Personal Life			
	Yes	N		
Variable	n (%)	n (%)	X^2(df)	p
Study Group			1.38 (1)	.24
Nursing 100	26 (81.3)	6 (18.8)		
Nursing 200	31 (91.2)	3 (8.8)		

Table 8f

Chi-Square Analysis of Bias Regarding Intervention Group by Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage

	Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage			
	Yes	No		
Variable	n (%)	n (%)	X^2(df)	p
Study Group			1.60 (1)	.21
Nursing 100	26 (81.3)	6 (18.8)		
Nursing 200	23 (67.6)	11 (32.4)		

Additional questions asked as part of the demographic survey were analyzed to determine whether prior healthcare work experience or experience with incivility in professional or personal life was significantly related to the change in MC scores among participants. None of the additional questions were statistically significant. Table 9 presents an independent samples *t*-test and one-way ANOVA analysis indicating that mean difference scores did not vary at a statistically significant level by study group, $t(57.68)=-1.20$, $p=.24$, gender, $t(64)=-.56$, $p=.58$, age, $F(2, 63)=.28$, $p=.76$, worked in a healthcare position for $\geq$ 6 months, $t(64)=-.33$, $p=.75$, experienced incivility while in the workplace, $t(64)=-.33$, $p=.74$, experienced incivility in your personal life, $t(64)=1.81$, $p=.08$, and experienced an ethical dilemma, issue, or situation that required moral courage, $t(20.47)=.34$, $p=.74$.

Table 9

Independent Samples T-Test and One-Way ANOVA Analysis of Pre-test to Post-test Moral Courage Difference Scores by Study Variables for Intervention Group

Variable	n	M (SD)	t/F(df)	p
Study Group			-1.20 (57.68)	.24
Nursing 100 (lower-level)	32	1.41 (2.28)		
Nursing 200 (upper-level)	34	2.26 (3.44)		
Gender			-.56 (64)	.58
Male	9	1.33 (2.40)		
Female	57	1.93 (3.03)		
Age			.28 (2, 63)	.76
19-20	24	1.50 (2.41)		
21	20	2.15 (3.38)		
22 or older	22	1.95 (3.15)		
Worked in a Healthcare Position for $\geq$ 6 Months			-.33 (64)	.75
Yes	17	1.65 (3.26)		
No	49	1.92 (2.86)		
Experienced Incivility while in the Workplace			-.33 (64)	.74
Yes	40	1.75 (3.01)		
No	26	2.00 (2.90)		
Experienced Incivility in Your Personal Life			1.81 (64)	.08
Yes	57	2.11 (2.84)		
No	9	.22 (3.27)		
Experienced an Ethical Dilemma, Issue, or Situation that Required Moral Courage			.34 (20.47)	.74
Yes	49	1.94 (2.51)		
No	17	1.59 (4.03)		

Multivariate Analysis

Table 10 presents a repeated measures general linear model examining pre-test to post-test changes in MC by Nursing 100 (lower-level) vs. Nursing 200 (upper-level) students. Multivariate analysis indicated that mean changes in MC by Nursing 100 vs. Nursing 200 students at the intervention site did not vary from pre-test to post-test at a statistically significant level, $F(1, 64)=1.41$, $p=.24$.

Table 10

Repeated Measures General Linear Model Examining Pre-test to Post-test Changes in Moral Courage Scores by Intervention Group

Timepoint	n	M (SD)	F(df)	p
			1.41 (1, 64)	.24
Pre-test				
Nursing 100	32	59.94 (3.37)		
Nursing 200	34	56.94 (5.07)		
Post-test				
Nursing 100	32	61.34 (2.63)		
Nursing 200	34	59.21 (3.47)		

Discussion

The primary purpose of this study was to examine the effectiveness of two educational interventions on moral courage development in nursing students. Unfortunately, the educational module intervention sample size was not large enough to allow comparison of data to the educational module plus an incivility simulation intervention. The results of the study are still beneficial, however, as the difference in pre-test/post-test moral courage change scores for all study participants indicated the educational incivility module plus incivility simulation intervention had a significant effect. Furthermore, increases in individual question scores indicate the impact of the combined educational module plus the incivility simulation-based activity. These increases identify the participants' agreement for basing their moral courage actions on professional and personal values when engaging in ethical dilemmas that put their patients' safety at risk. Additionally, these questions demonstrate the participants' willingness to engage in conflict despite personal risks. This is an important contribution to the research, as it suggests specific aspects of moral courage can be developed and measured in nursing students through the use of educational modules plus simulation-based activities.

A secondary aim of the study was to explore factors that affect moral courage scores including: (a) age, (b) course level, (c) gender, (d.) prior work experience in healthcare position ≥ 6 months, (e) prior experience of incivility while in the workplace, (f) prior experience of incivility in personal life, and (g) prior experience with an ethical dilemma requiring moral courage. The findings from this study indicate that these factors were normally distributed across the study participants and were not significantly related to the change in moral courage pre-test to post-test scores.

