Giving Voice To The Values Of Nurses

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Giving Voice to the Values of Nurses

Submitted to Faculty
Yale University School of Nursing

In partial Fulfillment
of the requirements of the Degree
Doctor of Nursing Practice

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Abstract

Problem
Nurses working on the frontlines in Labor and Delivery and Radiology face moral challenges in the workplace. It can be difficult for these nurses to take morally courageous action when they lack the knowledge, skills, and confidence to do so successfully. The goal of this DNP project was to enable nurses in labor and delivery and radiology settings to practice moral courage by examining relevant skillsets and providing training in core concepts. The program's intent was to support a moral culture and contribute to the retention of frontline nurses and improved safe patient care.

Methods
This project had three AIMS; (1) To develop a moral courage training program for nurses. (2) To implement and evaluate the program. (3) To make recommendations to stakeholders in the partner organizations with the goal of integration and scaling for broader initiatives promoting a culture of morality.

A moral courage course was developed based on “Giving Voice to Values” written by Mary Gentile (Gentile, 2009). The course was modified to address the specific work setting of frontline nurses. This training was taught in four-hour virtual sessions via Zoom: Video Conferencing software. Interactive discussion, reflection, and participant activities were the teaching methods utilized in this training. This program used the essential components in curriculum implementation based on the Strategic Instruction Model (Hoover, 2010) as an evidenced-based instructional foundational method.

The pre- and post-curriculum instrument utilized for assessment was The Nurses Moral Courage Scale (NMCS) in whole and in part respectively (Numminen et al., 2019). This instrument is unique and was selected because it was explicitly designed for nurses to as a scale to measure nurses' moral courage (Numminen et al., 2019). The NMCS categorizes responses
into four categories: 1) compassion and true presence, 2) moral responsibility, 3) moral integrity, and 4) commitment to good care (Numminen et al., 2019).

**Results**

The project results were evaluated using Kirkpatrick’s Levels of Evaluation (Kirkpatrick, 2007). Kirkpatrick includes four levels of evaluation; (1) Reaction – Engagement, relevance, satisfaction; (2) Learning- Knowledge, skills, attitude, confidence, commitment; (3) Participation and transformation – Confidence, transformation of behavior; (4) Results – Leading indicators, desired outcomes, analyze, disseminate. When the pre course data was compared to the post course data, an overall improvement in the nurse’s willingness to perform acts of moral courage was shown.

**Conclusion**

The use of the moral courage in nurses is needed in the health care setting especially with front line nurses where acts of moral courage keep patients safe and maintain a psychological safe environment. It is critical to have nurses who have the skills, knowledge and confidence to be morally courageous when moral challenges present themselves. This moral courage training for nurses was successful in providing nurses with the skills, knowledge and confidence to feel they will be able to improve their ability to morally courageous when needed, for themselves, their colleagues and especially their patients.

**Keywords** – moral courage, speaking-up, ethical culture, ethics in nursing, giving voice to values
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Chapter 1

Introduction

Despite the existence of organizational policies that support moral courage, labor and delivery and radiology nurses face challenges when they are confronted with the need to use said moral courage in ensuring safe patient care, dignity, integrity, and trust (Comer & Sekerka, 2018; Murray, 2010). A person possessing moral courage is defined as having the capacity to communicate and take honorably, congruent action, in the presence of fear, opposition, or disapproval. (Lindh et al., 2010; Sekerka et al., 2009; Staub, 2015; Woodard & Pury, 2007). Individuals who own this caliber of courage are compelled to vocalize opinions that highlight their values, even if they are at risk of being subjected to criticism or any other unfavorable response. In the face of such uncertainty, courage is required to address moral conflicts and wrongdoing when recognized. (Kritek, 2017; New York Society of Ethical Culture, 2008; Kang & Glassman, 2010). Nurses display this type of resolve by speaking up and voicing their values in the service of preserving or regaining moral alignment, dignity, respect, trustworthiness and or human welfare, for all involved (Aultman, 2008; Comer & Sekerka, 2018; Lachman, 2007; Murray, 2010; Staub, 2015). This Doctor of Nursing Project (DNP) gives prominence to the need for moral education and the development of knowledge and skills related to speaking up when morally courageous behavior is required.

Morally courageous behavior is integral to the delivery of safe and adequate healthcare, yet, labor and delivery and radiology nurses have to cope with challenges in this realm. As the complexities of providing healthcare escalate, nurses face thought-provoking moral situations more often. Moral courage allows one to preserve dignity, integrity, and trust of self, peers, or
their patients (Comer, & Sekerka, 2018; Murray, 2010). Moral courage can be displayed by nurses in support of patient’s in care related subjects such as; truth-telling, biased care provision, safe patient care, ethical sharing of information, patient advocacy, patient agency and autonomy, including the right people in care plan decision conversations and patient empowerment (Lindh et al., 2010; Sekerka et al., 2009; Staub, 2015; Woodard & Pury, 2007).

Moral courage has been defined as taking action and communicating what is right, even when afraid, or facing opposition, disapproval, or tangible loss, from others. (Lindh et al., 2010; Sekerka et al., 2009; Staub, 2015; Woodard & Pury, 2007).

**Examples of Moral Courage**

Often when we think of ethics and morality, we think of it in a biblical sense. There is a story in the Bible of profound moral courage in the story of Shadrach, Meshach and Abednego. These three men lived in Babylon under the rule of Kind Nebuchadnezzar. The king passed a law that all citizens of Babylon must begin worshipping a 90-foot statue of himself each day at certain times. The punishment for disobeying this new law was to be burned to death. Shadrach, Meshach and Abednego did not believe in worshipping statues and they made the courageous decision to honor their beliefs. They refused to worship the statute. This refusal by these three men was a profound act of moral courage, as they knew they would have to die for their beliefs.

A second example of moral courage comes from our history in the United States from the Civil Rights era. A woman named Rosa Parks was riding on a bus during a time when segregation laws were being enforced. The laws stated that as a woman of African descent, Rosa Parks was to relinquish her seat to her fellow Caucasian passengers if requested. Rosa Parks was aware of the law and that refusing to give up her seat would be breaking the law. She was also in support of the work being led by Dr. Martin Luther King to challenge segregation. Rosa parks
made the decision not to give up her seat and instead, stand up for equal treatment and justice. Ms. Parks knew there would be consequences, she knew at a minimum, she would be arrested. She displayed moral courage in her contribution to justice, by remaining in her seat on that segregated bus.

In connecting examples of moral courage to nursing, consider this final example of moral courage. An ICU staff nurse shares her concern for her patient with the charge nurse. The staff nurse has an intubated patient who is on a mechanical heart assist device and waiting for a heart transplant. The bedside nurse expresses distress because the patient is very agitated and is on minimal sedation of which she has exhausted already. The nurse is unable to settle the patient. In addition to the agitation she observes, the patient is showing a decline in their ability to compensate based on the trends with arterial blood gasses and lactate results. The nurse reports that she has reported the lab results and the agitation to the resident over the last three hours and no new orders have been written. Both the charge nurse and the bedside nurse must consider if they want to escalate the concern to the attending or continue with what they have been doing. Both nurses worry about retaliation from the resident. In an act of moral courage, the nurses call the attending and advocate for the patient and give their recommendations for next steps.

Moral courage can be displayed in many ways and for different reasons as demonstrated by the examples above. Acts of moral courage can be a small act of advocacy or intervening to save the life and dignity of many others. Courage moves individuals to maintain a moral position even in the presence of risk of rebuke, social, and financial loss from others (Comer & Sekerka, 2018; Murray, 2010). Acts of moral courage are executed with the hope of preserving or regaining dignity, respect, trustworthiness, and/or patient safety (Aultman, 2008; Comer&
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Sekerka, 2018; Lachman, 2007; Murray, 2010; Staub, 2015). I am reminded of the words of Theodore Roosevelt “Knowing what’s right doesn’t mean much unless you do what’s right.”

Statement of the Problem

Moral courage involves a conscious choice to speak and act, notwithstanding an antagonistic atmosphere, constructed by fear, financial loss, pain, personal loss or resistance from others (Lindhe et al., 2010; Sekerka et al., 2009; Staub, 2015; Woodard & Pury, 2007). Nurses, by extrapolation, demonstrate fortitude and good conscience by complying with clinical best practices, engaging in conduct that is morally correct, and speaking up, regardless of the risk for dismissal, penalties, or being spoken against by one's peers, are a looming possibility. It may implicate one as being an inconvenience though he or she can rest assured that, as a nurse, they championed the cause by defending the best care for their patients, inclusive of what they can afford to give or recommend. (Aultman, 2008; Comer & Sekerka, 2018; Lachman, 2007; Murray, 2010; Staub, 2015).

This Doctor of Nursing Project (DNP) strove to enable nurses in labor and delivery and radiology settings to practice moral courage, by examining relevant skillsets and providing training in core concepts, as they pertain to nursing practice. It enhanced the education and skills of frontline nurses, as they related to honing moral courage to foster an effective and confident display of moral courage in times of moral challenge and conflict. The project addressed gaps in traditional training concerning moral courage and aimed to promote a culture of morality in our healthcare organizations. (Borhani et al., 2014).

