Ethics e:learning education in long-term care: A SWOT analysis

by

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ABSTRACT

Ten ethics e:learning modules were designed, after results from a pre-intervention and literature review revealed long-term care staff members lack systematic approaches to ethical decision-making. Long-term care staff members and students from a provincial healthcare program completed the modules during a three-month period. Following this, qualitative data were generated using focus groups and interviews to examine the research question, “What conclusions can be drawn from implementing an ethics e:learning education intervention in long-term care facilities using a strengths, weaknesses, opportunities, and threats analysis?” My findings indicate that the a) strengths were participants’ abilities to control the learning environment; b) weaknesses concerned technical difficulties and the participants’ concentrating on sensational ethics; c) opportunities included the need for education and ability to integrate the modules into current infrastructures; and d) threats related to the culture of care that guides practice.
DEDICATION

This thesis is dedicated to my husband, Jeffrey, for his love, encouragement, and support through the duration of my graduate studies.
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List of Abbreviations

LTCF – Long-Term Care Facilities

SWOT – Strengths, Weaknesses, Opportunities, Threats
Chapter one: Introduction

1.0 Introduction

According to the New Brunswick Association of Nursing Homes (2014), in the province of New Brunswick, shifting demographics are placing greater demands on long-term care facilities (LTCF). Pijl-Zieber et al. (2008) argue that many LTCF have limited resources to address current demands which can be a source of ethical dilemmas for staff members. Further, Bolmsjö, Edberg, and Sandman (2006) claim ethical issues arise in everyday practice in LTCF. Fleming (2007) however, reports that staff members have few concrete methods to resolve these dilemmas. Many staff members want access to ethics education (Bollig, Schmidt, Rosland & Heller, 2015). In this research, I examine one method of delivering ethics education to staff members working in LTCF. I designed ten ethics e:learning modules for use by long-term care staff members and examined this e:learning program by applying a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis (Crane, Kerin, Hartley, & Rudelius, 2014) to determine the facilitators and barriers to implementing these ethics e:learning materials into LTCF.

This research was conducted in one educational institution and six LTCF in New Brunswick, a small, mainly rural province in Atlantic Canada with a population of 751,171 (Statistics Canada, 2012). In the 2011 New Brunswick Census, citizens aged 65 years and over made-up 16.5% of the population compared to the national percentage of 14.8% (Statistics Canada, 2012). In 2014, the New Brunswick Association of Nursing Homes reported that New Brunswick had the second oldest
population in Canada with members of rural communities aging at a higher rate than the rest of the country. According to the New Brunswick Department of Social Development (2009) projections indicated that the percentage of persons aged over 65 in New Brunswick was expected to increase to 25.7% by 2026. These projected increases are placing greater demands on LTCF now and in the future.

The New Brunswick Association of Nursing Homes (2014) reported provincial challenges that involved serious issues including underfunding for supplies and wages, no funding for technological innovations, and/or limited sector support for human resources. They further explained that strategies to overcome these challenges are being developed, but facilities in New Brunswick cannot adopt modern approaches to long-term care due to serious limitations in resources. To add to this, a study conducted by Augustsson, Törnquist, and Hasson (2013) reported that long-term care residents have more complex medical and psychiatric problems than ever before.

According to the New Brunswick Department of Social Development (2009) long-term care residents require either level three or level four care; both requiring twenty-four hour supervision. Level three care involves assisting medically stable residents who may have functional limitations and need help with personal and medical care. Level four care involves assisting residents who are living with cognitive and/or behavioural problems and who require medical and personal care along with their activities of daily living (i.e., eating, bathing, dressing, using the washroom, continence, and walking). These levels of care highlight the diverse needs of long-term care residents. Yet, there is little attention being given to the aging population especially
within provincial nursing educational settings (Gould, Dupuis-Blanchard, & MacLennan, 2013).

Gould et al. (2013) reported that in 2011 only 9.6% of the Registered Nurse workforce was employed in geriatrics and long-term care in Canada. They found that ageist attitudes, negative experiences in clinical practice, and “professional socialization” (p. 798) contributed to nursing students’ minimal interest in working in long-term care. These authors further discussed their concerns that nursing students are subject to negative attitudes and beliefs about the aging population; this type of nursing is not prestigious or valued. Moreover, Gould et al. suggested many students are not interested in working in LTCF since working with older adults is perceived to be routine and boring. As a result, Gould et al. argued that students believe they will lose their technical skills due to the stereotypes that: a) long-term care staff members exclusively distribute medication and, b) long-term care settings are for nurses who cannot work in fast-paced environments or are “lazy” (p. 805).

Educational requirements vary for long-term care staff members, which include Registered Nurses, Licensed Practical Nurses, and Resident Attendants. In Canada, entry level education for Registered Nurses is a four-year Bachelor of Nursing degree while Licensed Practical Nurses obtain college certificates averaging two-years (Gould et al. (2013). To date, national education standards do not exist for health care aides in Canada (Knopp-Sihota, Niehaus, Squires, Norton, & Estabrooks, 2015). Cruttenden (2006) reports that most of the hands-on care in LTCF is provided by Licensed Practical Nurses and Resident Attendants. The New Brunswick Association of Nursing Homes (2014) reported that there are no educational standards or regulatory guidelines
for Resident Attendants. Yet, Woods (2005) claims that nurses who receive ethical training are better prepared to cope with ethics than ever before, but still feel they are unable to enact ethical practice within the constraints of healthcare organizations.

1.1 Ethics in long-term care

Several authors report that staff members have few concrete methods to approach and resolve the ethical dilemmas that arise in daily practice (Fleming, 2007; Slettebø & Haugen Bunch, 2004). In Foner’s (1995) view, bureaucracies exist in LTCF to ensure efficiency in the delivery of care; yet, they have the potential to create barriers in providing care that benefits residents. Aylward, Stolee, Keat, and Johncox (2003) believe that training initiatives ensure learners gain new knowledge and develop skills. Ethics education can increase reflective and analytical skills; however, the influence of education on ethical behaviour and the effectiveness of current ethics training initiatives are still unknown (Cannaerts, Gastmans, & Dierckx de Casterlé, 2014; Cline, Heesters, Secker, & Frolic, 2012). Aylward et al. (2003) observe that educational initiatives in LTCF may not have evaluative components.

Ethical issues arise in everyday care in LTCF due to the conflicting values and interests of those involved in making care decisions (Bolmsjö et al., 2006; Dierckx de Casterlé, Izumi, Godfrey, & Denhaerynck, 2008). Healthcare organizations spend considerable time and effort creating policies and procedures that guide patient care, yet little time is spent examining ethical challenges and designing guidelines, interventions, and reviews. Nurses are key caregivers in these organizations along with other professionals who are also guided by personal and professional values, but who may be
positioned differently within the hierarchy of the organization (i.e., a Licensed Practical Nurse and a Resident Attendant) (Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Further, nurses care for residents and their families who have differing religious, cultural, and moral values, while nurses themselves hold personal and professional values that inform their care decisions. Ethical tensions can arise between two or more people who are involved in ethical decision-making. Professionals are expected to rely on ethical frameworks when making decisions, though they have little, if any, education on such frameworks and their applications in clinical situations.

The dominant ethical decision-making framework in healthcare is Principlism, originally formulated by Beauchamp and Childress (2012), which is based on four principles: autonomy (self-rule), justice (equal distribution of resources), beneficence (doing good), and non-maleficence (doing no harm). Principlism is further discussed in chapter two. According to Solum, Slettebø, and Hauge (2008) Registered Nurses are required to use their professional code of ethics as established by the Canadian Nurses’ Association (2008) to guide health care decisions; however, many nurses may defer to intuitional knowledge (Bolmsjö et al., 2006; Solum et al., 2008) or experience (Thompson, McCaughan, Cullum, Sheldon, & Raynor, 2005) to make such decisions, which can generate inconsistencies in delivering care as they are dependent on the values involved.

To illustrate, if one staff member believes that residents need to finish their meals or risk “wasting away,” another staff member may feel that with regular meals and snacks residents may feel full. The first staff member, then, may dedicate time to ensuring residents finish their meals (even if they express resistance); while, the second
removes their plates after an allotted amount of time (whether they have finished eating or not). In either case the resident’s autonomy may be infringed on which is not doing good (beneficent) and could be harmful (non-maleficence). Such routine decisions may not be considered ethical ones.

While routine decisions can be ethical in nature, caregivers may not reflect critically on them to inform and improve care (Komesaroff, 1995; Truog et al., 2015). For example, an ethical issue could involve whether a staff member makes eye contact with a resident when she passes him in the hall. Using a principle-based approach, the principles that apply are beneficence (doing-good) and non-maleficence (doing no harm). For Komesaroff (1995), ethical issues arise in every interaction including conversations between people, considering what intervention to implement, the goals of an intervention, and the context of the interaction. The degree of ethical sensitivity on the part of the caregivers can enhance or reduce residents’ quality of life and shape the quality of relationships. Gjerberg, Førde, Pedersen, and Bollig (2010) claim that providing care is dependent on staff members’ knowledge, skills, and attitudes. Bolmsjö et al. (2006) assert that although individual characteristics can influence whether ethical behaviour is realized they do not account for how context can shape decision-making.

Foner (1995) explains that although necessary to ensure efficient delivery of care bureaucracies can create challenges for staff members who provide care. She reminds us that the bureaucracy is in place to protect residents by ensuring that care is coordinated, uniformly delivered, and consistently completed. To illustrate, every resident will invariably receive meals and medication. Foner (1995) claims that the
uniform delivery of tasks can reduce elder neglect and abuse. While the bureaucracy is intended to protect residents, at times it can also create barriers in the delivery of care.

Long-term care staff members’ roles and responsibilities can be understood as task-oriented. Staff members are responsible for completing the routines defined for client care to meet the organizational requirements. Gould et al. (2013) write that education tends to be directed towards the tasks that learners will be assigned to perform in clinical settings. Task-oriented goals are objective, easily measured, and quantifiable (Foner, 1995). For instance, if the task is to help a resident get dressed the task is complete when that person is dressed. Providing care; however, is not limited to completing tasks and the emotional work of caregivers which is not easily measured may be neglected (Butcher & MacKinnon, 2015; Foner, 1995). For example, a staff member notices that a resident seems sad and she talks with him for twenty minutes. He appears happier afterward. While other staff members have finished their measurable tasks, such as making beds and putting laundry away, the interactive staff member does not have tangible evidence demonstrating that she has promoted the resident’s well-being by increasing his happiness.

Butcher and MacKinnon (2015) remind us that healthcare organizations overlook ethics in practice since technical ability generally supersedes emotional work in institutional care. Focusing primarily on the technical aspects of nursing can minimize concerns relating to ethical practice (Dierckx de Casterlé et al., 2008; Solum et al., 2008). Oermann and Gaberson (2014) claim that problems can arise since technical skills are only a portion of professional practice. Dierckx de Casterlé et al.
(2008) challenge the norm in LTCF arguing that conformist reasoning can be a barrier to meeting residents’ individual needs.

Organizational characteristics that can lead to job dissatisfaction for long-term care staff members related to inadequate training and orientation, no input regarding the provision of care, chronic understaffing, and minimal or no recognition for doing a good job (Bowers, Esmond, & Jacobson, 2003). Bowers et al. (2003) report that in the United States staff turnover more commonly occurs in for-profit LTCF than not-for-profit due to the low-pay and lack of benefits. Many of these problems are echoed in a Canadian study that reports the priorities of the LTCF result in understaffing; severe time constraints, demands that result in nurses being unable to fulfil what they perceive as their primary roles (i.e., caring for residents) leading to being unable to practice ethically (Beagan & Ells, 2007). For Cruttenden (2006), caring for residents in long-term care settings requires both relational and specialized skill-sets. E:learning education is one method of helping staff develop these skill-sets by focusing on the qualitative aspects of care.

LTCF education, delivered using a variety of formats, can prepare staff members by orienting them to and engaging them with the ethical dilemmas they could encounter in practice. Pijl-Zieber et al. (2008) support the idea that education can help caregivers identify and address ethical issues in practice. Messikomer and Cirka (2008) explain that the expectations of staff members to engage in ethical decision-making without any formal training or expert consultation is unreasonable as they are burdened with a duty that they are unprepared to fulfill. Education can assist staff members in
coping with the complex ethical challenges they encounter in daily practice (Lillemoen & Pedersen, 2012). For Dierckx de Casterlé et al. (2008), high priority needs to be given to the development of nurses’ ethical reasoning so that they reflect critically on their practice.

In practice, ambiguous ethical situations that fail to meet text-book definitions can occur. Oermann and Gaberson (2014) suggest that higher order critical thought might be necessary when information is limited, missing, and/or does not rest on theoretical principles. They explain that critical thought is a reflective and reasoned process of determining what to do in ambiguous situations. In practice, decisions that do not have clear solutions or challenge the decision-makers’ personal values can arise. For Oermann and Gaberson (2014), it is essential for long-term care staff members to be trained using content that tests both the theoretical and practical applications of the material.

Education can help staff members learn technical skills, but it can also focus on promoting values of person-centered care (Oermann & Gaberson, 2014). Yet, Bollig et al. (2015) argue that LTCF may not have systematic approaches to resolving ethical issues, while Bolmsjö et al. (2006) believe in the need for a structured approach in decision-making to avoid basing decisions on intuition. Systematic approaches can, in Lillemoen and Pederson's (2012) terms, increase staff members’ ethical competence. In current educational initiatives in LTCF examples of ethical conflicts provided to staff focus on the ethical issue itself rather than the resolution, causing frustration for staff members who are seeking better solutions (Gjerberg et al., 2010). Indeed, Bollig et al.
found that 86% of long-term care staff members expressed a need for ethics education.