Findings from this study support prior studies involving PBL, VS, role play, and active simulation in improving students' ability to recognize incivility in the workplace (Aebersold & Schoville, 2020; Clark & Ahten, 2013; Sharpnack et al., 2013). When asked to describe the encounter with the doctor, students' descriptions included: "intimidating", "unnecessary", "disruptive", "intentional", "unkind" and "paralyzing." These descriptions support Clark and Kenski's (2017) description of insolent behavior and "failing to take appropriate action when action is justified" (p.60). Several themes identified in Aebersold and Schoville's (2020) qualitative descriptive simulation study were also noted during the robust debriefing sessions including: (1) "chaotic environment", (2) "emotional response (3) impact on the nurse", and (4) great learning experience" (p. 27).

The uncivil episode began with the primary nurse (victim) informing the doctor of a low urine output and receiving a telephone order to perform an "in and out" catheterization. The unexpected appearance of the doctor during the catheterization prep made some students feel "uncomfortable" as the doctor stood over them and questioned "what's taking so long?" During the debriefing session, students expressed feeling disorganized in a chaotic environment while prepping for the catheterization. One student stated "I couldn't concentrate or even remember

how to put my sterile gloves on and I contaminated my sterile gloves." Another stated, "I felt frustrated and anxious, my hands started sweating and I couldn't get my gloves on."

Other statements expressed during the debriefing session indicated an emotional response. All targets of the incivility identified "fear" and "shock" as an emotional response, while bystanders expressed "feeling sorry for the victim", yet "paralyzed by fear and unsure of what to do." Several students admitted they had forgotten the acronyms from the educational module. A quick review of the acronym CODE and S^4 allowed the students to reflect on how to show courage and support the victim by recalling these acronyms.

The impact of the incivility on the nurse was also discussed during the debriefing session. Students were asked to describe a moment during the simulation that had an impact on them and how it made them feel. Many victim and bystander students identified feeling intimidated at the presence of the doctor. Some participants admitted they remained silent in order to protect themselves from being attacked. Kirrane et al. (2017) identify this as defensive silence. When asked if they would feel comfortable calling the doctor in the future, all students said "no." Further reflection allowed the students to relate the lack of desire to communicate with the doctor to potential harm to the patient. One student voiced how he would "avoid calling the doctor even about important things regarding the patient."

The learning experience, as viewed by the participants, was positive. Many expressed gratefulness for practicing this real-life event before encountering it in the workplace and identified the simulation as a "great learning experience." Other students voiced that the activity made them realize that incivility is a bigger problem than they thought.

The NLN Jeffries simulation theory was a good fit and supported the use of simulation to develop moral courage in nursing students. The concept of *context* was foundational for

introducing a real-life situation to the students. Through the use of the academic setting, a realistic setting mimicked an uncivil encounter with a healthcare provider during patient care.

The concept of *background* was a benchmark for planning the simulation, as the literature was replete with prior studies indicating a need for developing moral courage to address incivility for nursing students.

The *design* concept was carried out through introducing learning objectives with problem solving complexity. As students participated in the simulation, each student had an opportunity to address the incivility. Some students were primary victims, while others were bystanders and witnessed the uncivil encounter.

The *debriefing* concept following the simulation-based event (SBE) allowed for reflective activity. Using reflection, new interpretations and cognitive reframing were made possible. Evidence suggests that essential learning occurs in the debriefing phase (INACSL, 2016a). The debriefing phase of the SBE can heighten participant self-awareness and self-efficacy (INACSL, 2016c) as demonstrated in the study through participants' statements including "I know what I need to do now," and "it's important for me to stand-up for the victim." Use of the Gather, Analyze, and Summarize (GAS) debriefing model allowed for consistent and structured debriefing (INACSL, 2016c). During the *gathering* phase, the facilitator used open ended questions to actively encourage the participants' narrative descriptions of how the uncivil encounter made them think and feel. During the *analyzing* phase, the facilitator provided feedback on performance and allowed participants to reflect upon and analyze their actions. This type of reflection revealed the participants' thinking processes and allowed the facilitator to redirect their thinking when appropriate. During the *summarizing* phase, a review of positive aspects of the simulation and behaviors that require change was facilitated. This led to a

discussion on how the participant could incorporate the acronyms of CODE and S^4 when faced with behaviors of incivility in the healthcare environment.

The concept of measurable *participant outcomes* was demonstrated in the SBE. This study contributed a new measurable participant outcome of moral courage. This study demonstrated that the use of simulation can extend ethics education in nursing beyond the cognitive domain, as suggested by Sedgwick et al. (2019).

Strengths and Limitations

The strengths of this study included the experimental design, the strong conceptual fit of NLN Jeffries Simulation Theory, and the use of a validated instrument to measure self-perceptions of moral courage. Another strength is the adequately powered sample size for the educational module plus simulation activity intervention group. To date, no intervention studies have utilized simulation to explore and measure moral-courage development in nursing students in times of healthcare incivility. The results of this study will add to the literature and fill a gap in knowledge concerning nursing students' moral courage development.

Limitations of this study include the insufficient sample size for the comparison group, and the convenience sample of one Associate degree nursing program and one Bachelor of Science nursing degree program in a southern region of the United States. Additionally, the first-time use of the MCSP in nursing students added to the limitations of the study.