Significance of Addressing the Problem

Training health professionals to have moral courage promotes the retention of frontline nurses and improves safe patient care. (Comer & Sekera, 2018; Garon, 2011; Glassman, 2010;
Lindh et al., 2010). Ideally, this includes fostering confidence and skills which stimulate acts of moral courage in labor and delivery and radiology nurses.

Developing an ethical organizational culture begins with providing education and tools to empower nurses to display acts of moral courage when wrongdoings happen (Comer& Sekera, 2018; Eby et al., 2013; Lachman, 2010). A culture that supports morally upright actions yields the following: (1) An increased preparedness to speak up, (2) Improved retention of nurses, (3) Patient safety and quality outcomes through better inter-professional collaboration and (4) A more significant contribution to the ethical alignment of policies and day-to-day practices. (Borhani et al., 2014; Cummings, 2009).

This program responds to The Nurses' Code of Ethics as a standard set by The American Nurses Association (American Nurses Association, 2015). The Code of Ethics for nurses is a foundational document of reference to set the expectations and responsibility of nurses when ethical challenges arise. (Brown, 2015; Lachman, 2010; Purtilo, 2005). The Code is exemplary as it provides guidance for today's nursing practice, and the broader scope of the influence nursing has on society (Brown, 2015; Lachman, 2010; Purtilo, 2005). This document outlines the responsibility of nurses to positively contribute to an ethical climate and moral practice in the profession (Brown, 2015; Ernesto Dal Bo, 2013; Lachman, 2010; Purtilo, 2005).

Two provisions within the Code that have been identified as critical components to provide ethical care and support they need for moral courage are, "the preservation of the integrity and the relationship with colleagues and others" (American Nurses Association, 2015). These provisions are said to have been instrumental in the improvement of the mental and physical health of individuals within the Nursing profession. Additionally, the code provisions are reputed as having also improved the ethical climate, which contributes to a 'speaking up
culture' and patient safety. Achieving these outcomes affords nurses the opportunity to have a more informed perspective to take responsibility for actions that support their ideals of the highest good and for seizing opportunities to 'speak up.' A better understanding of the literature will help nurses overcome destructive coping strategies and feelings of diminished self-confidence when faced with moral fatigue at the workplace.

Chapter 2

Background

Aside from the nurses themselves, organizations also become beneficiaries when individuals display the aforementioned, proverbial 'moral courage.' Specifically, as a result of supporting and making an effort to cultivate an ethical environment, the organization honors its obligation of ethical and moral provision to all (Traudt et al., 2016). Fostering an ethical environment is a benefit in two ways: (1) It improves patient safety, quality and outcomes, and (2) It cultivates an organization of people who respect the dignity and integrity of others (Humphries & Woods, 2015). As an example, the act of moral courage helps in maintaining ethical boundaries in an organization (Serrat, 2017; Sharma, 2018).

Hamric and Blackhall (2007) sought to examine the relationship between moral distress and an ethical environment. In the study they conducted, they recruited a convenience sample of nurses (n=196) and physicians (n=29) from two hospitals, working in critical care areas. Moral distress patterns were shown to be similar for both hospitals. Hamric & Blackhall (2007) site end of life decisions where those involved felt pressured to maintain aggressive provisions, seen as not beneficial, were reported as morally challenging situations. In this study, nurses were shown to perceive these situations as occurring more frequently than did physicians (Hamric & Blackhall, 2007).
Indications of a positive organizational moral culture are: (1) The development of ethical critical thinking skills among nurses, (2) The ability to appreciate the value of caring for colleagues and patients with compassion and dignity and (3) The willingness to learn from experience and make changes to move towards the goal of a positive moral culture (Rushton & Stutzer, 2015). The expression of moral courage enables nurses to practice with integrity and confidence (Brown, 2015; Williams, 2017). Job satisfaction in Nursing correlates with the ability to display moral courage in challenging situations successfully (Borhani et al., 2014; Cummings, 2009). Conversely, nurses experience moral distress when faced with situations of ethical decision-making, and they are unsuccessful in exercising the moral courage needed to advocate for themselves, peers, patients, or patient family members (Borhani et al., 2014; Cummings, 2009; Kelly, 1996; Lachman et al., 2012). This type of distress is related to the inability to maintain personal and professional moral standards causing distress within the nurse (Borhani et al., 2014; Cummings, 2009; Kelly, 1996; Lachman et al., 2012; Traudt et al., 2016).

One factor that may impact moral distress in comparison to the display of moral courage is the imbalance of power between nurses and physicians. To build this idea, an example is when a nurse does not feel she is able to effectively take a stand against a treatment that will not contribute to the overall goals of the patient. When the nurse does not intervene, she will experience moral distress, and this may affect the trust of the patient and result in negative outcomes for the patient (Lachman et al., 2012; Traudt et al., 2016).

Each experience of moral conflict that is not acted on through moral courage can result in moral distress. "When moral distress is sustained, nurses experience burnout, lack of empathy, and a decline in nursing judgment and quality of patient care," (Kelly, 1996; Lachman et al., 2012; Laurs et al., 2020). Nurses participating in this training will potentially save the
organization money, that is related to the reduction in the high turnover of nurses, stress-related absences, mitigation of burnout, and improved patient safety (Borhani et al., 2014; Cummings, 2009; Kelly, 1996; Lachman, Murry, et al., 2012; Laurs et al., 2020).

Establishing a culture where nurses can voice their values through their opinions by speaking up helps to avoid or at least mitigate the harmful effects of moral distress (Edmonson, 2015; Traudt et al., 2016). Moral distress occurs, "When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." (Morley, 2018). When moral distress occurs, and no action is taken to mitigate the distress, negative feelings may develop, either towards one's self, others, or the organization (Morley, 2018; Laurs et al., 2020; Ulrich, 2017). "Self-hatred, low self-esteem, burnout, hardening, or jading can develop in nurses who have the perception of not being safe to act when moral conflict arises" (Morley, 2018). All of these possible results can jeopardize patient safety, negatively impact coping, and increase turnover rates (Borhani et al., 2014; Traudt et al., 2016; Ulrich, 2017). On the other hand, compelling expression of moral courage allows nurses to act when they recognize moral conflict, thus, never causing the nurse moral distress (Borhani et al., 2014; Cummings, 2009; Kelly, 1996; Lachman et al., 2012).

In providing a model for understanding and overcoming moral distress, several researchers trace the root causes of emotional disconnect between nurses and their patients (Brady et al., 2020; Oh & Gastmans, 2015).

Using the Maslach Burnout Inventory (MBI), it was found that nurses who were emotionally fatigued became disconnected from their patients (Oh & Gastmans, 2015). It was also found that increased moral distress mirrored emotional distress (Brady, et al., 2020). Furthermore, research conducted by both Wand (2018) and Beumer (2008) reinforced these
findings. Wand (2018) concluded that the more morally distressed nurses become, the more they experience negative emotions like frustration and anger. Beumer (2008) linked nurses' levels of anger to frustration to group activities addressing the issue of moral distress; a subsequent decrease in these emotions followed such activities.

Unsurprisingly, as researchers grapple with the emotional effect of moral distress on nurses, answers to the question of effective coping strategies begin to emerge. Exiting the Nursing profession is one of the negative coping strategies nurses employ as an expression of moral fatigue (Oh and Gastmans, 2015). Nurses either contemplated leaving the profession or actually decided to leave their jobs as a result of the emotional toll experienced from moral distress in studies investigating this phenomenon (Borhani et al., 2014; Corley et al., 2005; Cummings, 2009; Kelly, 1996; Lachman et al., 2015). It was reported that as much as 45% of nurses who participated in the study conducted by Oh & Gastmans, (2015) changed profession or wanted to leave their jobs with the primary reason being moral distress. Corley (2005) showed that 12% of the 111 nurses interviewed in her study left the nursing profession due to moral distress (Corley et al., 2005).

Hardingham (2004) identified an additional problem of 'moral residue, which is the ongoing feeling and personal discord from morally distressing experiences that continue after the event is over as a result of unresolved morally challenging situations and moral distress. Unlike the emotions of frustration and anger, which are related to moral distress, 'guilt, shame, and self-blame' are associated with moral residue (Hamric, & Mohrmann, 2015; Hardingham, 2004; Oh and Gastmman, 2015). The intensity and frequency a nurse must encounter morally changing situations with recourse for resolution is an indicator of the cumulative effect of moral residue
Once these negative emotions are internalized, nurses tend to distance themselves from their patients and behave indifferently to other professionals.

The 'frequency and intensity' of moral distress are intertwined with the values that shape healthcare institutions. By developing and encouraging nurses to become powerful advocates for their patients through the creed, intentional practices, protocols, procedures, and operational objectives, nurses are likely to display higher degrees of moral courage with confidence (Hardingham, 2004; Oh and Gastmans, 2015).

A study conducted by Mental Health America (2017) concludes that an estimated 500 billion dollars are lost annually due to low productivity stemming from work-related stress. Research has shown that absenteeism is one measure of the stress-related health of employees. Forbes magazine reports that the United States has an annual cost of $3.6 billion due to loss of productivity related to nurse absenteeism (Investopedia, 2013). For each nurse that leaves an organization due to unaddressed moral distress and lack of a morally safe environment, it will cost an organization between $22,000 and $64,000 to replace that nurse (Jones & Gates, 2007).