Using ethics training to prepare staff members to resolve ethical dilemmas could reduce feelings of moral distress, which occurs when nurses know the correct action to take, but feel powerless to take it due to real or perceived constraints (Pijl-Zieber et al., 2008; Redman & Fry, 2000). Varcoe et al. (2012) reports that moral distress can cause care givers to distance themselves, avoid, or withdraw from residents that they care for. Moreover, Gjerberg et al. (2010) found that unresolved moral distress may decrease job satisfaction and motivate staff members to leave their positions and/or their profession. Varcoe et al. (2012) advise when staff members’ moral distress is alleviated through the provision of practical solutions opportunities for growth and ethical reflection can arise. Staff members’ abilities to appropriately respond to ethical issues can promote increased quality of life and quality of care for residents. From an institutional perspective, reducing moral distress can result in decreased staff-shortages and staff turnover thereby increasing efficiency and morale (Pijl-Zieber et al., 2008).

For Oermann and Gaberson (2014), education provides learners with the opportunity to experience decision-making under different circumstances and to reflect on possible outcomes, which can strengthen critical thinking and decision-making skills. Thus, they suggest that students can establish and refine specific competencies and retain these over time.
1.2 Purpose of the research

The purpose of this research is to apply SWOT to analyse the implementation of an ethics e:learning program designed for long-term care staff in New Brunswick. This study was conducted in two stages. The pre-intervention, was completed in 2015, and with Dr. Clive Baldwin’s permission, forms the background for the intervention, this research study on ethics e:learning in LTCF.

In response to the challenge of long-term care staff members not having systematic methods to consistently address ethical issues I implemented an intervention consisting of ten ethics e:learning modules for use by long-term care staff members. Participants worked through the modules over a three-month period. Following their engagement with the modules, I completed a SWOT analysis (Crane et al., 2014) based on their perceptions of the ethics e:learning program.

Ethical conflicts can arise in everyday day practice in LTCF (Dierckx de Casterlé et al. 2008), yet few methods that can quickly resolve ethical dilemmas are available to staff members. Addressing ethical dilemmas within a reasonable time frame is critical to ensuring the safety and well-being of long-term care residents; however, few usable tools for assisting staff members in ethical decision-making exist (Fleming, 2007). Messikomer and Cirka (2008) emphasize that LTCF have few, if any, policies and procedures to help staff members navigate ethical situations in practice. Moreover, Redman and Fry (2000) note that nurses do not feel that they have access to these materials. Fleming (2007) asserts there are no universal standards to guide ethical decision-making. In this study, I used an interdisciplinary approach by drawing on nursing, philosophy, and education to form the background and analysis of this...
research. The ethics e:learning modules are intended to address the gap in the research by providing concrete methods to assist staff members in making ethical decisions.

In 2015, I participated in a research study entitled, “Making difficult decision in long-term care” (Baldwin, 2015) where thirty long-term care staff members working in five LTCF were interviewed. This study was partially reported in “Ethical decision-making in long-term care: A thematic analysis,” (Estey, 2015) which formed the pre-intervention of this research. Qualitative data were generated by conducting six interviews with long-term care staff members working in varying roles in a single LTCF. Using thematic analysis ethical issues encountered by long-term care staff were identified. The themes were discussed within a sociological context. These data, in combination with a comprehensive literature review, revealed staff members do not have access to a systematic approach to address the ethical dilemmas they encounter in everyday practice. Data from the pre-intervention were used to inform the intervention. The pre-intervention research is discussed in detail in chapter three.

The pre-intervention findings indicated staff members encountered ethical decisions daily, but had few, if any, resources to effectively and consistently address them, a situation borne out in an extensive literature review. Consequently, I developed ten e:learning modules on the topic of ethics. Long-term care staff members, as well as students and teachers from a provincial healthcare program engaged with the modules over a three-month period. Following this, I applied a SWOT analysis to explore the participants’ perceptions of the e:learning modules. The SWOT analysis identifies factors that can influence the implementation of the ethics e:learning program into long-term care. The ethics training was intended to provide concrete decision-making
strategies to staff members to better equip them to address the ethical issues they encounter in practice.

Berge and Giles (2008) describe a SWOT analysis as a tool that can be used to objectively analyse the internal and external factors that can influence an e:learning program. They explain that a SWOT analysis can be used to translate results into effective strategies in order to optimize the positive, and mitigate the negative, elements of introducing a program into an organization. Crane et al. (2014) note that conducting such as analysis involves an exhaustive appraisal of the internal strengths and weakness as well as the external opportunities and threats. In this study, each of these were identified in relation to implementing the ethics e:learning program into LTCF in New Brunswick. The goal is to utilize strengths, attend to weaknesses, capitalize on opportunities, and reduce threats (Crane et al., 2014; Montalban, Ogbuneke, & Hilderman, 2014).

While Fleming (2007) claims that LTCF have few useable resources for staff members to make ethical decisions, Berge and Giles (2008) offer a solution. They suggest applying a SWOT framework which can close the gap from an organizations’ current approach to a planned future position. To be effective, Berge and Giles (2008) advise that the educational endeavor needs to align with the organization’s goals and values to ensure movement of both occurs in the same direction.

I applied a SWOT analysis in order to identify: What conclusions can be drawn from implementing an ethics e:learning education intervention in New Brunswick LTCF.
1.3 Significance of the study

The SWOT analysis was useful for identifying the facilitators and barriers to implementing the ethics training in LTCF. Although ethics in long-term care may seem trivial, it is crucial due to the intricacies and risks inherent in caring for residents. Thus, this research is relevant to staff members, long-term care residents, and their family members since it was designed to enhance staff members’ ethical reasoning and in turn enhance the quality of care being delivered to residents in LTCF.

There are several benefits to engaging with ethics education for staff members. Hsu (2011) and Pijl-Zieber et al. (2008) believe that ethics education can assist staff members in recognizing ethical dilemmas and better prepare them to respond to those problems. Ethics education may encourage: moral accountability (Hsu, 2011), participation in ethical reflection, and engagement in ethically sound practice (Monteverde, 2014; Park, 2013). Staff members’ ethical competencies, well-being, and job satisfaction can be improved through education (Kontio et al. 2011).

Further, Pijl-Zieber et al. (2008) emphasize that staff members work in an environment with competing organizational values between cost, efficiency, and delivery of care. Ethics education can help foster the use of collaborative approaches within the interdisciplinary teams (i.e., dietary, rehabilitation, and nursing staff) and mitigate some of the hierarchical imbalances amongst staff members (i.e., Registered Nurses and Licensed Practical Nurses) by empowering all staff members. As more staff members complete the ethics modules, collaboration may increase as a shared understanding of what constitutes an ethical issue and how better to reason toward resolution may develop.
Residents’ family members might also benefit from the ethics training since the design of the modules promotes collaboration amongst family members, staff members, and residents. The e:learning can foster an interdisciplinary approach by highlighting ways in which family members add value and link staff more meaningfully to the residents’ life history. Family involvement, according to Rowles and High (2003), can provide continuity of the resident's life and its meaning while endorsing a sense of humanity with respect to the resident. The ten ethics modules were designed to challenge stereotypes such as family members’ concerns are as a result of feeling guilty for moving their relative into long-term care. In many instances, long-term care may be the best arrangement for the residents; therefore, it is important, regardless of the family members’ reasoning, to take their concerns seriously and view them as partners in the residents’ care.

Residents can benefit when staff members are better prepared to recognize and cope with ethical dilemmas. If staff members’ behaviours are guided by ethical insights, they might be less likely to engage in unhelpful or dehumanizing behaviours. Staff members might not have malicious intent, but they may still disempower or infantilize residents; in other words, treat residents as if they are children (Cheston & Bender, 1999). Additionally, they may engage in diagnostic overshadowing, which involves a staff member attributing a person’s behaviour to the disease with which s/he is living (i.e., dementia) (Hassiotis, Strydom, Allen, & Walker, 2003). This is another depersonalizing form of communication that can be used in LTCF (Hassiotis et al., 2003). To illustrate, when a staff member interprets a resident’s walking around the unit as meaningless “wandering,” relating this to dementia, rather than recognizing he may
simply feel restless, enjoys exercising, or is looking for someone. The ethics e:learning training was designed to shift attention from task-oriented care to person-centred care and provide concrete strategies for staff to draw on in practice contexts. Person-centred care does not always take a lot of time, but can increase residents’ well-being and quality of life.

1.4 Outline

This thesis is composed of five sections. In chapter one, I discussed ethics in long-term care and the purpose and significance of this research study. Chapter two examines relevant literature on ethical decision-making in long-term care, common approaches to ethical decision-making, education in long-term care, and the benefits and limitations of e:learning. Following this, in chapter three, I outline the methodology beginning with the pre-intervention which forms the background of this research study, the intervention. Next, I describe the use of focus groups and interviews for data generation which are then examined in detail by applying a SWOT analysis framework. In chapter four, the research findings are discussed relative to the SWOT analysis: the strengths, weaknesses, opportunities, and threats to ethics e:learning. Chapter five discusses the implications of these results. Finally, in chapter six the research and results are summarized and suggestions for future research are made.
Chapter two: Literature review

2.0 Introduction

Bolmsjö et al. (2006) remind us that ethical issues arise in every day practice in LTCF. Yet, Dierckx de Casterlé et al. (2008) warn that staff members may not reflect critically on these issues due to a lack of clarity regarding their scope and pervasiveness. Since most front-line caregivers in long-term care are nurses from different levels of practice - Licensed Practical Nurses or Resident Attendants - their levels of preparation for ethical reflection on daily activities may be limited in terms of knowledge and experience. Moreover, Varcoe et al. (2004), adds that as a sub-category of medical ethics the dominant framework used for ethical decision-making in clinical settings is Beauchamp and Childress’ (2012) Principlism. Although principle-based strategies are primarily used for ethical decision-making in LTCF (Paier & Miller, 1991; Slettebø & Haugen Bunch, 2004) some researchers assert that these are inadequate in resolving ethical issues in practice (see, Gallagher, Alcock, Diem, Angus, & Medves, 2002; Gervais, 1998; Slettebø & Haugen Bunch, 2004); therefore, alternative approaches may need to be used. Fleming (2007) adds that no standardized processes for ethics training exist for new or current long-term care staff members. As Rees, King, and Schmitz (2009) argue there is a gap in education on ethics in long-term care that requires timely attention.

2.1 Literature search

In response to the educational and practice-based need in LTCF, I conducted a literature search on availability and ways of accessing ethics materials in LTCF, ethics
education, e:learning, and the evaluation of e:learning. These searches were limited to English and to peer-reviewed articles published between 2000 and 2016. An extensive search of electronic databases using the search terms staff or nurs* and "ethic*" and "decision-making" and "long-term care" was conducted. The Web of Science produced 24 results, CINAHL, 27, PsychInfo, 13, and Health Source – Nursing/Academic Edition, 28. For the purpose of this study I reviewed articles focusing on ethical decision-making in long-term care environments.

A second review was conducted using the search terms ethics education and “elearning or e:learning or e learning” and “long-term care or nursing homes” and evaluation or evaluating. CINAHL produced 19 results, ABI/Inform, 12, Project Muse, 6, and EBSCO, 139. Further to these two searches, I reviewed the selected articles’ references for additional sources. This yielded 80 articles and book chapters relevant to the question, “What conclusions can be drawn from implementing an ethics e:learning education intervention in long-term care facilities using a strengths, weaknesses, opportunities, and threats analysis?”

2.2 Ethical decisions

Long-term care staff members are confronted with ethical situations daily (Fleming, 2007). Varcoe et al. (2004) assert that ethical dilemmas can be dramatic life or death ethical issues such as euthanasia; while Hasselkus (1997) describes everyday ethical issues such as, providing choice. Truog et al. (2015) suggest that while it is imperative to reflect critically on highly-charged ethical dilemmas the ordinary day-to-
day problems can often be overlooked. Bolmsjö et al. (2006) warn that commonplace ethical concerns can negatively affect both staff members and residents.

In long-term care life-lengthening measures are readily available and advancements in technology can create circumstances where choices between one or more courses of action exist that did not exist before (Edwards, 1996; Paier & Miller, 1991). Paier and Miller (1991) describe how decisions relating to withholding or initiating medical treatments create situations of ambiguity and confusion in the pursuit of the best course of action. Subjectivity can add complexity to a situation. For instance, one nurse believed that a course of action, such as delivering nutrients through a tube, reflected ethical behaviour; whereas, another nurse believed the same action prolonged a life with no quality (Edwards, 1996; Rees et al., 2009). While tube-feeding is an issue that requires critical reflection, it is not the only ethical dilemma encountered in LTCF. Solum et al. (2008) claim that the daily challenges in long-term care settings may not be recognized as ethical.

Ethical dilemmas, for Powers (2001), may present themselves as being mundane and therefore, not recognized as ethical. They are embedded in subtle interactions and are integrated in an ongoing process of negotiation and compromise (Dauwerse, van der Dam, & Abma, 2012; Komesaroff, 1995) between residents and staff members. To illustrate, a resident is watching the news and a staff member moves her by wheeling her to the dining area without informing her. In this situation, the staff member objectified the resident by moving her without her consent or assent or without explaining where she is being moved to, interfering with her current activity, and perhaps startling her. Issues of autonomy, objectification, and avoiding harm can thus
be seen to be involved. Komesaroff (1995) asserts that crucial ethical dilemmas can be embedded in simple interactions and can have a long-term influence on future interactions.