Recommendations

This is the first study that incorporates the use of the MCSP in nursing students and the first use of the MSCP to measure the participant outcome of moral courage following a structured simulation-based activity. The significant findings from this study warrant additional research in student nurses and the use of an educational module plus an incivility simulation

intervention. Repeating the study to achieve an adequately powered sample size for the comparison group is recommended and planned for future research.

It is also recommended to incorporate aspects of the educational module and SBE into a structured classroom assignment that can be later utilized as a research study through voluntary consent to use results through a post-hoc fashion. This could improve sample sizes for comparison purposes.

Summary

Student nurses and graduate nurses are among the most vulnerable populations to experience incivility in healthcare (D'Ambra & Andrew, 2014; Kim, 2018; Palumbo, 2018). To reduce the harmful effects of incivility, a call to strengthen nursing students' moral courage has been established (American Nurses Association [ANA], 2015; Fitzpatrick, 2018). The ANA's call for incivility education to begin in nursing school charges nurse educators with the task of imparting knowledge that fosters moral courage to respond to incivility for nursing students. This quasi-experimental study examined the effects of an educational module plus an incivility simulation activity on nursing students' moral courage development. The statistically significant differences in moral courage change scores among groups and the entire sample adds to the limited interventional studies that explore measures of moral courage during times of an ethical dilemma of incivility for nursing students. The NLN Jeffries Simulation Theory was a good fit and served as the guiding framework to support evidenced based simulation education in developing moral courage in nursing students when faced with behaviors of incivility in healthcare.

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Chapter 5

Summary and Conclusion

As healthcare workers, nursing students and graduate nurses may encounter stressful communication dilemmas in the clinical setting. Identifying incivility and recognizing its potential impact on patient safety can prevent its escalation to acts of bullying (Berry et al., 2020; Sanner-Stier & Ward-Smith, 2016). Nursing students need the opportunity to develop moral courage when confronted with behaviors of incivility in order to prevent harmful effects on nurses, patients, and organizations (ANA, 2015; Berry et al., 2020; Bickhoff et al., 2016; Bickhoff et al., 2017; Dang et al., 2016). While there is a large body of knowledge regarding the use of simulation to develop self-confidence, and critical thinking skills when faced with incivility (Aebersold & Schoville, 2020; Clark & Ahten, 2013; Clark et al., 2014; DeSimone, 2019; Sharpnack et. al., 2013) there are no prior studies examining the effect of an incivility simulation on moral courage development in nursing students.

Professional organizations in nursing have established the nurse's duty to address incivility and bullying and to advocate for a healthy work environment (ANA, 2015; TJC, 2017). Whether at the organizational, local, or state level, nurses are well positioned to advocate for social justice and patient safety through anti-bullying policies or workplace bills; however, getting involved also requires nurses to exercise moral courage in speaking-up. Nurse educators are tasked with the responsibility to prepare nursing students for the clinical work environment. This study was the first study that examined the outcome of moral courage development in response to a simulation intervention. Furthermore, this study supports the claim that the nursing curriculum is ideal for developing moral courage in nursing students prior to their entering the

workforce (Aebersold & Schoville, 2020; DeSimone, 2019; Koskinen et al., 2020; Lachman, 2010).

Next Steps

Although, some important statistically significant results were demonstrated in this study, other aspects for developing moral courage in nursing students need to be studied. Simulation to teach moral courage is valuable; however, a comparison study to examine traditional methods for embedding ethical dilemmas, such as incivility, into the curriculum should be studied. Furthermore, repeated studies utilizing the moral courage scale for physicians (MCSP) need to be conducted in order to validate similar findings in other regions of the country and world.

Also, the literature is replete with studies examining nurse and physician perspectives of incivility and bullying; however, these issues have not been explored through the voice of the patient. This rare angle for viewing the phenomena of witnessed healthcare acts of incivility needs further exploration and research as well.