The costs associated with nurse turnover include the following: advertising and recruitment, vacancy costs, and hiring and training costs. In addition, there are risks associated with potential patient errors and compromised quality of care due to factors such as new staff members learning in a new work environment, a poor work environment, or a culture of dissatisfaction and distrust resulting from lack of familiarity with new coworkers. (Jones & Gates, 2007).

The opportunity to develop the skills and confidence needed to move beyond fear and act on moral courage can empower nurses, contribute to a positive moral organizational culture and contribute to safe patient care (Brown, 2015; Ernesto Dal Bo, 2013; Sekerka et al., 2009). The literature tells us that moral courage is not a virtue of its own; instead, it propels individuals into
action, by encouraging the authentic endorsement of all other moral virtues of value to self and the organization (Ernesto Dal Bo, 2013; Lindh et al., 2010; Sekerka et al., 2009; Staub, 2015; Woodard, & Pury, 2007).

Review of the literature

The foundation of moral virtues is established by The Nurses Code of Ethics; it establishes the setting where each nurse is able to establish moral capital. (Ernesto Dal Bó, 2013). Moral capital is defined as a set of shared practices established as norms, which are extant in an organization or society, identifying cooperative and shared values as they relate to the individual and collective conduct (Bennett et al., 2014; Brown, 2015; Chambers, 2011; Ernesto Dal Bó, 2013; Jaye et al., 2018). Moral capital also refers to the presence of fundamental ethical attitudes within a group (Bennett et al., 2014; Brown, 2015; Chambers, 2011; Ernesto Dal Bó, 2013; Jaye et al., 2018). It allows judgment of what is good or bad, in comparison to those established norms resulting in moral solidarity and shared expectations of the members of the organization, and the community of the nursing profession. (Bennett et al., 2014; Brown, 2015; Chambers, 2011; Ernesto Dal Bó, 2013; Jaye et al., 2018).

Four features of moral capital are identified in the literature: (1) relational connection, (2) reflective practice, (3) personal agency, and (4) the importance of an enabling environment (Swartz, 2010).

The sense of connection must be recognized as a moral influence within the organization (Swartz, 2010). There must be an identified standard for ethical and moral action, and nurses must be able to recognize a connection among themselves and this standard (Swartz, 2010). Second is a reflective practice allowing nurses to be able to reflect on past experiences, noting
how this affected their professional connections and relationships (Swartz, 2010). The third is personal agency, involving the recognition of responsibility each nurse holds to maintain morally responsible care for the patients in their department and in their organization (Swartz, 2010). Last is an enabling environment, referring to how much does the organization permit or prohibits acts of moral courage (Swartz, 2010).

Moral capital is valued and vital because individuals of the group hold the common perception of a tangible or intangible reward for supporting the moral standards shared by the group. (Bennett et al., 2014; Ernesto Dal Bó, 2013; Jaye et al., 2018). The organizational culture is a critical component in the influence of the decision to display moral courage. The moral capital dynamic also lays the groundwork for moral and ethical organizational culture; it is perhaps the ideal destination of this work. This concept is discussed in terms of shared values within a team. These shared values can be explicit and implicit values determining the moral expectations of the group or organization. (Ernesto Dal Bó, 2013; Young, Egan, & Williamson, 2018). Moral capital empowers the nurse to take action and speak up; moral capital can be supported through efforts such as: facilitating inter-professional collaboration, moral behavior examples, education, and ethics journal club opportunities (Brown, 2015; Chambers, 2011; Ernesto Dal Bó, 2013; Purtilo et al.).

This concept of moral capital relates to moral courage because the moral expectation and values of the organization must be clear and well understood. When moral expectations are explicit, individuals of the group will know when the organizational values are being infringed upon, and they can begin the process of decision-making and intervention (Bennett et al., 2014; Ernesto Dal Bó, 2013; Jaye et al., 2018).
In an optimal setting, addressing wrongdoings would be the acceptable and expected course of action; in this optimal setting it would not require courage to bring attention to wrongdoings whether the wrongdoing is intentional or unintentional, because speaking up would be encouraged and embraced (Ernesto Dal Bo, 2013). The literature on moral courage informs readers of the benefits of moral education and skill construction (Huff, 2014). Skill-building should include the use of a Socratic-experiential learning model to maximize efficacy (Purtilo et al., 2005). In the experiential learning model, the learner builds understanding through a process of inquiry and reflection (Purtilo et al., 2005). Experiential learning occurs in three phases; first, the learner needs a concrete experience where they have had the opportunity to know what moral conflict is (Purtilo et al., 2005). Second, is a contemplation phase in which the student can engage in reflection on their experience, examining their observations and reactions (Purtilo et al., 2005). Third, is the application or conceptualization phase, helping the learner broaden and further develop their understanding of moral conflict and moral courage (Purtilo et al., 2005). The Socratic-experimental learning model refers to being guided through this process by the trainer using prompted discovery, sometimes called conversational learning (Purtilo et al., 2005). The trainer serves as a coach for the learners as they move through the three phases (Purtilo et al., 2005). The trainer asks open-ended questions and allows the student to discover their insights and apply past experiences (Purtilo et al., 2005).

Students learn moral courage when allowed to practice intervention, negotiation, inquiry, and conflict resolution skills (Moskop, 2016; Purtilo et al., 2005). Skill practice is best followed by a debriefing discussion to review what went well and what can be further developed for consistent success (Moskop, 2016; Purtilo et al., 2005; Scully & Rowe, 2009).
Standard components found in the evidence are also connected with the literature are concepts such as: identifying the need for moral correction, accepting responsibility and taking action, deciding to act despite fear, and shifting the culture to support morally courageous acts. All of these components must be addressed in an effective curriculum on moral courage. Moreover, consideration of how to deliver the education in a manner that will facilitate the maximization of efficiency and joy in learning the content must be a part of the process (Purtilo et al., 2005).

**Literature Summary**

The literature emphasizes the importance of organizational leadership which supports a culture that is inclusive of speaking up and upholding the moral standards of the organization and The Code of Ethics for Nurses. Education and skill- construction, along with recognition and reward, are contributing factors towards this goal. The curriculum must advance individuals forward, from where they are in their moral development, towards a deeper understanding of self, others, and justice, with moral conviction to intervene when necessary. As nurses move to more closely align their behavior and responses accordingly, their moral distress will be minimized, causing an inverse ethical empowerment of these nurses who are now endowed with the confidence to make a difference. Ultimately, the goal is to have an organization with a culture of justice, where following The Code does not require courage because nurses can act and speak up with hose around responding with appreciation and encouragement. This positive response will be due to the immense respect for the dignity, shared values, empathy, and compassion the group identifies as their common and normal behavior (Purtilo, 2005; Scully & Rowe 2009). When this pinnacle of culture is achieved, everyone understands the feeling of "putting yourself out there," to maintain moral and ethical values, thus, keeping everyone involved safe, and all
good-faith input and advocacy is respected (Purtilo, 2005; Scully & Rowe 2009). In this ideal setting, optimal maintenance of moral and ethical healthcare provision can be realized (Purtilo, 2005; Scully & Rowe 2009). The relationship between moral courage and an ethical climate is noted as a gap in the literature and an opportunity for further scholarly contributions (Nummimem et al., 2018). This project contributed to this gap in knowledge.

**Project Model of Change**

The Knowledge-to-Action (KTA) Framework was the change model used to guide this project on moral courage (White, Daya, Karel, White, & Abid, et al., 2020). The KTA framework is comprised of two components; knowledge creation and the action cycle (White et al., 2020). As indicated in the image of the framework, it is an iterative and interactive process. Within the "funnel" of the image, knowledge of the inquiry, synthesis, and creation are used to tailor the education (White et al., 2020).

Knowledge inquiry represents the literature search and translation of the evidence related to the knowledge of moral courage (White et al., 2020). This step is necessary to identify the gap in knowledge and inform areas of potential future research (White et al., 2020). Knowledge synthesis indicates the contemplation of the evidence; to compare, contrast, and begin to connect ideas and themes found in the literature to inform the knowledge to be shared with others. In moving forward, through the KTA process, the experience is refined, and knowledge tools and products are identified or developed (White et al., 2020).

The action cycle describes the activities in the application of knowledge (White et al., 2020). The cycle includes identification of the problem and the knowledge needed; adaptation of the knowledge to the context in which it will be applied (White et al., 2020). In this project, adaptations were required for nurses in the healthcare setting who work in the labor and delivery
and radiology department (White et al., 2020). Next, an assessment was needed to identify barriers versus facilitators towards the use of knowledge (White et al., 2020). The following questions were asked and answered for this assessment; “what keeps nurses from using this knowledge”; and "what helps nurses use this knowledge"? Knowing the answer to those two questions helped to develop an effective training (White et al., 2020). The next steps were to tailor the intervention, address the barriers, and include factors supporting the use of the knowledge taught in this training. Then the learning was monitored for perceived value and impact (White et al., 2020). The next step of KTA was to evaluate and measure the outcomes (White et al., 2020). The change achieved wase measured to indicate the knowledge provided and its impact. Lastly, in the KTA framework one must ensure the knowledge is sustained through continued refreshers, monitoring, rewards, and feedback as addressed in the third aim of this DNP [project. The KTA framework guided the process of the project for an effective, measurable, and sustainable outcome (White et al., 2020).
Supporting Theoretical Frameworks

A supporting framework for this project, James Rest Four Components Model on Kohlberg's theory of moral reasoning development, was extended in 1983 by James Rest. At first, Rest designed an easy-to-score measurement and administered it to mainstream businessmen and women to measure moral judgment (Rest, 1979), after which he defined the Four Component Model (FCM) of morality to explain how human moral action can be influenced by cognitions, affect, and social dynamics (You, & Bebeau, 2013; Rest et al., 1999). His prediction is that, in order to understand the FCM of morality, we must answer the question, "How does moral behavior come about?" (Rest, 1983). Rest then developed four components to describe how moral behavior is developed. These four components have been proven useful in
studying and understanding the effectiveness of moral functioning (You, & Bebeau, 2013; Bebeau & Monson, 2014).