For Dauwerse et al. (2012), daily issues need to be understood as moral problems so they are not discounted. Komesaroff (1995) adds to this by explaining how microethics, or daily ethical concerns, can arise in simple situations such as, the amount of time spent with residents, the degree of concern shown for residents, and articulating concerns to residents. Moreover, he suggests that other key components that may be ethically problematic involve staff members’ facial expressions, amount of eye contact, tone of voice, and sensitivity of touch when interacting with residents. Also, Komesaroff (1995) describes how the residents’ input in decision-making is received by staff members can positively or negatively shape interactions. Dauwerse et al. (2012) add to the discussion that such ethical dynamics are continuously negotiated and if carefully reflected on can create a space where positive ethical interactions can occur. Apparently minor interactions may have lasting repercussions on the relationships between staff members and residents.

When minor ethical concerns are ignored by staff members the consequences can affect the resident’s future interactions with the same or other staff members. Reflecting upon and addressing ethical concerns can contribute to everyone’s well-being (Bolmsjö et al., 2006). In contrast, Komesaroff (1995), states that the failure to think critically about microethics (minor issues) can cause residents to withdraw, refuse to share information, provide details about their experiences, and/or be receptive of staff members’ advances in providing care. When residents demonstrate resistance to
having care provided, Powers (2001) believes they may be stereotyped and labelled as exhibiting “problem behaviours” or “behavioural issues” (p. 339) rather than being recognized as having been dealt with possibly unethically. Ethical decision-making can be further complicated when residents have dementia.

Rowles and High (2003) report that over 50% of people in LTCF have some form of dementia. Dementia is an umbrella term used to describe diseases found in the brain that affect higher order thoughts and functioning including: “memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgment” (Cheston & Bender, 1999, p. 52). As a result, those living with dementia may have difficulty processing, retaining, communicating, and understanding information that can complicate decision-making; therefore, substitute decision-makers can be assigned (Gordon, 2002; VonDras, Flittner, Malcore, & Pouliot, 2009). Decision-making can be complicated when several people are involved since conflicts can arise between decision-makers (Gjerberg et al., 2010; VonDras et al., 2009).

Conflicts can occur between staff members and family or substitute decision-makers. Rees et al. (2009) identified that conflicts can arise when staff members perceive family members as lacking knowledge to make decisions that benefit the resident or that they disagree with the nursing care being provided. To illustrate, a resident has a daughter who insists he participates in physical therapy to regain mobility despite assessments having determined that he will not regain the ability to walk. Staff members may not want to dedicate scarce resources (distributive justice) such as time and equipment to an unachievable outcome.
In decision-making, according to Rees et al. (2009), a gap can also exist between the substitute decision-maker and the resident. For example, a resident may feel that her hip protectors are uncomfortable and restrictive; however, her decision-maker is concerned about minimizing her risk of falls and insists that she wears them. Using a principle-based approach (Beauchamp & Childress, 2012), a decision between the resident’s choice (autonomy) or her decision-maker’s desire to prevent harm (non-maleficence) and keep her safe (beneficence) needs to be made.

Finally, Gjerberg et al. (2010) found disagreements regarding how care is delivered between residents and staff can also arise. When routine-centred care is performed against the residents’ wishes (autonomy) the resident may feel coerced into involvement in activities such as bathing or eating (non-maleficence, beneficence). Thus, at times, the organizations’ culture of care - routine or resident-centred - can influence the delivery and quality of the care provided.

As Siegel et al. (2012) claim, sociocultural, political, professional, and policies interact in LTCF to shape how staff members deliver person-centred care. Koren (2010) explains that culture-change practices arose over the past decade due to shared concerns among stakeholders regarding traditional care practices in LTCF. She identifies that the goal of the culture-change movement was to improve the quality of care and quality of life for long-term care residents. Koren (2010) found that while culture-change initiatives have been recognized, these practices have not been adopted in many facilities due to the required investments of time, money, and leadership.

Koren (2010) warns that the complete adoption of person-centred care practices in LTCF is rare. The culture change movement in long-term care encouraged the
application of principles of care involving providing: “homelike atmospheres, close relationships, staff empowerment, collaborative decision-making, and quality improvement practices” (p. 313). She provides statistical data focusing on a National Survey of Nursing Homes indicating that 5% of LTCF met the requirements of delivering person-centred care, 10% met seven practices, 33% adopted some practices, 33% planned on incorporating changes and 19% were not practicing or planning to practice person-centred care. The culture-change movement reorients the facility’s culture to promote quality of care and quality of life for residents (Koren, 2010). Siegel et al. (2012) suggest that resistance to adopting these changes present challenges to staff members who provide care in these environments. Staff members encounter ethical decision-making daily and need strategies to assist them in making these decisions.

2.3 Approaches to ethical decision-making

The complexity of bioethics in the nineteen sixties and seventies created a need for specialized professionals to explore medical advances (Gervais, 1998). At this time, Beauchamp and Childress (2012) developed their ethical framework, Principlism. Principlism is based on the four principles of autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2012). Although Principlism is the dominant framework used in LTCF, critics assert that it fails to address ethical dilemmas that arise in everyday practice. Thus, alternative strategies in decision-making need to be used such as, ethics committees, case studies, ethics consultants, pastoral care, collaboration among staff members, and/or organizational policies (Dauwerse et al., 2012).
Much of the ethics in long-term care literature appeals to, cites from, or argues for or against the four principles of ethical decision-making developed by Beauchamp and Childress (see, Gallagher et al., 2002; Gordon, 2002; Redman & Fry, 2000; Slettebø & Haugen Bunch, 2004). Beauchamp and Childress (2012) argue that ethical decision-making needs to be based on four a priori principles: 1) autonomy, defined as self-rule, 2) beneficence, defined as contributing to the welfare of others, 3) non-maleficence, defined as doing no harm to others, and 4) justice, defined as fairly and equally distributing goods and services. These principles are equally weighed against each other in decision-making. Some ethics in long-term care literature supports the use of these principles in ethical decision-making. For example, Gordon (2002) believes that Principlism provides a universal framework and a reference list for ethical decision-making, while Gillon (1994) concurs that Principlism offers a universal moral framework and a culturally-neutral approach.

Other literature, however, suggests Principlism does not sufficiently address ethical dilemmas in practice (see Gallagher et al., 2002; Gervais, 1998; Pijl-Zieber et al., 2008; Slettebø & Haugen Bunch, 2004; Truog et al., 2015). For some authors, the principles are too abstract to resolve problems in every day practice in long-term care (Bolmsjö et al., 2006; Slettebø & Haugen Bunch, 2004; Varcoe et al., 2004). Edwards (1996) and Truog et al. (2015) agree that the principles are too simplistic to account for the complex layers involved in ethical decision-making. Park (2013) notes that the application of principles fails to integrate the affective understanding of the interpersonal relationships involved in decision-making. Chambliss (1996) supports Park in saying that reasoning through a hypothetical scenario is not equal to reasoning
through a situation embedded in an organizational context. Finally, Principlism fails to reconcile equal, but opposing, values (Gallagher et al., 2002; Pijl-Zieber et al., 2008). When applying Principlism, problems can arise when the principles themselves conflict. As a result, staff members may rely on alternative approaches when making decisions.

Some of the approaches staff draw on when facing ethical decisions, so Varcoe et al. (2004) tell us, include: collaborating with other staff members or residents’ family members, reporting to management, and/or ignoring or dismissing the issue (at times, out of necessity to avoid repercussions for themselves and/or residents). These authors inform us that staff members regularly negotiate their roles within the facility to meet their own personal values, organizational constraints, and professional codes of practice. MacNaughton (2005) elaborates on how the culture of power relations embedded in the institution represent how institutionally sanctioned knowledge influences the delivery of care. For instance, if care providers use paternalistic decision-making they limit resident participation in care decisions; whereas, person-centred care decision-making encourages a collaborative approach. Each approach produces different outcomes for residents.

The code of ethics for Registered Nurses serves as a foundation for nurses’ ethical practice by outlining the specific values and responsibilities expected of Registered Nurses in Canada (Canadian Nurses Association, 2008). Solum et al. (2008) cautioned that the code of ethics was typically not used for ethical decision-making in nursing practice since nurses generally had minimal knowledge and understanding of the content of professional codes of practice. Multiple methods of decision-making can
be applied in LTCF, yet, few concrete strategies to resolve ethical decisions in practice exist. Residents live longer and present with more comorbidities and chronic illnesses that may result in more challenging ethical issues in daily practice (Fleming, 2007).

Ethical dilemmas arise when residents decline to participate in activities that are deemed by caregivers as beneficial (Gallagher et al., 2002). Consider a resident who may choose to stay in bed day after day even though he risks losing his mobility. While getting up and being active may benefit his health and well-being by preventing bed sores and maintaining his mobility (beneficence and non-maleficence), he still chooses to remain in bed (autonomy). Further, residents may engage in behaviours that are not beneficial to their health conditions (Slettebø & Haugen Bunch, 2004). If a resident who has diabetes chooses (autonomy) to eat two desserts after meals, her insulin levels will likely increase and be harmful (non-maleficence); however, she may feel that this improves her quality of life (beneficence). Ethical issues regarding choice can be unclear when they involve competing values and call for decisions to be made. These findings imply that Principlism is insufficient in addressing ethical dilemmas arising in the context of long-term care. Consequently, staff members need access to methods of recognizing, approaching, and resolving the ethical dilemmas encountered in practice.

In the Netherlands, Dauwerse et al. (2012) investigated how ethics support can be delivered in LTCF. These researchers used an integrated mixed-methods study that revealed that in LTCF: 44% have ethics committees, 36% engage in moral case deliberation, 8% refer to ethics consultants, 78% rely on pastoral care, 65% attend multi-disciplinary meetings, and 54% rely on policies/guidelines. What was revealed in
their investigation was that ethics are inconsistently addressed and not prioritized in LTCF.

Ethical decision-making requires both clinical and ethical competence (Cannaerts et al., 2014). Yet staff, as several authors agree, may not: recognize the ethical nature of their decisions (Dauwerse et al., 2012; Fleming, 2007; Varcoe et al., 2004), share a common understanding around what constitutes an ethical issue (Dauwerse et al., 2012), understand the scope involved in ethical practice, (Dauwerse et al., 2012; Rees et al., 2009), or recognize ethics as an integral part of their role (Dauwerse et al., 2012; Lillemoen & Pedersen, 2013). As such, Handelsman (1986) posed that ethical thinking is a skill that requires development. VonDras et al. (2009) observe that the failure to engage in ethical reflection in LTCF may be due to limited educational opportunities to study ethics.

2.4 Education

Edwards (1996) informs us that nursing is an occupation involving direct care that requires extensive ethical thought. Other authors add to the discussion saying that in long-term care ethical concerns arise in routine work resulting in staff members making intuitive decisions (Bolmsjö et al., 2006; Solum et al., 2008). Varcoe et al. (2004) claim staff members rely on experience and intuition since nurses are unsure of how to draw on ethical theory to guide practice. Nursing ethics developed as a sub-category of medical ethics and historically, nurses were not recognized as decision-makers (Varcoe et al., 2004). This emphasizes the need for on-going in-service ethics
training in LTCF to develop skilled staff members in identifying, approaching, and resolving the ethical issues they encounter daily.

Intuitive decision-making can be problematic since, as Edwards (1996) and VonDras et al. (2009) agree, the foundation of nurses’ ethical thought is based on the context of everyday life rather than that of a medical setting. In other words, the ethical issues nurses encounter at work vary in scope, nature, and prevalence to those outside of healthcare settings. Edwards (1996) adds that nurses need ethical training due to the healthcare context which inherently consists of ethical situations that nurses would not have encountered in non-medical settings. These issues include, but are not limited to, high mortality rates of residents, cognition, dependency, and medical needs (VonDras et al., 2009). This, paired with the diversity and number of people with whom nurses interact (such as, other staff members, residents, and/or friends and family members of residents), endorses the importance of educating nurses in ethical matters.

The moral intuition developed by nurses under normal circumstances is inadequate to address the complex ethical dilemmas they experience daily at work (Edwards, 1996). To illustrate, if a staff member is asked to bathe a resident there are ethical issues involving preserving the resident’s dignity, sensitivity of touch, and making the resident comfortable. A staff member may approach “a bath” as a task to be completed; yet, this is an intimate interaction that needs to be handled in an ethically sensitive manner. Ethical issues arise daily, yet the existing ethical theories that guide nursing practice do not adequately address them (Varcoe et al., 2004).

Biomedical ethics has informed the development of healthcare ethics; accordingly, the focus is on highly-charged ethical issues (Varcoe et al., 2004) while
sidelining everyday ethics (Hasselkus, 1997). Chambliss (1996) reports the discipline of nursing was bypassed in the development of bioethics. Nursing ethics has been dismissed as “a legitimate, if very limited, term referring to a field that is a sub-category of medical ethics” (Woods, 2005, p. 6). During the 1980’s and 1990’s, the nursing profession sought recognition of nursing as its own discipline (Woods, 2005). In addition to being recognized as its own discipline, the need for training was also identified in the 1980’s.

In the 1980s, the need for training long-term care staff members was realized due to shifting social attitudes that supported a therapeutic model of care, more people being admitted into care who had complex care needs (Aylward et al., 2003), and nurses feeling powerless to act in accordance with their own ethical values (Woods, 2005). According to Woods (2005) and Varcoe (2004), a systematic approach has not yet been implemented to provide consistent strategies to identify and resolve ethical issues in practice.