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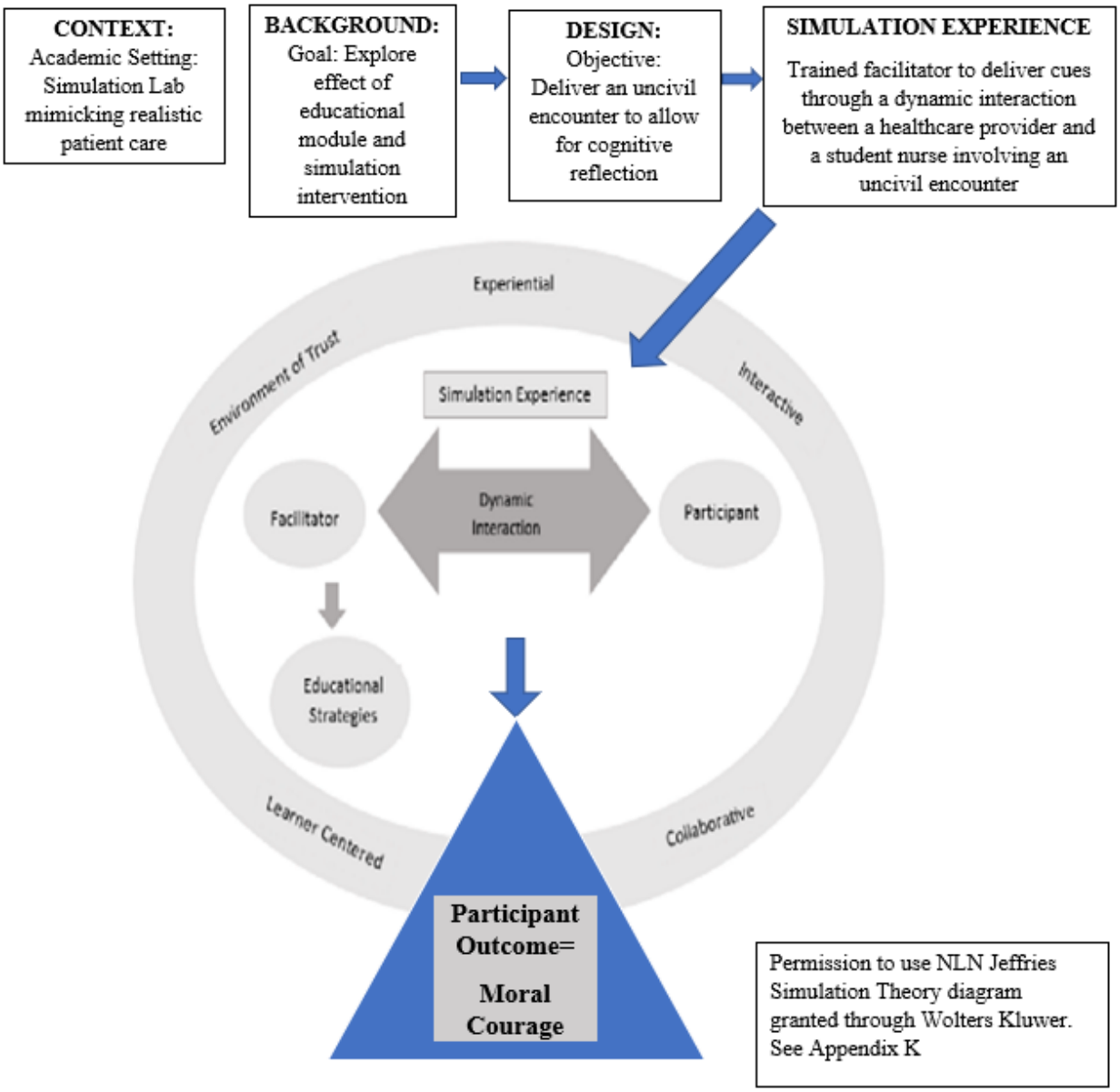
Appendix A

The NLN Jeffries Simulation Theory Applied to Moral Courage Development in Nursing Students Through Incivility Simulation



Appendix B

The University of Texas, Tyler Informed Online Anonymous Consent

Institutional Review Board # FY 2022-25
Approval Date: December 20, 2021

Welcome to a research study on Moral Courage

You are invited to participate in this study, titled, Nursing Students' Moral Courage Development Through Incivility Simulation. The purpose of this study is to see if an education activity can increase moral courage in nursing students. Your participation is completely voluntary. If you begin participation and choose to not complete it, you are free to not continue without any adverse problems.

If you agree to be in this study, we will ask you to do the following web-based things:

- Answer questions to a 5-minute survey
- View a 20-minute course about moral courage in the workplace
- Answer questions to a 5-minute survey within two weeks of viewing the course

We know of no known risks to this study, other than becoming a little tired of answering the questions. If this happens, you are free to take a break and return to the survey to finish it. You may also decide to discontinue participation without any problems.

The study should take you around 30 minutes to complete. When you complete the last survey, you will be sent a link to provide your email address if you wish to be entered into a drawing for a $100 Amazon gift card. Potential benefits to this study are: helping researchers understand moral courage in nursing students. You may benefit by learning more about moral courage and ways to communicate with other healthcare workers.

If you need to ask questions about this study, you can contact the principal researcher, Melissa Madden. Melissa can be reached at mmadden4@patriots.uttyler.edu or 318-382-3703. If you have any questions about your rights as a research participant, you can contact Dr. David Pearson, Chair of the UT Tyler IRB. Dr. Pearson can be reached at dpearson@uttyler.edu, or 903-565-5858.

If I choose to participate in this study, I will check "I consent" in the box below. I understand if I choose to not participate, I will check "I do not consent" in the box. By participating, I acknowledge I am at least 18 years of age. I know my responses to the questions are anonymous.

○ I consent, begin the study

○ I do not consent, I do not wish to participate

Appendix C

Louisiana Tech University Informed Consent

Welcome to a research study on Moral Courage

You are invited to participate in this study, titled, Nursing Students' Moral Courage Development Through Incivility Simulation. The purpose of this study is to see if an education activity can increase moral courage in nursing students. Your participation is completely voluntary. If you begin participation and choose to not complete it, you are free to not continue without any adverse problems.

If you agree to be in this study, we will ask you to do the following things:

- Answer questions to a 5-minute web-based survey
- View a 20- minute web-based course about moral courage in the workplace
- Complete your usual course simulation
- Answer questions to a 5-minute web-based survey within two weeks of completing the simulation

We know of no known risks to this study, other than becoming a little tired of answering the questions. If this happens, you are free to take a break and return to the survey to finish it. You may also decide to discontinue participation without any problems.