The four components of Rest's model of morality are moral sensitivity, moral judgment, moral motivation and commitment, and moral character and competence (You, & Bebeau, 2013). The first three sensitivity, reasoning, and motivation are directly related to the development of moral perceptions and aspirations in combination with moral reasoning. Rest's fourth component discusses character and competence or implementation of moral standards (You, & Bebeau, 2013).

**Moral sensitivity**

The focus of moral sensitivity is on the interpretation of every given situation to include, but not limited to, the various options that are available and how the options can affect the nurse and others around them. The word 'discernment' is synonymous with 'moral sensitivity' as it is distinguishing or sorting what is right (Bennett et al., 2014; Scully & Rowe, 2009; Serrat, 2017; Purtileo et al., 2005; Staub, 2015). In the context of moral courage, moral sensitivity is the ability to recognize a morally challenging situation as one that is different from other kinds of challenges. The person experiencing the situation will possess the ability to analyze and identify situations where there is a misalignment among a person's moral values, ethical values and what is happening in that particular moment (Bennett et al., 2014; Scully & Rowe, 2009; Serrat, 2017; Purtileo et al., 2005; Staub, 2015). Moral sensitivity is the first stage in Rest's theory. To access moral sensitivity or discernment, an individual must have an understanding of the effect that the actions of one person has on another (Yu, & Bebeau, 2013; Bebeau & Monson, 2014). The ability to connect morally challenging actions with the future impact on others provides a heightened level of moral sensitivity that will alert the nurse of a moral challenge (Yu,
Bebeau, 2013; Bebeau & Monson, 2014). There is an agreement in the literature that moral judgment is a contributory and fundamental component that allows an individual to display moral courage (Bennett et al., 2014; Scully & Rowe, 2009; Serrat, 2017; Purtilo et al., 2005; Staub, 2015).

Training nurses to develop ethical sensitivity also involves helping them to refine their ability to empathize so that they may analyze the perspectives of others and not just their own. Subsequent to honing this empathetic vision, they can be equipped to view circumstances from a socio-economic or cultural standpoint, including but not limited to, considering the legal and institutional perspectives of others. In the field of nursing, knowledge of The Nurses' Code of Ethics, the norms, and rules, while recognizing when and how to apply the standards of practice, are crucial factors in developing moral sensitivity. In practice, this moral component emphasizes the idea that the moral behavior of nurses can only be triggered when the professional Code of ethics is upheld and is morally fair.

**Moral Reasoning**

Moral reasoning is the next concept from Rest's theory. Moral reasoning is defined as an individual's capacity to determine a moral judgment and to be accountable for the decisions made and actions taken (Kritek, 2017; Purtilo, 2005; Raines, 1994). Once aware of the possibility of various lines of action, one must inquire which line of action has a greater moral justification. Asking questions such as, "Is there a choice that is more right than the other?" (Kritek, 2017; Purtilo, 2005; Raines, 1994). This process is highlighted in the work of Piaget and Kohlberg. At an early stage, people already follow their intuitions and make judgments on the fairness or morality of even the most complex human activities (Yu, & Bebeau, 2013; Bebeau & Monson, 2014). The psychologist is tasked with understanding how the intuitions come about,
and what factors govern the application of these intuitions to real-world events (Bennett et al., 2014; Kritek, 2017; Sekerka, 2009; Sharma, 2018). Moral reasoning requires thinking through one's values to choose to act, particularly when there may be competing values to consider (Yu, & Bebeau, 2013; Bebeau & Monson, 2014). The literature does agree that the process of deciding to act is a complicated one, and there is no straight path application for even most situations (Kritek, 2017; Purtilo, 2005; Raines, 1994).

Factors highlighted in the literature, as affecting the decision to act while the nurse is in the process of enacting moral agency, are awareness, competence, self-efficacy, integrity, and education (Bennett et al., 2014; Kritek, 2017; Sekerka, 2009; Sharma, 2018). The educator is tasked with understanding how to best promote reasoning and development, especially for students who have not developed the ability before professional education. The concept of moral agency reasoning is essential to this project on moral courage because it is moral reasoning that brings the nurse to the decision to intervene in a morally challenging circumstance, thus, wallowing in the opportunity to demonstrate moral courage (Kritek, 2017; Purtilo, 2005; Raines, 1994). The literature on moral courage indicates factors that will influence the next theme in Rest's theory of moral motivation and commitment.

**Moral Motivation and Commitment**

Moral Motivation and Commitment involves giving higher priority to moral values than to other personal values. People ascribe different values to different traits, such as careers, aesthetic preferences, excitement, affectional relationships, hedonistic pleasures, or institutional loyalties (Yu, & Bebeau, 2013; Bebeau & Monson, 2014). Giving priority to moral concerns appears to depend on how deeply moral notions penetrate a person's self-understanding, that is, "Whether moral considerations are judged constitutive of the self?" (Blasi, 1984). When a moral
dilemma is present, before an individual takes action, he or she must decide if there is a need for action and whether or not they are individuals who will undertake responsibility for intervening. Together, the need for action and the recognition of responsibility are motivation enough to take action (Rest & Marvaez, 1994). According to Blasi (1991), "The self is progressively moralized when the objective values that one apprehends become integrated within the motivational and affective systems of personality, and when these moral values guide the construction of self-concept and one's identity as a person."

**Moral Character and Competence**

A nurse may have good judgment, prioritize moral values, and be sensitive to moral issues, but is lacking in moral character and competence. He or she may get distracted or discouraged, and succumb to fatigue or pressure, failing to follow through on concerns with actions. This failure will result in a lack of moral action. Having set goals, self-discipline and impulse control, as well as the skill and strength to pursue one's goals, is presumed for this component (Yu, & Bebeau, 2013; Bebeau & Monson, 2014).

The Four Component Model (FCM) is not a linear problem-solving model. Rather, the components of the model are interactive (Rest, 1983). For example, a moral character may constrain moral motivation, while moral motivation may affect moral sensitivity (You, & Bebeau, 2013; Bebeau & Monson, 2014). Furthermore, unlike other moral function models focusing on the traditional three domains - cognition, affect, and behavior- the FCM of Morality assumes that cognition and affect both happen in all areas of moral functioning. Each of the four components of FCM is a combination of cognitive and affective processes contributing to the component's primary function (Yu, & Bebeau, 2013; Bebeau & Monson, 2014). In this study,
moral courage and ethical decision-making will be linked since nurses cannot take ethical action without first having the moral courage to implement it.

**Kidder's Ethical Decision-Making Model**

**In the second supporting model for this project,** Kidder developed an ethical decision-making model that also guided the development of adaptations applied to the developed curriculum. Rushworth Kidder offers nine checkpoints to be used when ethical decision-making is needed (Kidder, 2009).

1. Recognize there is an ethical conflict. This is the alert there is an issue that needs to be addressed.
2. Determine the actor and the risk. The person who is able to make a change to the circumstances must be identified. Consider the risk involved in speaking up about the issue;
3. Gather the relevant facts. One may need to learn the details of the issue in order to understand what the right or moral action is to take;
4. Test for right-versus-wrong. Thinking through each choice and evaluating whether or not it is in alignment with a gut feeling of what is right and socially acceptable.
5. Test for right-versus-values. In this checkpoint, core values are compared internally for conflict. A decision must be made towards which value will be upheld. An example is honesty versus loyalty;
6. Apply ethical standards and perspectives. The most relevant principle is applied to achieve justice, safety, or fairness;
7. Look for a third way. Look for another way to reconcile the issue. There may be a creative way to negotiate or compromise that is acceptable;
8. Make the morally courageous decision. Through our ability to be compassionate and empathetic, we must decide and act on our values; (Kidder, 2009).

Kidder explains that having the courage to be moral is all that is needed to be morally courageous (Kidder, 2009). Kidder's model highlights the overlapping intersection of principles (values), endurance, and danger as the conditions for moral courage. He relates moral courage to values of honesty, responsibility, respect, fairness, and compassion. He calls these the "five-fingered hand" of humanity's common moral framework. These components are all addressed in the curriculum developed for this project.

A notable quote from the book "Taking Action When Your Values Are Put to the Test" written by Kidder (2005) says the following: "... just as a single candle can destroy a whole closetful of
darkness, so, a single life, lived in the light of goodness and moral courage, can make an enormous difference in overcoming the reverberating void that calls itself evil, blackness, doubt, cowardice, fright, or mere bravado." The quote above is so powerful in its ability to create a visualization of the power of moral courage and the profound impact morally courageous actions can have.