Authoritative credentialing processes that set minimum standards relating to ethics training do not exist for individuals working in positions requiring ethical practice (Cline et al., 2012; Fleming, 2007). Budgetary constraints may result in LTCF having few usable tools to resolve ethical dilemmas on site (Fleming, 2007) and ethics support is absent in most LTCF (Gjerberg et al., 2010). Some facilities have ethics committees that meet three or four times per year, but they tend to focus on dramatic ethical dilemmas such as, euthanasia (Fleming, 2007). While some training programs do exist, Cline et al. (2012) identified that there is no evidence to support whether these initiatives meet their pedagogical goals. These authors add that many Canadian
healthcare organizations and universities are seeking methods of integrating training programs on ethics. Cruttenden (2006) focuses on education in LTCF to promote the development of specialized knowledge and skills so that staff member can address the individualized needs of residents.

Almost thirty years ago, Paier and Miller (1991) charged that staff members, family members, and residents felt ill-equipped to deal with issues arising in long-term care, demonstrating the need for education related to treatment decisions. Yet, today in 2017, these concerns still trouble the health care system. Though much of the literature over the last three decades has supported the need for ethics education in long-term care (McAlpine, Lockerbie, Ramsay, Beaman, 2002; Paier & Miller, 1991; Rees et al., 2009) few concrete strategies exist.

Rees et al. (2009) clarify that nursing education needs to focus on the development of conflict management and assertiveness skills to assist nurses in managing ethical dilemmas and more importantly, to advocate on their own behalf so they can then effectively advocate on behalf of residents. Rees et al. (2009) argue that education is essential in preparing staff members to resolve difficult ethical situations. Park (2013) suggests case-studies are an appropriate method to educate staff members. Case studies provide learners with the opportunity to experience ethical conflicts in a meaningful way, since learners are required to engage in the process of decision-making that encourages them to practice critical analysis and self-reflection. Staff members’ abilities to identify and address ethical dilemmas, as Fleming (2007) notes, enhances residents’ overall well-being. There is a critical need for flexible education
opportunities for staff members to develop ethical practice in healthcare (MacDonald, Stodel, & Chambers, 2008).

Education for long-term care staff members can be developed to model ethical behaviour so that they can develop best practices relating to the situations they experience (VonDras et al., 2009). For Knowles (1970), education is a life-long process of seeking out information and enhancing skills relating to self-directed inquiry. VonDras et al. (2009) identify benefits that allow staff members to provide better quality of care, reduce stress, and increase their job satisfaction. Learners have: the opportunity to develop new skills, current information on best practices, and the coping mechanisms they need to recognize and address ethical dilemmas. Thus, it is essential to provide continuing education so that staff members can have the skills to approach ethical situations they encounter to improve patient health (Pullen, 2006) and patient safety (Fleming, 2007).

Ethical training needs to be an ongoing career activity covering topics relating to ethics, the potential impact of dementia on residents’ personalities and behaviours, processes related to death and dying and the effects of medications (VonDras et al., 2009). Ethical decision-making is complex; it does not simply involve making a choice of one alternative over another. Instead, as Meisel and Fearon (2006) state, critical thought and reflection are necessary to resolve situations ethically. Education is not designed to present every situation the learner may encounter, but instead is meant to give the learners problem solving skills to resolve the ones they do (Bloom, 1956). Pairing ethical training and critical thinking is essential to ensure ethical practice
Additionally, using the principles of andragogy can ensure training materials are suited to adult learners.

Knowles (1970) developed the theory of andragogy, the practice of teaching adults based on four key assumptions. The first is fostering independence by encouraging learners to be self-directed (Knowles, 1970). To illustrate, staff members learn how to properly administer medication. Using an andragogy approach the learner is encouraged to become independent in completing learned tasks; therefore, staff members learn to administer medication unassisted. Knowles’ (1970) second assumption involves encouraging learners to draw on a reservoir of experiences. Therefore, staff members would be asked to draw on experiential insights to resolve issues rather than relying solely on the educational materials. The third is ensuring educational material is designed to fulfil the learners’ desire to know and emphasizes the necessity of education in real-world situations (Knowles, 1970). For instance, staff members may not value ethics training; therefore, the educator needs to ensure that learners identify the practical use and application of it (Knowles, 1970). Knowles’ fourth and final assumption focuses on the learners’ abilities to apply new skills. For example, staff members learn to offer residents face cloths so that they can contribute to their own care. Staff members however, cannot use learned skills when there are shortages of laundered items. The ability to apply learned skills promotes the training by supporting its usefulness.

Ethics training is meant to prepare staff members to: a) be skilled in detecting and effectively navigating ethical dilemmas (Hsu, 2011; Monteverde, 2014), b) accept moral accountability for their actions (Hsu, 2011), and c) provide adequate
justifications for their decisions (Park, 2013). LTCF often respond to the multi-faceted challenges associated with delivering care to an aging population living with complex biomedical and psychosocial needs by providing education that promotes staff members’ professional development (Stolee et al., 2005). Rapidly changing long-term care environments call for relevant education programs for staff members (Ross, Carswell, Dalziel, & Aminzadeh, 2001). Stolee et al. (2005) assert that education encourages competence and confidence in approaching care, and according to Park (2013) instructional approaches can influence the shaping of ethical competence. For Ross et al. (2001) continuing education needs to be viewed as an integral component of the personal and professional development of long-term care staff members. In Monteverde’s (2014) view ethics education facilitates a positive influence on the ethical behaviours of future healthcare workers.

Ethics training, Edwards (1996) informs us, provides nurses with the ability to recognize moral dilemmas, apply frameworks to resolve the issues (principles, ethical theory, and distinctions between issues), learn vocabulary for discussing and describing ethical dilemmas in a meaningful and effective way, and develop confidence in their decision-making skills. Although there are numerous methods of delivering educational materials such as, lectures, group discussions, role-playing, and presentations, e:learning is efficient and personalized, and therefore an appropriate method for long-term care settings.
2.5 E:learning

E:learning is a practical method of training long-term care staff members since it is flexible, cost-effective and, therefore, easy to implement in LTCF (MacDonald et al., 2008). Additionally, e:learning is centered around the learners’ needs (Keengwe, Onchwari, & Agamba, 2014) and can be designed using real-life scenarios for learners to process and apply to practical experiences. Finally, evaluation methods to measure the e:learnings’ effectiveness can be incorporated in the design.

Technology can be used to enhance knowledge, skills, and behaviours through the delivery of information via the Internet (Berge & Giles, 2008; MacDonald et al., 2008). E:learning has the benefit of minimizing barriers to attaining education (Santally & Alain, 2006) by providing accessibility to people who live in different geographical locations. New Brunswick is a small rural province with LTCF spread over a large geographical distance. E:learning reduces travel and scheduling challenges (Harrington & Walker, 2002) since modules can be uploaded to a learning management system and accessed by learners twenty-four hours a day, seven days a week from any computer with an Internet connection or even be provided as stand-alone modules. Kontio et al. (2011) add that e:learning is a flexible method of delivering education and it can be designed to suit the learners’ needs.

Staff members can access the e:learning when it is convenient for them (Halawi, McCarthy, & Pires, 2009; Kontio et al., 2011). Learners can also access the material in brief time intervals since they have the ability to exit the material and return to where they left without losing their progress (Halawi et al., 2009; Kontio et al., 2011). Santally and Alain (2006) believe mature learners may be motivated to participate in e:learning
since they can maintain full-time employment while continuing their education. MacDonald et al. (2008) conclude that this affords staff members the ability to earn educational credentials without negatively impacting their daily responsibilities.

Web designed e:learning modules are self-directed so that learners have control over their learning environments (Keengwe et al., 2014; Santally & Alain, 2006). Harrington and Walker (2002) explain that learners can repeat modules as needed and control the speed of the training, while Kontio et al. (2011) add that learners can also control the time and place of learning and satisfy personal objectives. Standalone modules provide staff members with the means to practice self-guided education allowing them to encounter and develop the skills to work through difficult situations (Higgs, 2012).

Long-term care staff members, in Hsu’s (2011) view, can work through ethical situations they may encounter in practice using e:learning training. The modules can facilitate and enhance knowledge (Keengwe et al., 2014). Well-designed scenarios can guide learners through problem solving processes and assist them in applying concepts, methods, and procedures effectively resolving the dilemmas (Hsu, 2011). Scenarios are meaningful and engaging in fostering understanding and resolving ethical issues (Cannaerts et al., 2014). Hsu (2011) notes that the active process of solving practice-based problems can encourage learning by constructing meaning and confirming understandings. While applying concepts to practical scenarios is useful, e:learning also has other benefits.

E:learning allows staff members to: 1) practice and learn about ethics in an environment where they can explore their personal views without having to publicly
broach controversial topics (Higgs, 2012); 2) have a safe place to fail by guiding them to the information and giving them the privacy and space for self-reflection without criticism (Dirksen, 2012); 3) engage in ethical reasoning by applying concepts and theories that they may or may not agree with (Higgs, 2012); 4) avoid intuitive decision-making by promoting the use of alternative approaches (Higgs, 2012).

By applying and practicing learned skills e:learning facilitates knowledge transfer into every day practice (Halabisky et al., 2010). E:learning encourages students to think critically and independently about the material (Higgs, 2012) and can be designed to leverage what learners already know (Dirksen, 2012). Dirksen (2012) outlines two reasons why this is beneficial. The first, in her view, creates early success for learners which increases their confidence and can be motivating. The second, she believes, involves retention where memory can be understood as a collection of isolated pieces of information. She explains that as people learn, one isolated piece of information connects to other isolated pieces of information creating a network, and when learners recall the original piece of information, the connections serve as markers to retrieve the desired information. Dirksen (2012) explains that information is easier to recall when more connections are established. She concludes that as learners process material they can recall it using these associations. Roy (2006) outlines when learners use their working memory relevant information is reinforced and transfers into long-term memory.

Information can be presented using interactive features to enhance the learning experience (Halabisky et al., 2010; Harrington & Walker, 2002). Enriched learning environments that include video and audio options increase motivation by stimulating
and engaging the learner (Harrington & Walker, 2002; Lam & McNaught, 2006). Dirksen (2012) claims interactivity can engage the learners; provide greater opportunities for success in absorbing the material, and according to Harrington and Walker (2002) can increase retention by 90% over reading the information. Roy (2006) asserts that e:learning allows for an open systems interaction since answers can be subjective; therefore, the course material can be manipulated based on the learners’ responses to measure their outcomes. Interactive course features can provide question specific feedback to build on the learners’ foundational knowledge and guide learners toward meeting course objectives (Dirksen, 2012; Roy, 2006). Interactivity is one method of promoting different learning styles.

Although there is no single agreed upon definition of “learning style” one that is widely accepted is Claxton and Murrell's (1987) which is the: "characteristic cognitive, affective, and physiological behaviors that serve as relatively, stable indicators of how learners perceive, interact with, and respond to the learning environment (p. 84). In other words, the learning style involves how people think, solve problems, and retain information (Harris, Dwyer, & Leeming, 2003). There are several methods used to identify learning styles.

The dominant learning styles are Gardner’s Multiple Intelligences, VAK or VARK, and Kolb’s learning styles (Dirksen, 2012). Dirksen (2012) explains that people learn in different ways, have different strengths and weaknesses, and everyone can learn using visual, auditory, and kinesthetic methods (unless they have some form of impairment). Studies conducted by Harris et al. (2003) and Roy (2006) found that individual learning styles did not impact performance in web-based environments.
Dirksen (2012) concurs by explaining, “the scientific evidence of effective use of learning styles is pretty weak” (p. 52). Dirksen (2012) maintains that the key assumptions of learning styles are that they can be measured and there are practical methods of adapting learning to those styles. According to Dirksen (2012), neither assumption has been proven.

Park (2013) claims that traditional methods of teaching ethics such as classroom-based lectures do not account for the context-based situations where the knowledge may be applied; therefore, learners may be unable to effectively implement this knowledge in practice. Park (2013) found that computer-based training on ethics can replicate practical decision-making by mirroring its complexities through provoking emotions associated with the process and outcome of the decision. As a result, learners think more critically about their decisions. Interactive case studies encourage learners to work through and carefully analyze situations (Hsu, 2011). Halabisky et al. (2010) suggest that e-learning is an effective method of educating long-term care staff members.

Halawi et al. (2009) found that a number of statistical studies have been conducted to evaluate the outcome of e-learning against traditional classroom-based lectures. Vidakovic, Bevis, and Alexander (2003) concluded mathematical e-learning was ineffective for students who lacked motivation and math skills. Kartha (2006); however, found no significant difference in learners’ abilities to relate information and number of facts learned. This supports Skylar, Higgins, Boone, and Jones’ (2005) findings that no significant differences between traditional learning and e-learning in performance or evaluations exist. Piccoli, Ahmad, and Ives’ (2001) work revealed no
significant differences in performance between traditional and e:learning courses; however, e:learners established higher self-efficacy, but lower satisfaction with the learning process.

Traditional classroom-based models, Berge and Giles (2008) claim, can be outdated before being implemented into the curriculum. These methods, they stress, are expensive to develop and facilitate since both instructors and learners have travel expenses, and require workplace operations to stop to enable everyone to participate simultaneously in a single location. MacDonald et al. (2008) found e:learning to be an effective medium for LTCF. Although e:learning can be effective in LTCF it is not without its limitations.

2.6 Limitations of e:learning

E:learning is limited in several ways. E:learning environments are asynchronous resulting in learners having to access the content in isolation (Pullen, 2006). As a result, instructors have fewer opportunities to evaluate the learner as the course progresses. E:learning primarily relies on written and visual communication; this can be problematic for some learners. The basic limitations of e:learning involve the nature of this method in terms of its design, though other issues arise due to the organization in which the material is being used.