The web-based study should take you around 30 minutes to complete. When you complete the last survey, you will be sent a link to provide your email address if you wish to be entered into a drawing for a $100 Amazon gift card. Potential benefits to this study are: helping researchers understand moral courage in nursing students. You may benefit by learning more about moral courage and ways to communicate with other healthcare workers.

If you need to ask questions about this study, you can contact the principal researcher, Melissa Madden. Melissa can be reached at mmadden4@patriots.uttyler.edu or 318-382-3703. If you have any questions about your rights as a research participant, you can contact Dr. David Pearson, Chair of the UT Tyler IRB. Dr. Pearson can be reached at dpearson@uttyler.edu, or 903-565-5858.

If I choose to participate in this study, I will check "I consent" in the box below. I understand if I choose to not participate, I will check "I do not consent" in the box. By participating, I acknowledge I am at least 18 years of age. I know my responses to the questions are anonymous.

○ I consent; begin the study

○ I do not consent; I do not wish to participate

Appendix D

Demographic Data

Please provide a response for each of the following questions:

1. Please confirm you are a nursing major? Yes or No
2. Choose currently enrolled course level:

   Louisiana Tech: Nursing 100 level _____Nursing 200 level_____

   The University of Texas, Tyler: Junior level_____ Senior level_____
3. What is your age in years? _____
4. What is your identified gender? Male _____ Female_____ Other_____

Additional Questions

1. Have you worked in a healthcare position for greater than 6 months?

   Yes or No
2. Have you experienced incivility while in the workplace?

   Yes or No
3. Have you experienced incivility in your personal life?

   Yes or No
4. Have you experienced an ethical dilemma/ issue that required moral courage?

   Yes or No

Appendix E

Moral Courage Scale for Physicians (MCSP) Version One, 2016

Reference: Martinez W, et al. Academic Medicine. 2016 Oct;91(10):1431-38

Instructions: Please indicate the extent of your agreement or disagreement with each of the following statements.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1. I do what is right for my patients, even if I experience opposingsocial pressures (e.g., opposition from senior members of the healthcare team, medical guidelines, etc.).	□	□	□	□	□	□	□
2. I use a guiding set of principles from my profession to help determine the right thing to do for my patients.	□	□	□	□	□	□	□
3. My patients and colleagues can rely on me to exemplify moralbehavior.	□	□	□	□	□	□	□
4. I do what is right for my patients because it is the ethical thingto do.	□	□	□	□	□	□	□
5. I go above and beyond what is required to do what is rightfor my patients.	□	□	□	□	□	□	□
6. When faced with ethical dilemmas in patient care, I considerhow both my professional values and my personal values apply to the situation before making decisions.	□	□	□	□	□	□	□
7. When I do the right thing for my patients, my motives arepure.	□	□	□	□	□	□	□
8. I do what is right for my patients, even if it puts me at risk(e.g., legal risk, risk to reputation, etc.).	□	□	□	□	□	□	□
9. I am determined to do the right thing for my patients.	□	□	□	□	□	□	□

Appendix F

Permission for use of the MCSP from Dr. Martinez

Martinez, William <william.martinez@vumc.org> | Melissa Madden

RE: Use of your MC

You replied to this message on 8/13/2020 12:15 PM.

Thanks for reaching out!
Here is info on using the scale: https://my.vanderbilt.edu/williammartinez/moral-courage-scale/
Please be in touch if you have questions or we can help
Best
Will

From: Melissa Madden <mmadden4@patriots.uttyler.edu>
Sent: Tuesday, August 11, 2020 10:45 AM
To: Martinez, William (University) <william.martinez@vanderbilt.edu>
Subject: Use of your MC

Dr. Martinez,

Hello, I am a PhD nursing student at the University of Texas, Tyler. I am currently entering my dissertation year and would like to request your permission to use the Moral Courage Scale for Physicians as well as the Speak up Climate for Professionalism Scale. I teach nursing students at Louisiana Tech University and would like to modify the scale for use with nursing students in my research study.

I have enjoyed reading your prior published work on both scales and would be greatly honored to use them for my research.

Cordially,

Melissa Madden, MSN, RN
PhD Nursing student at the University of Texas, Tyler

Moral Courage Scale for Physicians

The Moral Courage Scale for Physicians (MCSP) was developed by William Martinez, Sigall Bell, Jason Etchegaray, and Lisa Lehmann with funding from the Gold Foundation, American Philosophical Society, and the National Institutes of Health. Several items in the MCSP were adapted from the Professional Moral Courage Scale developed by Sekerka et al (J Business Ethics. 2009;89:565–579). The standard citation for the MCSP is: Martinez W, Bell SK, Etchegaray JM, Lehmann LS. Measuring Moral Courage for Interns and Residents: Scale Development and Initial Psychometrics. Academic Medicine. 2016 Oct;91(10):1431-38.