**Environmental Scan or Organizational Analysis**

This project was conducted in two organizations to facilitate a comparative study. This project was carried out in the labor and delivery and radiology departments so that findings can be compared, contrasting the settings and environments as well as answering questions such as the senior leadership at both organizations are in support of this work and will help to facilitate implementation. This contributed to the successful integration of the change. In this paper, a scan of each organization is presented to set the background, context, and setting in which the project was conducted. The author is employed in both organizations.

The first organization that participated in this project was Lucille Packard Stanford Children's Hospital (LPCH), which started as the Stanford Home for Convalescent Children in 1919. Over the years, LPCH has been a consistent asset to the Palo Alto community. The hospital has grown and is now known worldwide, currently providing 364 inpatient beds. LPCH cares for patients through cooperation with the Stanford University School of Medicine in a learning environment. This organization cares for a diverse patient population, including all ages.

LPCH nurses are organized within The Committee for Recognition and Nursing Achievement (CRONA) as a bargaining unit. The union interacts with the organization progressively. LPCH also supports an interactive nursing professional practice model embracing
the Caring Science Theory. This practice model supports shared governance, collaboration, and recognition for the nursing professionals. LPCH employees are approximately 2400 nurses.

The second that organization participated in this project was Kaiser Permanente of the Northern California Kaiser Permanente region (KPNC), located in Santa Clara, California.

The Kaiser Permanente Santa Clara hospital is located in the northern California region, in Santa Clara County. The organization has a focus on quality and preventative care. Kaiser Permanente (K.P.) members are provided with a wide range of resources encouraging healthy lifestyles, in addition to convenient preventative testing, screening, education, and treatments with the goal of helping patients to stay healthy and thrive. K.P.’s strengths are found in its ability to keep members healthy, maintain access to care, and to keep cost moderately low while providing convenient care. One of the many unique aspects of K.P. is the relationship between the organization and the unions in which K.P. employees belong. K.P. is traditionally a union environment, and this harkens back to the inception of the organization in the 1930s when medical care was provided by Doctors, Henry Kaiser, and Sydney Garfield. Care was offered to the contractors and laborers through a service of the union, in exchange for a set annual fee, paid for in partnership with the unions providing health care to their workers.

K.P. has honored the union partnership over the years, and this has shaped the working environment in the organization. Kaiser Permanente (K.P.) is a nationwide organization providing health care insurance and services to members in eight states and Washington, D.C. It has an operating budget of over $79 billion annually and employs over 59,000 nurses. K.P. designates its service areas by geographical location. There are eight regions maintained by K.P., with the northern California region having the largest K.P. membership in the nation with over 4,389,705 members.
The two units are comparable in size, nursing staff, and patient volume acuity. At Stanford children's hospital, the interest is proactive, working towards an ethical culture. At Kaiser Permanente, the interest is more reactive from the challenges experienced in the department.

Stanford nurses may experience a more significant percentage of privately insured patients, and their independent union representation influences the organizational nursing culture. In contrast to Kaiser Permanente, where the payer mix is balanced, and their unified statewide nursing union representation influences the organizational nursing culture. The diverse environments of these two organizations provided a contrast in settings for this project on moral courage with the opportunity to compare the process and results of the project's effectiveness, contributing to the strength and validation of methods used in the curriculum. In conclusion, both organizations have unique characteristics and offer opportunities to deepen the understanding of moral actions in the labor and delivery and radiology departments.

Forbes magazine reports that the U.S. has an annual cost of $3.6 billion due to loss of productivity related to stress-related nurse absenteeism (Investopedia, 2013). As previously mentioned, when a nurse leaves an organization due to unaddressed moral distress and a lack of a morally safe environment, the result is usually a cost to the organization, which ranges from $22,000 to over $64,000 to replace that nurse (Jones & Gates, 2007). Nurse turnover costs include the following: Advertising and recruitment, vacancy costs, and costs for hiring and training. Also, there may be risks associated with potential patient errors and compromised quality of care (Duffield et al., 2014; Ferinia et al., 2016; Shuck, 2019). Due to new staff learning in a new environment, frequent turnover can continue a culture of dissatisfaction and distrust with new people in the workplace who do not know each other (Duffield et al., 2014;
Ferinia et al., 2016; Shuck, 2019). Addressing moral courage offers benefits to organizations in employee engagement, vigilance in safe care, as well as a mitigating factor for burn out and nurse turnover saving tangible and intangible cost for the organization (Duffield et al., 2014; Ferinia et al., 2016; Shuck, 2019). The cost of the program included paying for the time of the participants. All materials were sent out in electronic format at zero cost. Access to additional organizational data was restricted until after the project approval process was completed.

The goal of the project:

The goal of this DNP project was to enable nurses in labor and delivery and radiology settings to practice moral courage by examining relevant skillsets and providing training in core concepts. The program aimed to support a moral culture, encourage resilience, and improve speaking up, retention of frontline nurses, and safe patient care. The project contributed to the organization's goals with a commitment to positive change for patients and nurses.

The Aims of the project were:

Aim 1: To develop a moral courage training program for nurses

Aim 2: To implement and evaluate the program

Aim 3: To make recommendations to stakeholders in the partner organizations with the goal of integration and scaling for broader initiatives promoting a culture of morality

Chapter 3

Methods

In as much as the various theories on moral distress, moral courage, and ethical decision-making ground this project, identifying the best methods needed to collect and analyze the data was critical to achieving the purpose of this study. The goal of this DNP project was to enable
nurses in labor and delivery and radiology settings to practice moral courage by examining relevant skillsets and providing training in core concepts. The program's intent was to support a moral culture and contribute to the retention of frontline nurses and improved safe patient care.

**Aim 1: To develop a moral courage training program for nurses**

The first aim of this project was to develop a moral courage training program for nurses based on a modification of the "Giving Voice to Values" (GVV) curriculum, written by Mary Gentile (Gentile, 2009). The GVV program teaches moral courage through voicing values. The GVV methodology is based on seven pillars. These pillars are values, choice, moralization purpose, self-knowledge, and alignment, voice reasons, and rationalizations based on a behavioral ethics approach (Christensen et al., 2016). (See Appendix A for learning objectives)

The following action framework and steps outline the curriculum:

- **Values**: Discuss shared values, agreement on commonalities;
- **Choice**: Examine beliefs about the choice to voice values when moral conflict arises;
- **Normality**: Expect values conflict as a natural part of communication;
- **Purpose**: Define professional purpose;
- **Self-Knowledge, Self-Image, and Alignment**: Developing a personal narrative; building on the students' individual strengths, emotional intelligence, and awareness;
- **Voice**: Practice scripts and expressions of values. Moral preparation. Ability to rehearse the decision-making process and role-play discussions;
- **Reason and Rationalizations**: Discuss common rationalizations for unethical choices and identify counterarguments.
The GVV curriculum was developed for Master of Business Administration students and was modified for this project to address specific healthcare concerns for the culture of nursing. The modifications included the following:

- **Immediate** navigation of conflict to voice personal and professional values
- **A focus on managing conflict with compassion**
- Integrating the power of **bystander support**
- Highlight nurses' responsibility based on the **Nurses Code of Ethics**

It was crucial to integrate these into the curriculum because the healthcare culture differs from business in the following ways: 1) Nurses are often in urgent or emergent situations that require an immediate response at the time the moral conflict is happening; 2) The Nurses' Code of Ethics guides nurses in establishing professional, ethical expectations; 3) In many situations of moral conflict, nurses must voice their values with someone who may feel they are in a superior position and 4) nurses are often able to support each other in conflict, therefore strengthening the expression of their values.

The core curriculum was already developed and tested, and the modification did not change this substantially. Therefore, it did not require review by an expert panel.

The GVV curriculum moves the learner through interactive discussions and activities in the topical outline described in appendix D.

**Aim 2: Implement and evaluate the program**

The modified GVV curriculum was taught to nurses in one four-hour session, meeting the following objectives through interactive discussion, reflection, and participant activities.

In the implementation process, this program used the essential components in curriculum implementation based on the Strategic Instruction Model (Hoover, 2010).
The five essentials are as follows: (See appendix B for course outline) (See appendix C for model; Hoover, 2010).

1. **Evidence-based interventions** – Validated teaching methods interventions

2. **Instructional Arrangements** - Teaching methods to facilitate learning and skills development

3. **Content and skills** – Subject of training, skill development, ways of thinking and thoughtfulness, and outcomes

4. **Class and instructional management procedures** – Structure of the classroom to support learning management, behavior guidance, and facilitate opportunities to think and learn

5. **Progress evaluation** - Assess learners' progress towards the objectives through responses and verbal feedback as well as formal feedback and evaluation

Evidence-based interventions are included through the foundational use of the GVV curriculum with the adaptations integrated for practical application in the healthcare setting, by nurses. (See appendix G for progression of course themes & topics)

The teaching methods used are:

   a) Small group discussions
   b) Interactive large group discussions
   c) Individual work
   d) Skill Practice

Due to the COVID-19 pandemic, the teaching methods for this training moved from an in-person classroom setting to an online platform. A review of the literature was completed to
identify evidence-based methods of teaching online training using Zoom. This course was conducted as a live online education and utilized interactive methods. The books reviewed for this research were "Engaging the online learner: Activities and resources for creative instruction" (Conrad & Donaldson, 2011). The second book was "Virtual training tools and templates: An Action Guide to Live Online Learning" (Huggett, 2017).