When e:learning is delivered as a standalone program the learning environment is asynchronous since learners use the training in a time and at a location that is convenient for them (Kontio et al., 2011; Pullen, 2006). Donnelly and O’Rourke (2007) argue that asynchronous learning environments present challenges since learners lack
interaction and active participation with teachers and other students. Also, Harrington and Walker (2002) note that learners are unable to ask immediate questions. Davis and Wong (2007) believe barriers are created when teachers and learners do not meet face-to-face. For Donnelly and O’Rourke (2007), it is essential that discussions of meaningful content extend beyond the standalone environment for learning to occur.

Online environments, by their nature, eliminate spontaneous generation of ideas fostered by teacher-learner, question-response discussions (Donnelly & O’Rourke, 2007; McAlpine et al., 2002). Problematic, as well, are the limitations instructors face when unable to measure the learners’ comprehension of the material throughout the course (Dirksen, 2012). If used effectively, the frequent administration of tests can help instructors gauge the learners’ progress through the course material and provide opportunities for the instructor to follow-up with learners who appear to be struggling with some of the course material.

E-learning relies heavily on written and visual communication and students’ success can depend on the ownership they take over the training material (Davis & Wong, 2007). It is important for the material to accommodate different learning needs by considering the educational levels of the learners (Aylward et al., 2003). Ross et al. (2001) claim education levels can influence both the learners’ confidence and desire to participate in training. Various alternative options of conveying information such as the provision of audio features and the use of images and/or video clips exist and can be used to address some of these issues. Meeting learning needs is a key element in the design of the training, but so too is the content itself.
Another challenge associated with developing e:learning involves choosing appropriate and relevant content (Pullen, 2006). Bowen and Graham (2013) remind us that it is essential to consider the relevance of the information being produced from the perspective of the end-user. They suggest consulting participants in the research design to capture appropriate content. In effect, this can bridge the gap between knowledge and practice (Alde, Cheek, & Ballantyne, 2009). Bowen and Graham (2013) caution that if problems experienced by end-users are not identified and addressed by researchers then it is unlikely the material will be relevant or useful in practice. Bowen and Graham (2013) also warn that if participants are passive recipients of information rather than actively engaged in the development process the content may be unsuitable.

Several negative outcomes can occur when end-users are not involved in the development of training materials. For instance, in health research, problems may be treated as simple and linear, thus failing to recognize the complexities in practice and provide adequate solutions (Alde et al., 2009; Bowen & Graham, 2013). If research is not designed as a response to an expressed need it likely will not be valued within the organization (Bowen & Graham, 2013) and will be considered a superficial intervention that does not have practical applications (Van de Velde et al., 2016). The training needs to align with the organization’s values to mitigate the limitations of e:learning.

Aylward et al. (2003) warn that many research studies fail to consider the organizational barriers of implementing a training program. They charge that LTCF rarely encourage training initiatives, offer fewer incentives, and place little value on training. The success of training interventions relies on the facility’s support of the training through their internal policies and practices (Aylward et al., 2003; Schnelle,
Cruise, Rahman, & Ouslander, 1998). When training follow-ups occurred, Aylward et al. (2003) argue staff members demonstrated increased knowledge, but at the same time did not modify their behaviours due to limited organizational support. Schnelle et al. (1998) recommended that it is important to identify whether the organization can support the intervention. Understaffing, limited financial resources, space, and equipment shortages all create barriers in implementing training programs (Harrington & Walker, 2002; Ross et al., 2001).

To minimize the limitations of e:learning, Dirksen (2012) suggests designers need to consider who the learners are and how they will use the training. Content needs to be appropriate and relevant to suit the learners (Pullen, 2006). Further, research should involve identifying whether the organization will support the training internally. In chapter three, I describe how these limitations of e:learning were addressed in the ethics modules designed for long-term care staff members.

2.7 Summary

Long-term care staff members encounter ethical decisions daily (Fleming, 2007). Although ethical issues are common few concrete strategies exist to help staff members identify, approach, and resolve these issues. E:learning training can provide a flexible, accessible, and cost-effective (MacDonald et al., 2008) method of providing concrete strategies for ethical decision-making for long-term care staff members. For this research, I developed ten e:learning modules on ethics in order to help staff members navigate the daily ethical issues they encounter. In the following chapter, I
describe the methods and methodology used to design, implement, and evaluate the ethics training for use in long-term care environments in New Brunswick.
Chapter three: Methods

3.0 Introduction

The aim of this study, “Ethics e:learning education in long-term care: A SWOT Analysis” was two-fold: 1) to develop and implement ethics education for use by long-term care staff members and 2) to evaluate, using a SWOT analysis, the participants’ perspectives of the e:learning program. In this chapter, I outline the methodology used to conduct this research. This chapter is divided into the following two sections. The pre-intervention which reached completion in 2015 explored the processes of ethical decision-making used by long-term care staff members. The pre-intervention informs this research study. The intervention, involves the design and implementation of ten ethics e:learning modules for use in New Brunswick LTCF and the qualitative methods used to generate data.

3.1 The pre-intervention

The pre-intervention, completed in 2015, captured data relating to the ethical issues experienced by New Brunswick long-term care staff members. The findings from the pre-intervention, in combination with a comprehensive literature review, were used to generate data for the intervention. The pre-intervention received ethics approval from the Research Ethics Board of St Thomas University; ethics approval for the intervention, “Ethics e:learning education in long-term care: A SWOT Analysis” is discussed later in this chapter.

In the pre-intervention; thirty staff members, working in varying roles, from five LTCF in New Brunswick were interviewed. The qualitative data were recorded and
transcribed verbatim. Analysis involved identifying themes in the data. The findings indicated that participants recognized that the ethical issues encountered in practice arose from several sources. The first source described here involves concerns relating to residents’ families.

Some participants described that the residents’ family members had limited knowledge relating to resident care, which caused ethical concerns. At times, family members advocated for inappropriate or ineffective treatments which generated ethical decisions relating to the allocation of resources. Staff members cited family members’ expectations as another source of ethical dilemmas they encountered. For instance, family members might expect that the resident receive several back rubs every day, but staff members could not accommodate this due to time constraints. Lastly, staff members recalled family members who created ethical tensions through inappropriate or aggressive behaviours such as, yelling at or threatening staff members.

Limitations in material and human resources were also sources of ethical conflicts, at times; shortages of available or functional equipment required for care such as, lifts were reported. Additionally, shortages in laundered items such as, towels and wash cloths raised frustrations for staff members. Staff shortages heightened tensions between staff members when trying to balance their individual roles against the needs of other staff members. Lastly, two participants discussed residents’ violent behaviours towards staff members as high risk situations creating ethical conflicts.

The final ethical dilemmas that emerged in the pre-intervention involved the residents’ finances. As a rule, residents’ money is a finite resource. Yet, participants expressed frustration when this money was spent on over-the-counter medications,
promoted by the medical team, when the medication’s effectiveness was questionable. In addition, concerns were raised regarding the disappearance of residents’ belongings from theft, misplacement, or from having been discarded. Lastly, limited financial resources led to problems when purchasing personal care items and necessary clothing for residents.

Whereas, staff members could identify ethical issues they showed limitations in having the resources and skills to address them, a factor supported by the literature (Dierckx de Casterlé et al., 2008; Varcoe et al., 2004). Beauchamp and Childress’ (2012), Principlism, was explored, but criticisms about this model, as discussed in chapter two, emphasized the problems with applying this framework in practice.

The pre-intervention was completed in 2015. The research reported in this thesis, involved staging an intervention to address the gaps identified in the literature review and in the pre-intervention findings.

### 3.2 The intervention

The intervention used data from the pre-intervention with the permission of Dr. Clive Baldwin the principal investigator, and involved the development and implementation of ethics education for use by long-term care staff members, teachers, and students of a provincial educational facility. In this section, I discuss the university ethics approval for the study, the study sample, and research questions. Subsequently, I outline the design of the training materials and detail how Bloom’s taxonomy informed the design. I then discuss the evaluation component and detail methods used for data generation and analysis. I end by describing the limitations of the study.
3.2.A Research ethics

I received ethics approval for the intervention, the study reported here, from the Research Ethics Board at the University of New Brunswick. I recruited staff members from LTCF, students enrolled in a provincial healthcare program, and teachers from the same educational institution. I presented the information to LTCF and the educational institution to recruit participants. The names of the facilities where the interviews and focus groups were conducted were not disclosed. Participation was voluntary and participants could opt out of the research at any time without penalty.

In this study, the participants were recruited from local LTCF and one provincial healthcare program; therefore, participants were assigned pseudonyms to provide anonymity. Measures were taken to mitigate risks associated with the research by storing the participants’ personal information and research data separately in locked filing cabinets to prevent the linking of personal and research data by anyone, except for the researchers. Using focus groups for data collection prevented total anonymity of participants; however, participants were asked not to disclose information discussed during the focus group and signed consent forms agreeing to this.

3.2.B Participants

The thirty participants from the pre-intervention were invited to test the training material developed during the intervention. Many participants did not partake in the intervention due to discontinuing employment, changing their roles, or opting out of the study. Consequently, information packages were distributed by the LTCF administration inviting staff members to volunteer for the research. Further, participants
from a provincial healthcare program were invited to participate in the research. Consequently, two different information packages were distributed.

The information package distributed in the LTCF included a cover letter (see Appendix A) and two envelopes, one labelled “New participants” and one labelled “Returning participants.” Each envelope contained a form requesting the participants’ contact information (see Appendix B for new participants and Appendix C for returning participants), a focus group consent form (see Appendix D), a return envelope, and an information sheet outlining the purpose of the research and what would be involved if they chose to participate (see Appendix E). The “Returning participant” envelope also included an interview consent form (see Appendix F).

The information packages that were distributed at the educational institution included a cover letter (see Appendix G), an information sheet (see Appendix H), a focus group consent form (see Appendix I), and a return envelope. Participants from the educational institution were offered a fifty-dollar gift card to participate in the research and long-term care staff members were given a fifty-dollar gift card for their participation in the research.

Every participant was given seven days to read the information, ask questions, and think about their decision prior to being asked to consent to participate. Participants were informed that they could access information about this study through the Narrative Studies (2013) website. Participants signed consent forms prior to participating in the individual interviews (see Appendix F and Appendix J) and focus groups (see Appendix D and Appendix I).
Of the thirty participants from the pre-intervention three people returned to the second stage of the study. In total, nine new participants joined the research study. Two participants dropped out of the study (one was a staff member and one was a student). The participants who dropped out of the study are discussed in further detail in chapter five. Every participant was female. Of the ten participants, there were six staff members (from two different facilities), two teachers, and two students.

3.2.C Research question

A SWOT analysis was used to examine the question, “What conclusions can be drawn from implementing an ethics e:learning education intervention in long-term care facilities using a strengths, weaknesses, opportunities, and threats analysis?” After participants tested the training materials I evaluated what the potential barriers and facilitators to implementing an ethics e:learning program were.

3.2.D Designing the modules

In this section, I provide details relating to the distribution of the training using a free, easy to manage, learning management system which is an application that distributes, tracks, and reports data on the ethics e:learning modules. Next, I describe the process involved in choosing content and designing the modules and review relevant demographics in New Brunswick. Following this, I detail the content of the ten modules.

The modules were designed using Articulate Storyline, an interactive e:learning course development software. The packages were uploaded to a free learning management system that was used to manage and track the participants’ results and
progress. Once the modules were uploaded to the learning management system minimal maintenance was required to manage the course. The training was economical and easy to implement and it did not impact the daily operations of the facility. Participants accessed the training at their convenience from any computer with Internet access.

The training consisted of ten modules, each focuses on a specific theme and could take up to one hour to complete. Additionally, the content was drawn from interview data collected during the pre-intervention and was negotiated with two long-term care Chief Executive Officers.

To encourage participant engagement, the modules used scenarios based on interview data. Participants were asked to identify, think about, and provide possible solutions relating to these scenarios. In some instances, participants were asked to apply a specific framework such as Principlism to a scenario and in other instances participants were asked how they made decisions. The modules were designed to accommodate long-term care staff members in New Brunswick.

According to the New Brunswick literacy rates (2017) one in five people score below average on their literacy levels. Considering the average reported New Brunswick adult reading level scores and provincial literacy rates, the modules were written at an eighth-grade reading level. Proficiency is determined by different levels (OECD, 2016). Level two reading skill indicates that a person can integrate two or more pieces of information based on criteria, make comparisons, reason about information requested in the question, and/or identify information from various parts of a document by navigating within a piece of text (OECD, 2016.). Due to the reported
low literacy levels in New Brunswick audio features and images were included in each of the ten modules. Additionally, each module was based on a specific theme.

3.2.D.a Module one – What are ethics? And, four ethical theories

The first module captured how participants made ethical decisions and explained four ethical theories, Principlism (the dominant framework based on four principles), Deontology (duty-based ethics), Consequentialism (outcome ethics), and Utilitarianism (serving the greatest good for the highest number of people). It also outlined alternative ethical theories (Casuistry, Ethic of Care, and Virtue Ethics), identified what constituted an ethical issue, and provided general information relating to ethics. This module was designed to establish a baseline by asking a series of questions to identify the participants’ initial ethical awareness.

3.2.D.b Module two – Who may be involved in ethical decision-making?

The concept of ethics and who might be involved in ethical decision-making such as, family members, residents, and staff members was explored in module two. This module introduced capacity, the ability to understand and retain information long enough to weigh the information, to make the decision, and communicate the outcome of the decision (which was further discussed in module five), by asking participants two questions to identify how, if at all, the issue of capacity changed the decision.