- **Moral Courage Scale for Physicians (MCSP)**
  (Version One, 2016)
- **Frequently Asked Questions**

Permission

We consider the MCSP to be publicly available. You are free to download and use the scales in your research and/or to assess moral courage of health professionals in a healthcare setting. We do ask, however, that you cite the scale correctly if and when you use them. In addition, we do appreciate knowing and being able to track the different ways our scale is being used. We appreciate emails letting us know how you plan to use the scale and letting us know your experience after using it. Please email William Martinez, MD, MS, at william.martinez@vanderbilt.edu.

Scoring

All scale items are measured on a 7-point Likert scale from "strongly disagree" (1) to "strongly agree" (7).

A summary score for the scale may be computed using the following formula: scale score = (mean of the scale items – 1) x (50/3). Thus, summary scores range from 0 (worst) to 100 (best).

Appendix G

Procedure for Incivility Simulation Educational Intervention

1. Upon confirmation of eligibility, 136 total participants consenting to participate in the study (from both nursing education institutions) will complete the MCSP scale. The participants unique identifier will then be taken from the survey and recorded in SPSS for future data analysis.
2. All participants will complete the final MCSP, within two weeks following the education activity (online education or simulation activity).

Educational Intervention Protocol

I. Online educational comparison group:

After eligible participants have signed consent for participation in the education module, participants in both groups will receive the same online educational link to the module. Access to the link is provided here:

https://rise.articulate.com/share/UFNLqtyVQUlIQXEFEWe70F9gHGx3asnJ

II. Before the end of two weeks following the educational module, the comparison group will complete the post-test MCSP.

III. The online educational module teaching concepts will focus on:

A. Understanding incivility in healthcare

i. The potential negative impact on patient outcomes

ii. Implications for the need to exercise moral courage

iii. Personal/professional values

iv. Willingness and self-confidence to respond to incivility through moral courage

Appendix G Continued

v. Kidders' five core values of moral courage

vi. Strategies necessary for moral courage identified by Lachman (2010)

1. CODE, where C stands for courage, O for obligation, D for danger management and E for expression through action

vii. Keller et al.'s (2018) S^4 model will also be reviewed during the education session. Stand up, Support, Speak up, Sequester

viii. Example cases of moral courage in nursing when faced with incivility

The Simulation Intervention Group

I. In addition to the educational module linked above, the simulation group will receive the simulation intervention.

A. Incivility simulation will take place in the academic simulation lab with use of a high-fidelity manikin to serve as a patient.

B. Incivility simulation will utilize one of two trained standardized actors to serve as uncivil physician

C. The primary researcher will serve as the facilitator to guide the simulation activity and delivery of cues.

II. The simulation intervention group will consist of three student roles for each simulation activity and will be repeated until all students from the intervention site have participated.

A. One student will serve as the primary nurse and will be the target of the uncivil episode. One student will serve as a nurse peer (bystander). One student will serve as the charge nurse

Appendix G Continued

B. Pre-briefing will last 15 minutes and will focus on pre-simulation prep work, patient problems, goals for the patient, and any skills needed to carry out the planned simulation activity that will focus on usual patient care.

C. The simulation activity will focus on usual patient care and last approximately 20 minutes with an interjected encounter of healthcare provider incivility during the clinical simulation. The healthcare provider will be played by a trained standardized actor utilizing the following script.

   i. **Script:** During the usual simulation the healthcare provider enters the room.

      Healthcare provider addressing the primary nurse: Could you tell me the patient urine output from last night?

      Student: the urine output was 100 mL for the last 12-hour shift.

      Healthcare provider: Why didn't anyone call me? Are you stupid? This patient only has one kidney! That isn't enough urine output! Didn't anyone teach you that in school?

         Student: (This is where the student and the bystanders will have a chance to respond to the incivility. It is unknown what the students will say). There will be an opportunity to seek the charge nurse.

Appendix G Continued

D. A debriefing guide will be utilized by the researcher to incorporate INACSL standards of best practice and the NLN Jeffries Simulation Theory. Debriefing will discuss the uncivil incident and focus on what went well in regards to the response to incivility from the four students assigned roles and will last approximately 25 minutes. Components of debriefing education will focus on:

    i. Review of pre-simulation online educational module

    ii. Demonstrating role-play for the bystander roles using the S^4 model: Stand up, Support, Speak up and Sequester

E. Following the incivility simulation, the post-test MCSP will be administered within two weeks following the incivility simulation intervention.

Appendix H

Institutional Review Board Approval- The University of Texas, Tyler

Melissa Madden

From:	do-not-reply@cayuse.com
Sent:	Monday, December 20, 2021 12:26 PM
To:	Melissa Madden
Cc:	Barbara McAlister
Subject:	IRB-FY2022-25 - Initial: Exempt - Waiver of Signed Consent

The University of Texas at TYLER

INSTITUTION
3900 University B
uttyler.edu/research

December 16, 2021

Dear Melissa Madden,

Your request to conduct the study: *Nursing Students' Moral Courage Development Through Incivility Simulation Education,* IRB-FY2022-25 has been approved by The University of Texas at Tyler Institutional Review Board as a study exempt from further IRB review subject to **Category 3.(i)(A). Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.**

While this approval includes a waiver of signed, written informed consent, please ensure prospective informed consent is provided, if applicable, unless special circumstances are indicated in the approval email. In addition, please ensure that any research assistants are knowledgeable about research ethics and confidentiality, and any co-investigators have completed human protection training within the past three years, and have forwarded their certificates to the Office of Research and Scholarship (research@uttyler.edu). This approval is valid for one year.