Evaluation Plan

The evaluation of the training was based on the Kirkpatrick training outcomes evaluation model (image is shown in the appendix G & H). Each activity served as a part of the learning assessment. As the students discuss thoughts, reflections, and practice skills, the instructor is able to gather real-time development of knowledge and skill. Formal evaluation of Aim 2 was as follows: (See appendix H for Kirkpatrick's Four Levels of Evaluation)

The levels of Kirkpatrick’s model and what is included in the evaluation in each level:

Level 1 – Reaction

Engagement, relevance, satisfaction

Level 2 – Learning

Knowledge, skills, attitude, confidence, commitment

Level 3 – Participation and transformation

Confidence, transformation of behavior

Level 4 – Results

Leading indicators, desired outcomes, analyze, Disseminate
- Pre- and post-training surveys to evaluate the participants' knowledge and practice related to moral courage. Level 2 & 3 of Kirkpatrick’s levels of evaluation.
  - Pre and post-test matching
  - Report of participant self-evaluation related to willingness to change their attitude and response to moral challenges
- Post course satisfaction assessment. Level 1 of Kirkpatrick’s levels of evaluation.
- Analysis of data related to the desired outcome of improvement in willingness to perform acts of moral courage with confidence. Level 4 of Kirkpatrick’s levels of evaluation.

The pre- and post-curriculum assessments utilized The Nurses Moral Courage Scale (NMCS) in whole and in-part respectively (Numminen et al., 2019). This instrument is unique and was selected because it was explicitly designed for nurses to as a scale to measure nurses' moral courage (Numminen et al., 2019). The Professional Moral Courage Scale, the Moral Courage Scale for Interns and Residents, and the Moral Courage Scale for Physicians (MCSP) were evaluated during the process of reviewing the literature to find an appropriate instrument for this project. (Martinez et al., 2016; Sekerka et al., 2009). None of these moral courage scales were as fitted for this project as the NMCS. (See appendix E for NMCS) (See appendix F for Themes of NMCS)

The Nurses Moral Courage Scale was the best fit for this work. "The instrument is based on the theoretical model developed in the concept analysis of moral courage in nursing and on related nursing literature" (Numminen et al., 2019). The NMCS categorizes responses into four categories: 1) compassion and true presence, 2) moral responsibility, 3) moral integrity, and 4)
commitment to good care (Numminen et al., 2019). The researchers who developed this instrument conducted content validity with an expert panel of 7 experts, meeting the recommended scale content validity index of 0.90 or higher with a score of 0.90 (Numminen et al., 2019). A psychometric evaluation of the NMCS was completed by the developer of the instrument a "Confirmatory factor analysis (CFA) was computed to confirm the final NMCS structure" (Numminen et al., 2019).

Table 1

*Cronbach’s alpha coefficients in the Finnish data*

<table>
<thead>
<tr>
<th>Sum variable</th>
<th>Items</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion and true presence</td>
<td>12, 20, 25, 27, 30</td>
<td>0.81</td>
</tr>
<tr>
<td>Moral responsibility</td>
<td>13, 16, 17, 23</td>
<td>0.81</td>
</tr>
<tr>
<td>Moral integrity</td>
<td>11, 14, 19, 21, 22, 29, 31</td>
<td>0.82</td>
</tr>
<tr>
<td>Commitment to good care</td>
<td>15, 18, 24, 26, 28</td>
<td>0.73</td>
</tr>
<tr>
<td>NMCS</td>
<td>All items</td>
<td>0.93</td>
</tr>
</tbody>
</table>

Table 2

*Cronbach’s alpha coefficients in the Belgian data*

<table>
<thead>
<tr>
<th>Sum variable</th>
<th>Items</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion and true presence</td>
<td>12, 20, 25, 27, 30</td>
<td>0.62</td>
</tr>
<tr>
<td>Moral responsibility</td>
<td>13, 16, 17, 23</td>
<td>0.80</td>
</tr>
<tr>
<td>Moral integrity</td>
<td>11, 14, 19, 21, 22, 29, 31</td>
<td>0.81</td>
</tr>
<tr>
<td>Commitment to good care</td>
<td>15, 18, 24, 26, 28</td>
<td>0.71</td>
</tr>
<tr>
<td>NMCS</td>
<td>All items</td>
<td>0.91</td>
</tr>
</tbody>
</table>

The instrument itself was shared in an email sent by Numminen (2020), along with written permission to use this instrument. The scale is sectioned by topics. This project used the
21 contiguous questions dealing with the nurse's perception of their own moral courage as well as two separate questions on morally courageous behavior in different contexts. These are all rated on Likert scales from 1-5 (low to high) with no reverse questions, yielding possible total scores from 33-105. (Numminen et al., 2019).

A quantitative analysis of the NMCS was conducted, and the results were analyzed using the Chi-squared test to compare pre and post-test scores on the NMCS. Along with the course evaluation, the survey was given electronically, before and after the training session. As an incentive, nurses were awarded CEU contact hours for their participation in the training through the nursing education department at Kaiser Permanente.

**Aim 3: Present findings to stakeholders in the organizations with the goal of sustainability, integration, and scaling for broader initiatives, promoting an ethical culture.**

In collaboration with organizational leaders and educators, training and assessments were implemented. The leadership in the labor and delivery and radiology departments were instrumental in communicating with the frontline nurses. The nurses were trained and are the foundation and the catalyst for change within their respective departments and their organizations, as they proceed on their journeys to sustained, ethical cultures.

Continuing organizational presentations will be conducted at leadership forums with the operational and nursing leaders, including the CNE, CEO, and educators of each organization. This aim is also be accomplished by training departmental educators to teach the program throughout the organization. The discourse with each organization regarding this long-term goal has begun. Meetings have been held to determine the steps for the sustainability of each organization.
Together with the departmental leaders, we have discussed, explored and agreed on the importance and added value of coaching the trainers, as this relates to the mission of the organizations, and the results that the labor and delivery and radiology departments want to attain.

**Explore effective training strategies**

1. Inspiring educators to become trainers.
2. Building quality relationships with trainees by understanding their needs.
3. Using effective questioning and nonverbal strategies and visual aids to deliver content.
4. Testing to see whether the trainers understand their mission.
5. Leaving a memorable mark on attendees, etc.
6. Monitoring for improvement of training materials and approaches, by getting live feedback from participants.

**Protection of Human Subjects**

This Project has been deemed a QI project by the Yale University IRB and the Yale review was accepted by Stanford Children's Hospital and Kaiser Permanente. Participants all were offered the opportunity to speak with a clinically trained and/ or certified therapist made available through the organization's Employee Assistance Program (EAP) in the event any of the discussions brought difficult memories. All discussions within the training were held in strict confidence by the trainers and trainees. Any reference to the content of discussions within the course were and will be absent of all identifying information.
As a member of the administrative leadership for both organizations, the trainer did not conduct this training with nurses who are in their direct reporting structure.

**The DNP Project Leadership Immersion**

Moral courage is about authenticity, humility, and leadership. We must commit to continually learning. Embarking on a journey to build an ethical culture requires a robust plan with many projects like this moral courage training. Teaching nurses to use their communication skills, act with confidence, and uphold the values they identify with as a nurse, a team member, an employee, and as a human being.

Addressing leadership immersion occurs in several domains of the DNP education essentials. Those identified are advancing nursing practice, interprofessional collaboration, and systems leadership.

Advancing nursing practice is noted through the development of a nurse's ability to intervene when moral conflict arises, potentially avoiding harm to patients or coworkers; also, the advancement of nursing practice is supported through the collection of evidence and the publication of the results.

Inter-professional collaboration has been supported through improved communication for all trained nurses. The nurses are able to advocate with all professions within the department and the organization, through voicing their values when moral conflict presents itself.

Systems leadership is developed through working with organizational leaders and educators, with respect to the planning and implementation of the training for the labor and delivery and radiology departments.
I engaged the leaders in both organizations. Project hours were accumulated through the development, implementation, and analysis of the training. The objectives of the leadership immersion were to:

1. Collaborate with organizational and departmental leaders to plan training for the departments.
2. Engage leaders in the review and revision of the training if needed prior to implementation.
3. Implement the training by providing education as outlined.
4. Analysis of the results of the NMCS and 6-week post-survey.

(See Appendix I for the Project Timeline.)

**Recruitment of course participants**

Frontline nurses working in the labor and delivery and the radiology departments were invited to attend the course voluntarily. The department leaders shared course registration and fliers were shared on the unit and placed up on huddle board and in the break rooms. The department managers agreed to allow the nurses to use education hours to be paid for their time, and the course was offered with four CEUs that can be applied to license renewal.

An online registration process was used via the Microsoft TEAMS platform. Nurses interested in registering were able to scan a QR code to access the registration form where initial information was collected and utilized to communicate next steps and student number assignments. The student number assignments were used to facilitate anonymous matching with the pre and post course assessments. Emails were sent to confirm course registration, assign the student number and provide the pre-course assessment. The day before the course a reminder
email was sent as a prompt to complete the pre course assessment and attend the course the following day.

This course was offered on four different dates with AM and PM options and one weekend option to accommodate varying schedules.

**Data Collection**

Data was collected using Microsoft TEAMS forms for online facilitation of the assessments. The nurses completed the entire nurses moral scale at the pre-course assessment along with some demographic questions.