Moreover, it presented concepts such as, consent, assent, capacity, direct disclosure, and indirect disclosure. Some terms were revisited in later modules to provide concrete examples, reinforce their importance, and emphasize their relevance to ethical decision-making.
3.2.D.c Module three - Principlism

Beauchamp and Childress’ (2012) framework of Principlism was examined in module three. Using relatable scenarios, each of the four principles were discussed in detail. The limitations of Principlism were also described and concrete examples of when the principles conflict in decision-making were provided. Module three offered several examples where the participant needed to identify applicable principles, apply relevant principles, and determine when they conflicted.

3.2.D.d Module four – Person-centred care

The fourth module introduced Brooker’s (2007) VIPS model of person-centred care, an approach that is commonly cited as being used in long-term care. The VIPS model promotes: a) the absolute Value of all human life, b) an Individualized approach, c) understanding the resident’s Perspective, and d) providing a Social environment that supports psychological needs. Numerous concrete examples on the provision of choice in practice were established in module four. Concepts that were raised were risk, acceptable risk, and self-reflection. Module four considered how capacity, language, and microethics influenced care and how challenges that arise in practice can be addressed. Capacity was further explored in module five, language in module seven, and microethics in module eight.

3.2.D.e Module five – Capacity

Module five focused on the influence of capacity in decision-making by emphasizing the importance of ensuring that resident choice is not denied on the basis of capacity. Module five offered methods of accommodating people with dementia and
highlighted choices such as, what to wear or with whom to spend time, which might not necessarily be influenced by residents’ capacity. This challenged current discourses (MacNaughton, 2007) around capacity. Concepts such as, infantilization (treating an adult like a child), hyper-cognition (measuring quality of life against cognitive abilities), therapeutic nihilism (the expectation of inevitable decline for people with dementia), and diagnostic overshadowing (attributing a person’s behaviour to the disease with which s/he is living) were examined in module five.

3.2.D.f Module six - Family

Module six addressed the positive and negative influences that family can have on a relative’s transition into care. This module explored two types of transitions: positive and negative, and the outcome that the transition could have on the family’s relationship with staff members in the facility. Module six focused on the value family members can add to residents’ transitions. Additionally, it introduced difficulties residents may have with the transition to care and emphasized the importance of recognizing the changes people encounter when moving into care. Residents’ rights and the maintenance of these rights after moving into care were also discussed.

3.2.D.g Module seven – Language

Module seven, using guidelines developed by Alzheimer’s Australia (2015), explored the importance of using respectful, accurate, inclusive, and non-stigmatising language when describing residents and the negative consequences of failing to do so. Direct quotes were taken from interview data from the pre-intervention to demonstrate words and phrases that are common place, but that need to be avoided and why. For
example, the phrase, “he is a lift.” Task-directed language turns the person receiving care into a passive object. An alternative phrase might be, “he needs help getting up.” Based on Alzheimer’s Australia (2015) guidelines, alternative words and phrases that were respectful, accurate, inclusive, and non-stigmatising were supplied. Stereotypes and stigma were also reviewed to raise awareness and confront common beliefs that can diminish residents’ well-being.

3.2.D.h Module eight - Microethics

Microethics or ethical issues that are mundane or minor in nature are described in module eight. In this module, the notion that ethics always involves dramatic life or death events such as euthanasia was challenged and instead the focal point was on the daily issues that pervade practice. Module eight also considered the importance of daily interactions that occur between people. For instance, when a resident asks a staff member a question does the staff member face the resident? Make eye contact? Respond to the resident? Ethics permeates every interaction, inevitably influencing the quality of the caregiving relationships.

3.2.D.i Module nine – Guided case-study

Module nine did not introduce any new content. Instead it presented a guided case study for participants to read through and then respond to multiple choice questions. Questions were based on content from previous modules. Excerpts from the case study were used and participants were asked to identify ethical theories and concepts, and to justify why these responses were applicable. The case study was a composite case that was designed from the pre-intervention data.
Module ten was an independent case study where participants read through a composite case and then responded to the questions with short-answer written responses. Participants had the opportunity to use their words to answer the questions and were allotted the time and space to explore the questions in depth. After submitting each response, immediate feedback was provided.

Small markers existed in multiple points in the modules and could be clicked should the participant require more information. See Figure 1. The markers provided definitions, examples, or facts relating to the course content. For example, in module seven a marker opposed, “flight risk”, a common phrase used to describe people who have a desire to leave the facility, when clicked displayed: “The phrase, “flight risk,” implies a person is attempting to escape and suggests criminality.” The markers were intended to reinforce content, provide examples, or clarity to content. Markers were also used during tests to provide feedback.

Figure 1: Marker
At the end of modules one through eight there was a test containing twenty multiple choice questions. Generally, five of the questions were on course content. For instance, one of the module three questions was: what are the four principles of Principlism? These questions evaluated general course knowledge.

The remaining questions required participants to apply content. To illustrate, a question in module three was, “What principles are in conflict if Fileno is lonely and he would like you to spend time with him; however, you have not finished providing care to other residents?” In this instance, participants were required to identify the conflicting principles in the scenario.

If a participant selected an incorrect response she received a message as to why her chosen response was incorrect. See Figure 2. For example, if a participant selected an incorrect response to the question about Fileno, she received feedback, which read: “Every principle conflicts in this scenario.” Following this, she could click the marker for additional information that revealed: “Fileno’s choice (autonomy) is to have company, which conflicts with your time (distributive justice). Failing to spend time with him is not doing good for him (beneficence), and could cause harm (non-maleficence) to him if he is left alone.” Feedback on every incorrect response elaborated on why the option the participant selected was incorrect, what the correct answer was, and why it was incorrect.
Figure 2: Example of feedback from an incorrect response

If the participant chose the correct response she received a message that read:

“That’s right! You selected the correct response.” See Figure 3. Every correct answer had a marker, when clicked, the participant received feedback as to why the answer was correct and an additional example to reinforce learning. Many of the learning strategies used to develop the training material were based on Bloom’s taxonomy.

Figure 3: Example of feedback from a correct response
3.2.D.a Bloom’s taxonomy

Bloom’s (1956) taxonomy, a classification system for evaluating learning objectives, was used to develop a concrete method to evaluate the ethics e:learning training. Bloom’s system is divided into six categories: knowledge, comprehension, application, analysis, evaluation, and synthesis. Lam and McNaught (2006) assert interactive technologies that use audio features can meet all of the objectives in Bloom’s taxonomy.

The first category of Bloom’s (1956) taxonomy is knowledge that is demonstrated by the learners’ abilities to recall information such as, facts, terminology, categories, principles, and/or theories. Participants were required to recall information and apply it within modules. To illustrate, every module tests general course content that demonstrated whether or not participants remembered the material. Additionally, participants had to recall content between modules. For instance, consent was first introduced in module two and was revisited in later modules, the participants’ recall of the concept and ability to apply it correctly was assessed.

The second category, comprehension, was evidenced through the learners’ abilities to paraphrase and interpret the material and extrapolate information without referencing outside sources (Bloom, 1956). Participants’ comprehension was tested when they were required to apply specific theories or terms. For example, consent requires verbal agreement while assent is an expression of approval. These concepts are closely related, but participants needed to understand the differences in order to apply the terms correctly.
Application, the third category of Bloom’s taxonomy, was performed through the learners’ abilities to apply abstract theories, processes, or procedures to concrete situations. Participants were asked to apply specific theories or identify what applies in the given scenarios. In module five, for example, a scenario was: “Milla, a staff member, is waking Mr. John Jones up. She enters his room, without knocking, and in a slow, sing-song voice, says, “Wakey, wakey sleepy head, it’s time to get up Johnny,” as she pulls open the blinds. Can you identify how Milla infantilizes Mr. Jones?” Following the participant’s response, she received feedback that Milla’s approach infantilizes Mr. Jones by: 1) speaking in a sing-song voice, 2) using child-like words such as, “wakey, wakey,” and “sleepy head,” 3) speaking needlessly slowly, and 4) calling Mr. Jones by his first name in a diminutive form.

Bloom’s (1956) taxonomy’s fourth category, analysis, was conveyed through the learners’ abilities to break the material into its constituent parts and observe how it was relatively organized through implicit and explicit information. The scenarios were designed to encourage participants to identify relevant information and assess whether or not the details were applicable. Some scenarios included superfluous information to ensure participants could properly assess the situation. For instance, in the above scenario when Milla infantilized Mr. Jones she entered his room without knocking. Here, participants were expected to recognize that this information did not pertain to infantilization and rather was a failure to respect the resident’s right to privacy. This strategy was used throughout the modules and participants needed to identify and apply relevant details.
Category five, synthesis, was demonstrated through the learners’ abilities to draw on multiple sources to combine them as a unified whole (Bloom, 1956). Participants practiced synthesizing content from modules one through eight in modules nine and ten. Modules nine and ten each had one case-study that required participants to apply concepts they learned from the previous modules. The first case study was guided and the second case study was independent which ensured learners could apply concepts, theories, and terms that they learned previously.

The sixth and final category, evaluation, was evidenced by the learners’ abilities to judge the quality of the modules based on accuracy and consistency and make comparisons using external criteria against theories and facts (Bloom, 1956). Each participant evaluated each module upon completion prior to receiving her test results. At the end of each module each participant was asked five questions relating to the clarity of the module, the relevance of the content, how the module could be improved, and how the training as a whole could be improved.

Bloom’s (1956) taxonomy was used to create concrete objectives. Clear objectives were defined at the beginning of each module. For example, by the end of module three on Principlism, participants could: 1) name and describe the four principles, 2) apply the principles to ethical scenarios, and 3) identify when the principles conflict. Each outcome was measurable and whether the participant achieved the goals was clearly indicated. Dirksen (2012) emphasized the importance of avoiding unclear objectives such as: “staff will understand Principlism.” Dirksen (2012) reminds us that “understanding” is an abstract term and not easily measured; therefore, evaluation is difficult as there are no clear expectations of what the learner needs to
accomplish. Although Bloom’s (1956) taxonomy is commonly used for classifying educational objectives it does have limitations.

Case (2013) believed that the misapplication of Bloom’s taxonomy was destroying the education system since Bloom’s taxonomy was intended to be an evaluation method rather than a teaching method. For Hirst (1974), the objectives were often viewed in isolation which failed to appreciate their interrelatedness. In Hirst’s (1974) view, it is impossible to learn facts in isolation without attaching other concepts and meanings to them.

As Case (2013) noted instructors used the taxonomy to justify not introducing students to higher level thought processes due to their inability to master lower level thought processes. Instructors, Case (2013) claimed, would not ask students to synthesize if they have not comprehended. This arises from the taxonomy having been organized as a one-way hierarchy (Paul, 1985; 1995). Case (2013) suggested that this resulted from the false assumption that higher order tasks are more difficult to master than lower order ones. Additionally, Furst (1981) found disagreement in the literature regarding the order of evaluation and synthesis in the hierarchy since evaluation is inherent in synthesis; therefore, should not be positioned higher on the scale. Furst (1981) argued that evaluation and synthesis were equal and that the taxonomy ought to be split into “six parallel taxonomic categories” (p. 446), and other categories such as “understanding”, be added to the taxonomy.

To teach critical thinking skills effectively, Paul (1985) found that teachers needed to have a solid foundation in critical thought. Castle (2003) supported this and discussed the importance of classifying the meaning of critical evaluation to ensure
learners could achieve measurable goals. Paul (1985) added that teachers needed to be mandated to take a well-designed course that analyzed and nurtured their critical thought.

Accounting for these criticisms, the ethics e:learning was designed so that learners did not need to achieve a skillset such as knowledge, prior to being introduced to another such as synthesis. Participants were exposed to, and expected to engage with, the e:learning on multiple levels of the taxonomy simultaneously. Paul (1985) warned that learning needed to be a process-driven rather than a product-driven goal.

The ethics e:learning modules were developed based on data generated from long-term care staff members during the pre-intervention stage. Content was checked and approved by two LTCF Chief Executive Officers and was developed in collaboration with my supervisors to ensure it was appropriate, relevant, and accurate. The module content was designed to resonate with participants’ experiences to ensure they made systematic and strategic changes (MacNaughton, 2005).

3.2.E Data generation

Participants finished the modules in three months. After this period, data were generated using two methods. First, short semi-structured interviews using open-ended questions (see Appendix K) were conducted to gain insight regarding the participants’ experiences and to collect feedback about the training. Second, focus groups were conducted using vignettes to gather insight on participants’ approaches to ethical decision-making. In this section, the rationale for using interviews and focus groups to generate data are discussed.
In total, I conducted ten semi-structured interviews with a standard set of open-ended questions (see Appendix K) (Burnett, 2009). The interviews lasted between ten and twenty minutes and focused on the strengths and weaknesses of the training, whether the content was useful and appropriate, and whether content needed to be added, omitted, or expanded on. Participants were asked to explain whether or not the training was applicable in practice or not.

Semi-structured interviews were useful data collection methods to explore questions on the quality of the modules. They invite participants to raise important issues (Burnett, 2009; Taylor, Bogdan, & DeVault, 2015) and can have a broad scope (Burnett, 2009). An interview guide was used, but, at times, participants were asked follow-up questions on topics that were introduced during the interview.

Three sets of one to two-hour long focus groups were conducted with three or four participants at a time. The focus groups were arranged during times that were convenient and in locations that suited the participants. The first occurred before the participants used the training materials and the second occurred after. Focus groups captured the participants’ experiences since they had the opportunity to build on, contradict, and create themes based on their experiences (Burnett, 2009). During the focus groups participants discussed reasoning through ethical scenarios. Data were captured by recording and observing the participants’ interactions.