Appendix H Continued

Please review the UT Tyler IRB Principal Investigator Responsibilities, and acknowledge your understanding of these responsibilities and the following through return of this email to the IRB Chair within one week after receipt of this approval letter:

Prompt reporting to the UT Tyler IRB of any proposed changes to this research activity.

- **Prompt reporting to the UT Tyler IRB and academic department administration will be done of any unanticipated problems involving risks to subjects or others.**
- Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations in original proposal.

- Any change in proposal procedures must be promptly reported to the IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subject.
- Submit a Closure form when study is concluded. See Cayuse Resources on our Cayuse IRB webpage for instructions on how to do so.
- **Please retain the information pertaining to this study in printed or electronic form for three years from the completion of the research.**

Best of luck in your research and do not hesitate to contact the Office of Research and Scholarship if you need any further assistance.

Sincerely,
University of Texas at Tyler Institutional Review Board

Appendix I

Institutional Review Board Approval- Louisiana Tech University

LOUISIANA TECH
UNIVERSITY.

OFFICE OF SPONSORED PROJECTS

MEMORANDUM

TO: Dr. Melissa Madden

FROM: Dr. Richard Kordal, Director of Intellectual Property & Commercialization (OIPC) rkordal@latech.edu

SUBJECT: **HUMAN USE COMMITTEE REVIEW**

DATE: January 10, 2022

STUDY: **HUC 22-050**

In order to facilitate your project, a REVIEW has been done for your proposed study entitled:
"Nursing Students' Moral Courage Development Through Incivility Simulation Education"

The proposed study's revised procedures were found to provide reasonable and adequate safeguards against possible risks involving human subjects. The information to be collected may be personal in nature or implication. Therefore, diligent care needs to be taken to protect the privacy of the participants and to assure that the data are kept confidential. Informed consent is a critical part of the research process. The subjects must be informed that their participation is voluntary. It is important that consent materials be presented in a language understandable to every participant. If you have participants in your study whose first language is not English, be sure that informed consent materials are adequately explained or translated. Since your reviewed project appears to do no damage to the participants, the Human Use Committee grants approval of the involvement of human subjects as outlined.

Appendix I Continued

Projects should be renewed annually. ***This approval was finalized on January 10, 2022 and this project will need to receive a continuation review by the IRB if the project continues beyond January 10, 2023.*** **ANY CHANGES** to your protocol procedures, including minor changes, should be reported immediately to the IRB for approval before implementation. Projects involving NIH funds require annual education training to be documented. For more information regarding this, contact the Office of Sponsored Projects.

You are requested to maintain written records of your procedures, data collected, and subjects involved. These records will need to be available upon request during the conduct of the study and retained by the university for three years after the conclusion of the study. If changes occur in recruiting of subjects, informed consent process or in your research protocol, or if unanticipated problems should arise it is the Researchers responsibility to notify the Office of Sponsored Projects or IRB in writing. The project should be discontinued until modifications can be reviewed and approved.

A MEMBER OF THE UNIVERSITY OF LOUISIANA SYSTEM

P.O. BOX 3092 • RUSTON, LA 71272 • TEL: (318) 257-5075 • FAX: (318) 257-5079

AN EQUAL OPPORTUNITY UNIVERSITY

Appendix J

Evidence of Manuscript Submission and Acceptance from the *Journal of Christian Nursing*

Date: Nov 16, 2020
To: "Melissa Madden" mmadden4@patriots.uttyler.edu
From: "Journal of Christian Nursing" Cathy.Walker@intervarsity.org
Subject: NCF-JCN Decision

Nov 09, 2020

RE: NCF-JCN-D-20-00113R1, entitled "A Time to Speak: Learning from Patients' Experiences Related to Healthcare Worker Incivility"

Dear Mrs. Madden,

I am pleased to inform you that your work has been accepted for publication in Journal of Christian Nursing. Please note my personal comments below regarding your manuscript, as well as any comments from our reviewers. All manuscript materials will be copy and content edited / checked, then forwarded to the production staff for placement in an upcoming issue. We may publish your article ahead-of-print online before in print, or online-only in conjunction with a print issue. Note that you will receive a final copy for proofing before the article is published.

As an accepted author we would like to thank you for sharing your work in JCN and invite you to join NURSE CHRISTIAN FELLOWSHIP at 43% off the regular membership fee. Go to http://ncf-jcn.org/membership/join-ncfusa to learn more.

Complete the membership form and when you are directed to make payment, enter DISCOUNT CODE: JCNA43.

We would love to have you be a part of NCF!

Thank you for submitting your interesting and important work to the journal.

https://www.editorialmanager.com/ncf-jcn/

Your username is: *********
****

With Kind Regards,

Dr. Kristen Mauk
Senior Editor
Journal of Christian Nursing

Appendix K

Wolters Kluwer Health, Inc. License

This Agreement between Student request for Dissertation project for PhD in Nursing at the University of Texas at Tyler -- Melissa Madden ("You") and Wolters Kluwer Health, Inc. ("Wolters Kluwer Health, Inc.") consists of your license details and the terms and conditions provided by Wolters Kluwer Health, Inc. and Copyright Clearance Center.