The post-course assessment consisted of questions 33 – 45 of the Nurses’ moral courage scale in addition to participant course satisfaction questions. The post-course assessment was limited to questions 33 – 45 of the Nurse’s moral courage scale because the previous questions in the assessment tool ask the participant to answer questions describing their moral courage behaviors “in reflection”. This survey was given to the participants at the end of the course.

**Chapter 4**

**Results**

**Participants**

A total of 13 participants completed both the pre-course and post-course assessments.

Table 3

*Participant demographic divided by department where they work*

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor and Delivery</td>
<td>8</td>
</tr>
<tr>
<td>Imaging / IR</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 4

*Participant demographics divided by organization of employment*
Demographics of participants

The demographic data was collected in the pre- and post-course assessment and matched using student numbers for completed pre and post course assessments.

The gender breakdown: Gender – 14 female and 1 male

As shown, it the graph below, the age range of the nurses who filled out the pre- and post-course assessment was well distributed with the largest number being in the 30 – 39 age grouping.

Table 5

**Participant demographics divided by age groupings**

<table>
<thead>
<tr>
<th>Age range</th>
<th>30 - 39</th>
<th>40 - 49</th>
<th>50 - 59</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of nurses who completed the pre-course assessment</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

The racial diversity of the group who completed the pre- and post-course assessment is as seen in the graph below. Nurses were allowed to self-identify their race. They were placed in one of the four categories of Asian, Black, Hispanic or White based on how they self-identified.

Table 6

**Participant demographics divided by race**

<table>
<thead>
<tr>
<th>Race</th>
<th>Number of nurses who completed the pre-course assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>5 / 13</td>
</tr>
<tr>
<td>Black</td>
<td>2 / 13</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0 / 13</td>
</tr>
</tbody>
</table>
Self-report of years working in healthcare showed a range between 4 - 29 years among the nurses completing a pre- and post-course assessment.

Table 7

*Participant demographics showing years of nursing experience*

<table>
<thead>
<tr>
<th>Years in healthcare</th>
<th>0 – 5 years</th>
<th>6 – 10 years</th>
<th>11 - 20 years</th>
<th>20 – 29 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**Procedure**

Training delivery

The training was conducted in one four-hour session each time it was delivered. The same materials were presented to each group in an interactive format. It is of note that each group was unique aside from the trainer, who was a constant as the facilitator for each group. Since each group was unique in its participant make up, the discussion in each group was also unique, resulting in variations in the participant input, questions, and discussion for each session.

The delivery format/ setting was online using zoom, delivered live to the participants by the trainer. Ground rules regarding confidentiality and respectful interactions were shared at the beginning of the training with each group before the course content was delivered.

The trainer kept the course content consistent for each group and maintained the pace of the course to complete to content in the four-hour time frame allotted.

**Analysis**

The analysis is discussed in relationship to Kirkpatrick’s levels of evaluation:

Level 1 – Reaction
Engagement, relevance, satisfaction

Level 2 – Learning

Knowledge, skills, attitude, confidence, commitment

Level 3 – Participation and transformation

Confidence, transformation of behavior

Level 4 – Results

Leading indicators, desired outcomes, analyze, Disseminate

Level 1 – Satisfaction/ reaction

The post assessment contained eight participant satisfaction questions. These questions with participant response provide the data needed to conduct Kirkpatrick’s level one of evaluation, which is to evaluate the participants level of satisfaction with the training. The participants were asked to rate their answers on a scale of 1 -5 with 5 being the highest score of “excellent”. Eight participant satisfaction questions were included in the post course assessment. The questions and participant answers will be shared and discussed in detail below.

1. This training program met my expectations and learning needs related to moral courage in nurses.

2. The information was presented at an appropriate learning level and format for this stage in my career.

3. The program format was effective to facilitate learning.

4. Was the instructor’s knowledge adequate and effective to facilitate your learning?
5. I learned skills and concepts that will help me be more effective and strategic in my work.

6. The instructor engaged the class in productive discussions and encouraged participation effectively.

7. The program provided me with new ideas and resources.

8. I would recommend this course as a valued experience to my colleagues.

In the table below the light green indicates favorable response of 4 out of 5 and the dark green represents favorable responses of 5 out of 5 with 5 being representing the highest level of favorability. The number at the top of each bar indicates the number of participants who selected each response.

---

**Figure 3 - Post-Assessment course satisfaction perceptions of participants**
As illustrated in the above Pareto chart, favorable ratings of a 4 or 5 was reported by all of the nurses with no neutral or unfavorable responses to the satisfaction assessment questions. These results correlate with Kirkpatrick’s level 1 of evaluation.

**Level 2 – Learning – change in attitude, knowledge, behavior, and skill**

The Pre and post data analysis were completed using SAS software. A limiting factor of the analysis is the small sample size, therefore some of the planned statistical analyses were not performed.

When matching and comparing the pre and post assessment from the Nurses Moral Courage Scale (NMCS), overall effectiveness of the course was assessed by participants’ perception of their willingness to be morally courageous in action. The eleven of the NMCS questions were paired for pre and post comparison and answered on a Likert scale with 1-2 being unfavorable, 3 being neutral and 4-5 being favorable. The data was grouped in this manner for analysis. The participant responses were calculated accordingly as reflected in the table below with the yellow bar indicating unfavorable responses, the light green indicating neutral responses and the dark green indicating favorable responses. The number at the top of each bar, indicates the percentage for each response. The data analysis revealed that the nurses are more willing to perform acts of moral courage after taking the course compared to pre course response.
**Figure 4** - Pre-Assessment self-reported perceptions vs. Post-Assessment self-reported perceptions

**Table 8**

*Statistical Analysis of assessment results comparing pre-course perceptions vs post-course perceptions*

<table>
<thead>
<tr>
<th>Statistic</th>
<th>DF</th>
<th>Value</th>
<th>Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>2</td>
<td>15.9639</td>
<td>0.0003</td>
</tr>
</tbody>
</table>

The eleven of the NMCS questions were paired for pre and post comparison and answered on a Likert scale with 1-2 being unfavorable, 3 being neutral and 4-5 being favorable. The data was grouped in this manner for analysis. The participant responses were calculated accordingly as reflected in the table below with the yellow bar indicating unfavorable responses, the light green indicating neutral responses and the dark green indicating favorable responses. The number at
the top of each bar, indicates the percentage for each response. The data shows a statistically significant result for perceptions of willingness to perform acts of moral courage overall post training (Chi-Square, p<.0003) and for race and willingness (Chi-square, p<.0001), with Black / African American nurses more willing to perform acts of moral courage post-training than their Asian / Pacific Islander and White / Caucasian counterparts.

In the table below the yellow bar indicates unfavorable responses, the light green indicates neutral responses and the dark green represents favorable responses.

![Table of RACE by answer](image)

**Figure 9.** Post assessment Self-reported perceptions divided by race

**Table 5**

**Statistical analysis of results divided by race – Chi-Square**

<table>
<thead>
<tr>
<th>Statistic</th>
<th>DF</th>
<th>Value</th>
<th>Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi-Square</td>
<td>6</td>
<td>30.9796</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>
There were no significant differences comparing tenure, as well as the two departments the nurses worked in.

Level 3 – Participation and transformation

During each of the course sessions, participant engagement was high from each participant. The instructor encouraged input, questions and sharing throughout the course helping assess the learning progress of the nurses as the class progressed in real time. 100% of the nurses in the course participated in writing a script they would use as a foundation to moral courage conversations and this was shared, discussed and practiced as time allowed within the course timeframe. The participants expressed the following quotes in their post course assessment when asked; “After taking the nurses moral courage course, I would act differently as follows:”

- “I now have a basis on what to say and how to say it. The class gave me confidence in myself and how I can manage conflict.”
- “I learned to really bring up concerns I have with anyone, instead of letting them fester and grow. It may not be easy at first, but in the long run, the advantage will be worth it.”
- “I will be more likely to standup for what's morally right now than what I was doing before.”
- “I would use the information obtained from the course to assistance with speaking up as needed.”
- “This course helped remind me of the skills I know from NVC and that they can be used in health care setting. Demand better communication from self and colleagues, less fear about communicating when there is conflict.”
These comments by participants indicate course satisfaction, appreciation and willingness to use the knowledge and skills taught in the course in their nursing practice.

Level 4 – Results

Level 4 of Kirkpatrick’s levels of evaluation was completed through the evaluation of the results and assessment of implications and future opportunities. Assessments were made for levels 1-3 (the reaction, learning, participation and transformation) as discussed.

Results show an overall achievement of the goal of improvement in the willingness of course participants to perform acts of moral courage. Discussion points from the data results in satisfaction of the fourth level of Kirkpatrick’s levels of evaluation.

Chapter 5

Discussion

The overall goal of improving the willingness of nurses to perform acts of moral courage from taking this course was achieved based on the self-reported answers of the participants to the pre and post assessments.

One interesting result from the data assessment is the statistically significant difference in the responses from the African American (AA) nurses compared to their Asian and Caucasian counterparts in their self-reported willingness to perform acts of moral courage. There are a few questions to consider in light of this result: 1) How might this impact the perception of AA nurses when they are in contrast with others? 2)
How might this information be used to help shift the culture in a department or organization? And 3) Can moral courage education help others better value acts of moral courage and view them in a more positive light?. These probing questions require further examination in future work.