Focus groups revealed the participants’ insights by examining their beliefs, attitudes, and experiences, something Litosseliti (2003) asserted cannot be achieved by using other methods. Focus groups involve a group setting (Stewart, Shamdasani, & Rook, 2007; Taylor et al., 2015) and allow participants to expose taken for granted
assumptions through reflection and discussion (Burnett, 2009). Communication between the facilitator and participants add context and depth relating to their experiences, and participants can position themselves within the group by comparing, contrasting, and receiving feedback on their views (Morgan, 1997). Focus group facilitators obtain clarification, ask questions, and connect participants’ ideas (Litosseliti, 2003; Stewart et al., 2007), allow access to the group's everyday use of language and culture (Litosseliti, 2003). Vignettes were used to generate conversation in these focus groups.

During the focus groups, participants were asked to respond to text-based vignettes generated from data collected during the pre-intervention. Vignettes were selective and focused on ethical issues, the research topic being explored. In these focus groups vignettes were designed to generate ethical debate.

Hughes and Huby (2002) report that vignettes are valuable for detecting the subtle nuances that insiders tended to know, but may not have been aware of. Further, vignettes are useful for the exploration of sensitive topics (de Macedo, Khanlou, & Luis, 2015), such as ethical issues, since participants can explore the dilemmas by positioning themselves within the context of the vignette (Hughes & Huby, 2002). de Macedo et al. (2015) suggest that vignettes can stimulate group discussion and can be used to encourage participants to reflect on given scenarios.

Hughes and Huby (2002) claimed that text-based vignettes can be less effective than video-based vignettes. These authors added that participants may not retain text-based material if they have difficulty reading. Hughes and Huby (2002) suggested that for a sensitive topic such as ethics, text-based material was suitable as it gave
participants the opportunity to review the case and form an opinion rather than having an emotional response elicited from a video.

One limitation of focus groups can involve how effective the facilitator is at moderating the group since control over the data collection process can be lost (Litosseliti, 2003). Inexperienced facilitators may ask leading questions or provide cues to encourage participants to respond with data that supports their research (Litosseliti, 2003; Morgan, 1997; Stewart et al., 2007).

Group dynamics could strongly influence the focus groups. It was important to avoid interviewing persons of authority with their staff members to avoid potential conflicts (Burnett, 2009; Morgan, 1997). Further, Litosseliti (2003) cautioned if one participant dominates the group a false consensus may be achieved through silencing or agreement since other participants may not be willing to share different opinions. Morgan (1997) suggests that participants may only share partial information to avoid feeling judged by other participants.

The limitations of focus groups in this study were addressed through group management to mitigate potential power imbalances by ensuring supervisors were not interviewed alongside the staff they manage. At the beginning of the focus groups I asked everyone to participate in the conversation and asked participants not to interrupt each other. During the focus groups, I made eye contact with participants, and encouraged openness during the discussion by asking for contributions if a participant had not had input. I addressed dominant participants by thanking the dominant participant for her contribution and then opened the conversation to other points of view.
3.2.F Analysis

Data analysis involved descriptive thematic analysis, where overarching themes discussed by participants were identified, analyzed, and reported (Braun & Clarke, 2006). Thematic analysis offered flexibility in identifying themes within the data, was easy to use, summarized key features in the data, and highlighted similarities and differences while at the same time generating unanticipated insights (Braun & Clarke, 2006) relating to the research question. The research question involved applying a SWOT analysis to the ethics training program.

Montalban et al. (2014) characterize a SWOT analysis as a tool that can be used to audit elements that affect an organization by examining the internal strengths and weaknesses and identifying the external opportunities and threats. Berge and Giles (2008) express that it is beneficial to strategically plan the implementation of a training program to ensure that the goals of the e:learning and the business culture are well-aligned. Moreover, Berge and Giles (2008) define the goal of the SWOT analysis is to engage in an evaluation of the internal and external factors that influenced the project to optimize the strengths and opportunities while reducing the weaknesses and threats.

Organizations have more control over the internal factors than the external factors so it was imperative to ensure these were appropriately divided (Montalban et al., 2014). Internal factors are within the organization’s control such as, the design of the material and promoting support from management; while external factors are outside of the organization’s control and include influences such as, an aging population with complex care needs and the technical ability or motivation of the learners.
The interviews and focus groups were audio-recorded with the participants’ consent. Analysis involved identifying common themes that represented the participants’ perspectives of the e:learning. The data were transcribed verbatim so that data were more accessible for comparison without revisiting each recording. Following Braun and Clarke’s (2006) recommendation emerging themes were noted during the process of transcriptions.

Prior to transcribing, audio recordings and transcripts were assigned unique identifying codes. The recordings were transcribed following strict guidelines to ensure consistency. Transcription guidelines dictated that square brackets were inserted around words such as, “um” or “uh,” and when participants coughed or laughed. For example, [laughs]. Additionally, participants use of, “hmhm” were included. Further, pauses that were more than three seconds in length were noted thusly, [X secs]. When the content was unclear three green highlighted question marks were inserted with a time-stamp. One time-stamp was included on every page.

Atlas.ti computer software was used to code and analyze the data. Initially, data were coded in small sections. Following the advice of Boeije, (2002) a constant comparison technique was used in coding by returning to previously coded interviews to identify if any sections or words were missed or had become more apparent on a second or third read. Data analysis was an iterative process. To determine themes, each time an interview was revisited a deeper understanding of the information was developed (Braun & Clarke, 2006). Clustering codes to refine the master list was a collaborative process with my supervisors to identify emerging themes.
Analysis of the interviews involved identifying themes relating to both the quality and content of the training material. Participants had the opportunity to describe their experiences of using the training materials and if they felt that they could apply skills learned from the modules in practice. Participants were asked to identify whether or not they felt better equipped to address ethical issues. Module content may be revised based on these responses.

Analysis of the focus group transcripts involved exploring changes in participants’ perspectives on e:learning. Evaluation involved identifying the strengths, weaknesses, opportunities, and threats of implementing an e:learning program. Also, changes in participants were identified relating to topics covered in the material.

3.2. G Limitations

Five LTCF participated in the pre-intervention and a sixth facility asked to join the intervention. Five of the six facilities agreed to allot work time for participants to complete the training; however, only one facility upheld this arrangement. From this facility, five people volunteered to participate. From a second facility where time was not allotted, two people participated. There were no participants from the four facilities that did not allot time during work to complete the training. Therefore, healthcare students and teachers were invited to participate in the study. Two students and two teachers joined the study from the educational organization. Every participant was female. Following the implementation of an ethics e:learning program evaluation of whether or not knowledge is sustained over time needs to be identified; however, this
was not accomplished within the time constraints of this research study. Evaluation, using knowledge translation, is discussed further in chapter five.

3.3 Summary

Data from the pre-intervention stage was used to form the basis of the ethics e:learning modules developed for the intervention. Qualitative methods in the form of semi-structured interviews and focus groups were used to explore the research question relating to the strengths, weaknesses, opportunities, and threats to implementing this ethics e:learning program into LTCF. In chapter four, I examine the findings of this research using a SWOT analysis framework.
Chapter four: Findings

4.0 Introduction

My literature review revealed that in LTCF ethics are inconsistently addressed, if at all. In LTCF, there appear to be no standards for ethical practice and few useable tools exist for daily decision-making. I addressed this gap by developing ten e:learning modules on the topic of ethics. Six long-term care staff members, two teachers, and two students completed the training. Using interviews and focus groups, I explored the question, “What conclusions can be drawn from implementing an ethics e:learning education intervention in long-term care facilities using a strengths, weaknesses, opportunities, and threats analysis?” To present my findings I divided this chapter into four sections based on a SWOT analysis framework: “Strengths of the ethics e:learning modules,” “Weaknesses of the ethics e:learning modules,” “Opportunities for implementing the ethics e:learning modules,” and “Threats to implementing the ethics e:learning modules.”

4.1 Strengths of the ethics e:learning modules

Strengths are internal positive factors that could contribute to the successful implementation of the ethics training into long-term care. First, I describe participants’ comments about having control over some aspects of the learning environment including the pace, the length of time spent per session, and having the ability to modify the training to suit their own needs. Next, I discuss how participants felt about the training in terms of whether it was easy to navigate, concise, and/or applicable in their
daily practice. In the last section of this chapter, I describe the changes that occurred in some participants’ ethical sensitivity.

4.1.A Control over learning

Amber and Gracie indicated that the ability to use the training at their own pace was helpful. Gracie pointed out, “I did like it because it’s self-paced.” Brooke reported:

I made notes and then as you went through the modules there was enough time – it didn’t automatically switch slides that I could sit and make notes, link it up with a specific key words in each module to be able to refer back to, to help with the learning which I found was awesome.

Gracie added, “if you didn’t finish it you could go back into it.” In other words, she liked having the ability to exit the modules and return to them without losing her progress. Monica felt that an advantage of the training was that she could skip content she was familiar with. Amber enjoyed having unlimited access to each module as she would redo a module if she was unhappy with her grade or if she felt that she had not grasped the material.

Most of the participants indicated that they liked having audio features available as the audio provided clarity to the content and scenarios. For example, Brooke explained, “by listening as well, you read out the power points. That helped…” Carrie commented on the benefit of having the ability to mute the sound, “I found very quickly that if I didn’t listen to the person talking through the slides and just read them myself I got through them faster.” For Ella, the modules were also easier without audio since she
read quickly. Learners appreciated having control to suit their own learning styles while working through the modules.

Brooke stated, “I liked how it varied. The format sometimes varied… different font or different push a button here or flip the page on this. That was nice; it kind made it interesting.” Some modules were formatted like books. The content was divided into book chapters. Participants could navigate backwards or forwards by turning the book’s pages. In other modules, the content was divided into tabs and participants navigated using arrows that moved either backwards or forwards. Interactive features like these were built using varying formats to engage learners.

Brooke added, “I liked the small little blue question buttons that could [um] help if someone had more question as to what the term meant. As in like in a dictionary. So that was very helpful as well.” Each module contained markers that, when clicked, displayed additional information which was discussed in chapter three. While the layout was important in engaging learners, so too was the ease of use for participants.

4.1.B Ease of use

Overall, participants described the ethics e:learning as well-organized and easy to work through. Gracie felt that the modules were well-done, well put together, clear, and specific. Mabel concurred that the materials were well put together. Carrie had no issues with using the e:learning. Amber explained that:

In the beginning, when you start, it’s like wow! There’s a lot of information here and I’m getting bombarded with facts and information, but in the end when you get to the end of the modules it,
it all comes together. It, it makes the circle. So it’s like, OK, I see why
that was in there now and it was repeated so many times. I get it.

The materials were more in-depth than Brooke anticipated, but she said that this
broadened her scope of ethical understanding.

Monica explained that she had taken ethics courses before and was familiar with
the content, yet, the training was beneficial as it brought ethics to the forefront of her
mind and reminded her that daily decisions have ethical considerations. Work becomes
routine, she said, and it is easy to get caught up in the tasks. Overall the training
brought awareness regarding how critical these daily decisions can be. As with Monica,
Amber and Peach had taken ethics courses before and Peach identified that the training
acted as a refresher.

In both the written and interview feedback several participants claimed that the
best part of the training materials were the scenarios. Scenarios were used as examples
that were designed to illustrate course content. Janet, for example, explained that she
liked the scenarios the best as they defined situations that she had encountered for years
in her practice. Gracie included in both the immediate written feedback and the
interview that the scenarios were realistic and therefore useful. Ella’s feedback was
similar; she found that the scenarios were useful due to their commonality in everyday
life.

Participants who had taken ethics training before - Amber, Sue, and Peach –
found a difference between these modules and the courses taken previously, in that,
these modules were specific to LTCF and put the material into real-life perspective. In
Peach’s view, “They were [um] work related. I think the other course it was just an
ethics course so it wasn’t specific to my job.” She added that, “it was easier to apply the knowledge to the fact that I could relate to every situation.”

In the ethics e:learning modules, the presentation of relevant, valuable, and relatable content was indeed a strength. Due to this, the content influenced participants’ experiences of using the training. The training also updated the knowledge of participants who had already taken ethics courses.

4.1.C Changes in participants

The notable changes that occurred were: a) some participants felt they were better able to describe the situations they encountered in LTCF; b) some participants altered their practice as a result of developing a deeper understanding of ethics; and c) one participant was better able to identify what constitutes an ethical issue and had demonstrated an enhanced understanding of how to provide person-centred care to residents.

While module seven focused on the use of respectful, accurate, inclusive, and non-stigmatising language based on Alzheimer’s Australia (2015) guidelines, the importance of using this type of language was embedded in every module. Each module promoted the provision of person-centred care. Brooke described how she connected theory with practice-based incidents she experienced in clinical settings. Brooke had witnessed a staff member who engaged in diagnostic overshadowing (the attribution of a person’s behaviour to the disease they are living with). In this instance, the resident was walking around and her behaviour was attributed to her diagnosis of dementia. Brooke explained:
I’m able to sit back and see how that applies to the clinical setting and make changes. [um] One of those examples, I think I mentioned a few minutes ago, was looking at that reasoning when I asked that individual in a nursing home why this lady wanders referring back to that situation and recognizing that was a perfect example and I did not just let her continue to wander. I tried to intervene and tried to connect with that lady to try to understand. So now I was able to put a term and have a better understanding of what it was that I saw. So, I, that’s what I found with the learning modules that the different terms now have a name that I can put to a specific incident and pull that information for further learning and intervention in the clinical settings.

Although person-centred language does not support referring to a resident’s behaviour as “wandering”, there was a positive shift in Brooke’s behaviour when she tried to intervene and connect with the resident. Other participants also developed the ability to name or describe events they encountered in practice.