License Number: 5060341444731
License date: May 01, 2021
Licensed Content Publisher: Wolters Kluwer Health, Inc.
Licensed Content Publication: WK Health Book
Licensed Content Title: Simulation in Nursing Education
Licensed Content Author: Pamela R Jeffries PhD, RN, FAAN, ANEF
Licensed Content Date: Sep 3, 2020
Type of Use: Dissertation/Thesis
Requestor type: University/College
Sponsorship: None
Format: Print and electronic
Will this be posted online? Yes, on a secure website
Portion: Figures/tables/illustrations
Number of figures/tables/illustrations:1
Author of this Wolters Kluwer article: No
Will you be translating: No
Intend to modify/change the content: yes
Current or previous edition of book
Current edition: Title
Dissertation Proposal Simulation to Teach Moral Courage in Nursing Students
Institution name: University of Texas Tyler
Expected presentation date: Sep 2021
Portions: figure 2.1 on page23
Publisher Tax ID:13-2932696

Appendix L

Notification of Pre-publication Version of Accepted Journal Article to *JCN*

Reply Reply All Forward

Kristen Mauk <kristen.mauk@intervarsity.org> Barbara McAlister; Melissa Madden; Cathy Walker Tue 1:1

Re: response to inquiry

From: Kristen Mauk <kristen.mauk@intervarsity.org>
Sent: Monday, March 21, 2022 10:51 AM
To: Barbara McAlister <bmcalister@uttyler.edu>; Melissa Madden <mmadden4@patriots.uttyler.edu>
Cc: Cathy Walker <cathy.walker@intervarsity.org>
Subject: response to inquiry

Dear Dr. Calister and Ms. Madden,

I need to know if you are posting the original submission of the article to *JCN* or the revised submission after peer-review. You are permitted to post the *pre*-submission with a statement that it was submitted to the *Journal of Christian Nursing* and will undergo peer-review etc. However, after the *JCN* team has begun working on the manuscript, this version cannot be uploaded to a repository without written permission from *JCN* as the copyright owner. Please let us know if you have further questions.

I hope this helps to clarify.

Thanks,

Dr. Mauk

Kristen L. Mauk, PhD, DNP, RN, CRRN, GCNS-BC, GNP-BC, FARN, FAAN
Senior Editor, *JCN*

Biographical Sketch

NAME: Melissa Madden, MSN, RN

POSITION TITLE: Assistant Professor

EDUCATION/TRAINING

INSTITUION AND LOCATION	DEGREE	Completion Date	FIELD OF STUDY
Kilgore Community College Kilgore, Texas	ADN, RN	05/1990	Nursing
The University of Texas, Arlington, Texas	BSN	05/20001	Nursing
Northwestern State University Alexandria, Louisiana	MSN	05/2015	Nursing
The University of Texas at Tyler Tyler, Texas	PhD.	Present	Nursing Philosophy and Research

A**. Personal Statement**

My nursing career started as a Medical Surgical RN on a fast pasted telemetry unit. After seven years, I transitioned into a Post Anesthesia Care Unit RN where my passion for caring for the surgical client deepened. Upon completion of my BSN degree, I was promoted to peri-operative Educator at a Level I trauma center. My love for education

Biographical Sketch Continued

grew as I trained all new hires in the peri-operative units. Upon relocating to Louisiana in 2006, I engaged in a new area of education as the Director of Education for all hospital employees at a small community hospital. Deepening my quest to understand best practices, I enrolled in the Masters degree program for Nurse Educators at Northwestern State University. Upon completion of the MSN program, I began teaching Associate Degree nursing students in a public university. Teaching nursing students has become my calling in nursing. My own personal experiences in nursing have driven my desire to prepare young new nurses to transition into practice. The literature is replete with methods for transitioning new graduate nurses, but lacks evidence-based interventions that prepare them for ethical dilemmas. The passion to equip nursing students for handling ethical dilemmas has led me to the PhD degree of which I am currently seeking. Along this journey, I have discovered new passions related to research, including concerns among different ethnic cultures. I plan to pursue this new passion upon completion of the program.

B. **Positions and Professional Memberships**

Positions and Employment

1990-1999 Med/Surg RN and PACU RN

1999-2006 Peri-operative Educator, PACU RN

2006-2015 Director of Education, Minden, LA

2015-2022 Assistant Professor, Division of Nursing, Louisiana Tech, Ruston, LA

Professional Memberships and Honors

2020- Present Pi Kappa Phi Honor Society, the University of Texas, Tyler

Biographical Sketch Continued

2018 – Present	Alpha Chi Honor Society, Texas Alpha XI Chapter
2016- Present	International Nursing Association of Clinical Simulation in Nursing Fellowship Awarded
2014- Present	Sigma Theta Tau International Nursing Honor Society
2015- Present	Louisiana State Nurses Association, member
2015- Present	American Nurses Association, member

C. Contributions to Science

Madden, M., & McAlister, B. (in press). A Time to speak: Learning from patients' experiences related to healthcare worker incivility. *Journal of Christian Nursing*.