As most organizations have adapted diversity and inclusion goals. In part, inclusion is displayed by seeking a better understanding and appreciating the strengths of others who differ in ethnic, race or religious backgrounds. The data collected from the nurses participating in this course begs for consideration of an opportunity to highlight the value and positive contributions made when acts of moral courage occur. This may open the door for enhanced understanding and appreciation in an area where AA nurses may have been previously perceived negatively for displaying acts of moral courage.

**Limitations**

This project was able to accomplish the primary goal of improving the willingness of nurses in Labor & Delivery and Radiology, to perform acts of moral courage when presented with moral challenges. There were some limitations of note to the project that should be considered.

The first limitation of note is that all course participants were volunteers and took the course for CEU credit to be used towards license renewal. This aspect of the participants needs to be considered because all of the participants represent nurses who were interested in learning about moral courage and motivated to earn the CEU credit for participating in the course. It must be acknowledged that the response from these interested and motivated nurses may be different from colleagues who were not interested enough to participate in the course.
The second limitation was the time constraints of the project. It would be optimal to allow an amount of time to lapse, then survey the nurses again for a self-report of actual improved acts of moral courage compared to prior taking this course. Due to time constraints, this was not a viable option for this project.

The third limitation was the shift made from a plan to offer an in-person format to a virtual format conducted using the Zoom platform. The use of a virtual platform was necessary due to the COVID-19 pandemic and public health safety constraints related to in-person gatherings. COVID restrictions and in interest of public health, this course could not be conducted as an in-person offering. The virtual format may have potentially impacted participants in the interaction and engagement, as well as the instructor’s ability to minimize distractions and interruptions. These elements may serve as a barrier in learning and realizing the full benefit of the course.

The final limitation was related to the race related results from the data collected in the project. The percentage of AA nurses (26%) taking the course is higher than the percentage of AA nurses in the nurse population. According to the Nursing Workforce Projections by Ethnicity and Race 2014-2030( 2017), 11% of registered nurses are African American and will remain a constant through 2030. This is a noted limitation due to the findings of an increased willingness of AA nurses to perform acts of moral courage when compared to their non-AA colleagues. It is unknown if this result is impacted by the overrepresentation of AA nurses who participated in this course.

**Recommendations for future projects**

In consideration of future recommendations, there is opportunity to further explore the limitations mentioned in this paper. The results of this project could be better considered
applicable in a broader sense with a larger participant pool and in a coordinated effort with leadership making this a mandatory course for all nurses in a particular population or department. This will also help to balance the race of the participants to better reflect the overall ratio of the nurses in the organization. In addition, there is space to learn more about the concrete and sustained changes in behavior of nurses after taking this course with the inclusion of a time lapsed survey and or interviews. Time lapsed survey and or interviews, will supply data on frequency of actual acts of moral courage compared to prior to taking the moral courage course. The consideration for a post course interview will offer an opportunity for a more granular collection of data from the participants and may possibly introduce new themes for analysis that a formatted survey will not allow enough freedom in the responses to offer. As mentioned in the previous section of this paper, the opportunity to offer this course in-person may also be a more effective format for the participants to optimize learning. The final recommendation for future consideration is to explore the concept of accountability and expectations as an individual, a team and an organization. This addition, can contribute to a uniform set of expectations for those participating in the course, assisting in the goal of shifting the culture in the organization.

Conclusion

The use of the moral courage in nurses is needed in the health care setting especially with front line nurses where acts of moral courage keep patients safe and maintain a psychological safe environment. It is critical to have nurses who have the skills, knowledge and confidence to be morally courageous when moral challenges present themselves. This moral courage training for nurses was successful in providing nurses with the skills, knowledge and confidence to feel they will be able to improve their ability to morally courageous when needed, for themselves, their colleagues and especially their patients.
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Appendix A

**Objective I** – At the completion of this curriculum, the learner will understand basic concepts related to ethics, moral action, courage, and professional responsibility.

**Objective II** - At the completion of this curriculum, learners will analyze their personal and professional values.

**Objective III** - At the completion of this curriculum the learner will recognize the opportunity to make a choice when conflict occurs.

**Objective IV** - At the completion of this curriculum the learner will apply the Nurses Code of Ethics to their own professional practice.

**Objective V** - At the completion of this curriculum the learner will develop a script expressing their values based on individual strengths.

**Objective VI** - At the completion of this curriculum the learner will evaluate the benefits of bystander support and identify two reasons that are meaningful to the participants.
Appendix B

First, action will be an introduction to the instructor and the course and sharing what is to be expected during our time together.

1. **Topic: Shared Values of the Group as it Relates to Shared Experience** – in the human experience, as a nurse, as an advocate for compassion, dignity, and safety.
   a. **Activity 1: A small group discussion** of, "A tale of two stories" – this asks students to participate in small groups to reflect on the experience with moral challenges, including a time of positive action and a time of non-action.

2. **Topic: Normalize Conflict and Moral Challenges.** Transformative communication is the ability to effectively engage in conflict, with compassion (Regier, 2017). The students will learn to view conflict and moral challenges as a shared responsibility to find common ground and communicate what they are experiencing and what they would like to see happen (Regier, 2017).
   a. **Activity 2: Facilitate through interactive discussion.** Discuss common views of conflict, then discuss how one can recognize the opportunity in conflict to improve relationships, safety, and trust.

3. **Topic: Connecting Purpose and Motivation.**
   a. **Activity 3: Discuss the Nurses Code of Ethics.** The Code sets the standard for nurses and the responsibilities they have to each other, patients, and the community, to take moral action when needed. This sets a professional standard and professional norm to their behavior and provides context for understanding the need and importance of learning to take moral action when values are being challenged.
4. **Topic: Explore Self-Knowledge, Self-Image, and Alignment.**
   
a. **Activity 4: The learners are given time to create a personal narrative**
   
   regarding their decision to act when moral challenges arise. The learners are also asked to identify the strengths and frames of reference. This exercise will assist the learner in alignment when they are ready to express themselves in moral advocacy.

5. **Topic: Developing the Voice of the Learner.**
   
a. **Activity 5: Practice voicing values.** GVV is predicated on providing a safe space within the training for the learner to continually practice, speaking up. The goal is to build the learners' confidence and comfort, at least moving them beyond feeling awkward and unsure of themselves. This concept is also a time to discuss counterarguments and morally reasoned responses that can be considered by the learner.
Appendix C

Five Essential Curricular Components

Understanding and applying these five components is necessary given the dynamic nature of classroom instruction, assessment and management (Hoover, 2010)
Appendix D

Training management procedures are as follows:

The training was held as a live online training using Zoom. The facilitator maintained the pace of the discussions and kept the timing as planned for each session offered.

Training Agenda (4 hours) (one 15 min break after activity 3) (5 min transitions).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>10 min</td>
</tr>
<tr>
<td>Activity 1</td>
<td>35 min</td>
</tr>
<tr>
<td>Activity 2</td>
<td>45 min</td>
</tr>
<tr>
<td>Activity 3</td>
<td>45 min</td>
</tr>
<tr>
<td>Break</td>
<td>15 min</td>
</tr>
<tr>
<td>Activity 4</td>
<td>45 min</td>
</tr>
<tr>
<td>Activity 5</td>
<td>1 hour</td>
</tr>
</tbody>
</table>
Appendix E

(Numminen, Katajisto, & Leino-Kilpi, 2019) Nurses Moral Courage Scale Themes
Appendix F

Nurses Voicing their values:
Moral courage in action

<table>
<thead>
<tr>
<th>Shared Values and shared experience</th>
<th>Normalize conflict and moral challenges</th>
<th>Connecting Purpose and Motivation</th>
<th>Explore self-knowledge, self-image and alignment</th>
<th>Developing the Voice of the learner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflect on experience with moral challenges</td>
<td>Transformative communication. Effectively engage in conflict</td>
<td>Nurses Code of Ethics and responsibility to each other, patients and community</td>
<td>Create a personal narrative, identify strengths</td>
<td>Practice voicing values. Build confidence and comfort</td>
</tr>
</tbody>
</table>

1  2  3  4  5

Progression of learning through the nurses voicing their values training
Appendix G

Kirkpatrick Model: Four Levels of Evaluation

Monitor & Adjust

Phase 1: Reaction
- Engagement
- Relevance
- Customer Satisfaction

Phase 2: Learning
- Knowledge
- Skills
- Attitude
- Confidence
- Commitment

Phase 3: Behavioral Change
- Ability to act when faced with moral challenges

Phase 4: Results
- Leading indicators
- Desired outcomes
- Analyze
- Disseminate

Reflect, Connect, Transform
Appendix H

Project Timeline

- **July – Aug 2020**
  - Finalization of Curriculum
    - Final Revisions
    - Live online considerations

- **Sept – Nov 2020**
  - Implementation of the program
    - Scheduling Class with org leaders
    - Establishing online platform and technology considerations
    - Teach course to L&D Nurses

- **Nov – Feb 2021**
  - Program evaluation & Write up project findings
    - Green marketing is a practice whereby companies seek to go above and beyond traditional marketing.

- **Feb – March 2021**
  - Present findings to organizations and make plans for sustainability
    - Present findings to stakeholders in the organizations with the goal of sustainability, integration and scaling for broader initiatives, promoting an ethical culture.
Appendix IJ

Timeline Gantt chart

- Finalization of Curriculum
- Implementation of the program
- Program evaluation
- Project findings write up
- Present findings to organizations and make plans for sustainability

Days of the Project