After completing the training Amber recognized that she had developed a better understanding of information sharing and the importance of respecting residents’ confidentiality. Though she was aware of information sharing before completing the training, it was not to the degree that it is now. For example, now, before sharing information she identifies if the person requesting the information has power of attorney, an enduring power of attorney, or is next of kin to the resident rather than
assuming the person is privy to the information. Amber recognizes the residents’ rights and the limitations of the person who is requesting the residents’ personal information.

During the first focus group, there were more than ten ethical issues in the vignette, yet Sue only identified three. In the second focus group, Sue quickly identified a broader scope of ethical issues and reported a deeper sense of the types of issues that were prevalent. Sue explained, “what really bothered me is they have five other “lifts,” for one thing, I hate it when they say “lifts” instead of “people.” It drives me crazy… So, right away they made him feel like he wasn’t important.” Not only did she identify the use of inappropriate language, but also later in the focus group she drew on the correct terminology to describe persons who needed assistance getting up; rather than calling them “lifts.” Sue also noted changes.

During the first focus group when Sue was asked to provide examples of possible resolutions for the character in the vignette, she was unable to do so and she said, “I don’t know.” Following this, Sue offered an example from her experience that did not apply to the vignette. During the second focus group, Sue offered a range of applicable and potential solutions for the vignette’s resident, “David”, and his family members, “Margery” and “Jeremy”:

Well, just taking time to spend time with David or, you know, getting him out. If, if they know they have five other people they need to help with, but he seems to really have depression, well make him the first one, you know, so he is down there so he can communicate. Just little things. Find out what makes him happy and try to assist with that and even just talking to [um] Jeremy and
Margery and saying, “Look, he’s getting really depressed lately, maybe you can up your visits a little bit.” So it’s not just on the staff, you know.

Rather than avoiding the question as she had done previously, Sue suggested spending time with David, ensuring his care is prioritized, offering suggestions for socialization, and taking a collaborative approach by including his family in care. Sue’s comment that: “it really doesn’t take a whole lot of time to make somebody feel like they’re important,” and her emphasis on, “just little things.” were significant. This insight is explored in chapter five.

4.1.D Support from management

The final strength of the ethics e:learning course focuses on support from organizational management. Managerial encouragement can be delivered through behavioral support that focus on practicing learned behaviours or instrumental support when resources are dedicated to the training (Janes, Fox, Lowe, McGilton, & Schindel-Martin, 2009). In this research, one Chief Executive Officer was a participant who provided both behavioral and instrumental support (Janes et al., 2009) to the staff members to participate in the e:learning training.

Behavioural support occurs when a manager promotes the use of the training by practicing and engaging in learned behaviours (Janes et al., 2009). The Chief Executive Officer who participated in this research was involved from the beginning to the end of the interview and both focus groups. Additionally, she assisted in designing the training
materials and offered valuable insight on improving the modules. She followed-up by promoting the staff members’ use of the modules.

Support was provided to participants when the Chief Executive Officer endorsed their participation in the e:learning by providing adequate time and space to complete the modules during working hours. Further, she requested that the modules be included in her facility’s annual staff education program, which emphasized her dedication to and value of the ethics training. The support provided to staff members might have encouraged their overall participation in the training as 40% of the participants in this study worked at this facility.

The LTCF and the provincial healthcare institution’s senior managers agreed to sign a certificate of completion in recognition of the participants’ successful completion of the ethics e:learning. Participants were not notified that they were to receive this certificate until part-way through or upon completion of the modules as it was intended to provide recognition for their achievements.

4.2 Weaknesses of the ethics e:learning modules

The internal, negative challenges that arose during the implementation of the ethics e:learning were examined as weaknesses using the SWOT analysis. Two main issues became evident during the pilot of the e:learning course. Technical issues occurred when participants used the modules due to the learning management system or when they used incompatible browsers, tablets, and cellphones. Participants were generally satisfied with the content of the modules; however, they offered suggestions
for improvement within the current content as well as additional modules that could be added to the course.

4.2. A Technical issues

At times, technical issues unrelated to the modules arose; however, from an end-user perspective the point of failure is irrelevant. The two technical issues participants encountered were the failure of the learning management system and the participants’ use of incompatible browsers, cellphones, or tablets.

While some participants did not experience technical issues, some did. Participants contacted me by phone or e-mail to report the difficulties that they encountered that caused them frustration and anger. Some participants threatened to quit if these difficulties were not addressed immediately. Some participants expressed frustration saying that they did not have time to troubleshoot the problem, while others answered questions relating to the issue. In the beginning, it was challenging when a participant experienced a problem, but was unwilling to inform me what the issue was. Towards the end however, I could identify the problem through a simple process of elimination. For example, if the problem was not apparent when I logged into the learning management system then it was reasonable to assume that the participant was using an incompatible web-browser.

The learning management system presented difficulties for some participants due to the settings for this course. The modules needed to be completed in sequence. To illustrate, a participant could not access module four unless modules one, two, and three were completed in that order. Problems arose when the learning management system
failed to track the participants’ responses which meant that the next module would not become available. To resolve this issue, I manually deleted the participant’s attempt in the learning management system and asked her to complete the module a second time. In every instance but one, the participant agreed to repeat the module, then progressing as intended. In one situation, the participant refused to retake the module. Consequently, I changed the settings so that she could advance to the next module.

The second problem that arose involved the participants’ use of incompatible browsers and/or the use of cell phones or tablets. There were two web browsers that worked with the e:learning, Internet Explorer and Chrome. Firefox and Safari web browsers were not supported since the triggers in the modules would not function. Triggers were abstract switches that initiated an event following another event. For instance, when an image was selected by the participant, a trigger caused a hidden forward button to become visible. In Firefox, the forward button remained hidden since the triggers did not work which resulted in the participant being unable to advance. When a participant reported these issues, I asked her to use a supported browser – Chrome or Internet Explorer. Participants experienced the same problem when using cell phones/tablets. In these situations, I also asked the participant to use a supported web browser on a computer.

4.2.B Changes to the current content

Most of the feedback on the current content was positive; however, there were minor suggestions for improvement. These included changing how the tests were delivered, reducing the amount of interactivity in the modules, inserting slide count
downs in place of the estimated time frame to complete the modules, and adding quick reference features.

Mabel suggested that test questions should appear immediately after the course content, this way learners would not have to remember specific definitions. Mabel did not take notes as she progressed through the modules, which compromised her progress since she found it difficult to remember content. Peach, who disliked the written component in module ten, explained that she knew the material; however, having to write it out resulted in her losing her train of thought and feeling disjointed. Peach suggested that every module have multiple choice questions as opposed to short-answer questions. Monica agreed and added that the written component “could be grueling, at times.” She preferred responding to multiple choice questions over short answer questions.

For Peach and Carrie there was too much interactivity in the modules. Peach explained that it was “Like going back and forward or whatever. Like just make it constantly that you just click next.” Similarly, Carrie outlined:

I might have thought there was a little bit too much interaction like clicking on buttons and then that button, then you know, something else would pop up and you had to click another one to go back to the other screen and sometimes I thought OK, do we need to make it this difficult as far as going back and forth?

I followed-up by asking Carrie which modules should be modified and have reduced interactivity. She replied that, “A couple modules and I can’t remember which ones, Jenn, there was a fair amount of that.” She added, “Not always and some of it was
really good, but [um] there definitely was sometimes when it was a little bit too many.” To clarify, I asked her if the modules needed to be linear, and she agreed that this would be an improvement. Further to that point, Carrie suggested that by reducing the interactivity some of the information could be condensed.

At the beginning of each module there was a slide that informed the learner the approximate time frame required to complete the module. Carrie explained that being provided an expectation of how long it might take to complete the module was good, but if a person read the material without using the audio features they could finish the modules sooner. Consequently, she suggested including a slide countdown to display the learner’s progress. To illustrate, a module has 50 slides in total and the learner is on slide 20. This appears as 20/50 on the slide. When the learner advances the top number, 20, updates to 21 while the bottom number 50, remains static. This represents the number of slides remaining. Currently, an estimation of the time to complete the module is provided, but can fluctuate depending on variables such as, the use of audio features, how quickly the participant reads, familiarity with content and more. Another suggestion involved inserting a method of displaying key terms in order to respond to questions.

In module ten participants read a case study and were asked to respond to short-answer questions. Module ten did not have any multiple-choice questions and the responses were not graded; however, detailed feedback was provided immediately following each question. Ella, Carrie, Amber, Sue, and Brooke all suggested that an improvement to module ten would involve having access to the concepts beside the question either through a side-by-side window, a link that connects to the term, or
access to the definitions. Several participants said that they used “Google” to complete this module, but Ella indicated that she would have preferred to have had access to the module content since the terms were: “all clearly described.”

Three participants, Carrie, Amber, and Monica requested the introduction of features that were already built into the training, for example, the ability to return to previous slides. In module one and during the quizzes participants were only permitted to move forward apart from that participants could move both backwards and forwards in every single module. This feature could be added to module one and the quizzes and could be accentuated in the other modules to ensure participants are aware that they can move backwards.

4.2.C Additional content

Participants suggested module content that could be added to the training materials. They were asked to identify if the content should be added to the current materials or as additional modules. Their answers varied based on what they felt needed to be included. For example, Carrie and Peach suggested that a module on Medical Assistance in Dying should be developed due to its fast-approaching presence in LTCF.

A module on helping family members cope at the residents’ end-of-life was proposed by both Janet and Peach. Peach explained that staff members often spend time with grieving family members when residents die. She offered that residents’ deaths are harder for the family members than for the residents themselves. Janet agreed that the exploration of grieving and how to help families with the loss of a relative would be a valuable module. She added that 75% of residents, “shut themselves down” by refusing
to eat when they were previously “good eaters,” implying that such residents are prepared for their deaths.

Janet also recommended that a module be developed on violence against staff members. She reported that, “An eye-opener to a lot of people like you think of dear old grandma, well with dementia and things it turns the personality right upside down and reverses it most times.” Janet suggested that it would be useful for people who are entering the workforce in LTCF to be trained on how to address violence against staff members, since new staff members do not always receive any training on how to handle themselves. Janet revealed that in her experience, “you learn how to handle things… you learn when to step back when you should and, and when you should be a little more aggressive or whatever or step up to them.”

An issue outlined by Gracie that frequently arises in LTCF, but was not in the e:learning, involved residents forming relationships with each other and sexual relations between residents. Gracie was concerned that, the frequency of this is increasing, this is ethical, and this is complicated. When asked whether this topic needed to be integrated into a current module or designed as a module in and of itself, Gracie suggested that a full module on this topic would be valuable.

Ella recommended that content on cultural diversity be added since the e:learning modules seemed culturally insensitive. To illustrate her point, module seven emphasized the importance of body language, using touch, and making eye contact with residents. In her immediate written feedback, Ella suggested that the training was culturally insensitive since in some cultures making eye contact is disrespectful. Her comment revealed that there is an opportunity to include content about raising
awareness around cultural differences that exist, respecting cultural differences, and learning about cultural nuances.

Participants suggested topics that could be integrated into the e:learning based on what they felt was missing. Each of these topics were ethical in nature and could, to some degree, be included in the training; however, not necessarily as full modules. It is feasible to integrate some topics into current modules including, violence towards staff members, end-of-life issues in relation to family, and the importance of recognizing and respecting cultural differences. Although other topics such as, Medical Assistance in Dying and/or residents forming relationships with each other could be designated as separate modules that explore the ethics involved with these dramatic ethical dilemmas. The selection of additional modules will be discussed in detail in chapter five.

4.3 Opportunities for implementing the ethics e:learning modules

Opportunities are external factors that can positively influence the implementation of the e:learning modules. The sources of opportunities included the need for ethics training demonstrated by the participants’ limited understanding of ethics and their desire for ethics education and the availability of, Itacit, the learning management system used in New Brunswick LTCF.

4.3.A The need for ethics education

The need for ethics education in LTCF is covered by several authors in the literature (McAlpine, Lockerbie, Ramsay, Beaman, 2002; Paier & Miller, 1991; Rees et al., 2009). Participants, Amber, Ella, Carrie, and Brooke stated that they learned new content about ethics that they did not know prior to completing the modules. In her
immediate feedback, Brooke wrote, “I found this information really informative and included new terms that I certainly was not aware of.” Amber added, “I found it most interesting the part about the power of attorney and enduring power of attorney. Those were items that I really was not as aware of as I thought I was.” Peach explained: “I think in nursing especially there’s more grey areas than black and white.” Mabel stated, “ethics has a lot to do with every day living with someone in a nursing, nursing home situation, long-term care facility and I guess I wasn’t aware of that.” Further Mabel concluded:

I’m not used to ethics anyway, you know, like using that word and [uh] as I said, I didn’t, I didn’t think that it belonged in, in nursing homes and I didn’t think and I wasn’t aware of us having to deal with that.

For Amber, the modules increased her knowledge relating to information sharing and as a result, she now pays closer attention to the resident’s paperwork regarding the roles that people are assigned and whether she shares the resident’s personal information with them or not. Carrie explained:

I learned from it, you know, it was very informative. [um] So there were things in the modules that I would not have known before taking the module. [um] So that was very good. So, definitely increased my knowledge base around ethics in long-term care.

In the following excerpt, Ella identified how the modules broadened how she thought about ethical dilemmas: “I’m used to looking at it from like, a care giver point of view, and it’s not looking at the whole picture. It’s just, you know, doing what you
can in an allotted amount of time basically.’” She added that, “it gave me a new way to think about things… I try to look at it more from the families’ perspective too because like it really is hard.” In the immediate written feedback, she also offered that she had never learned about assent before.

Each of these responses emphasized the need for this ethics education in LTCF since participants are staff members, teachers, and students who work or teach where ethics exist in everyday interactions. Some of the participants have worked in long-term care for several decades and some participants are new to the field, yet many of them have limited knowledge about the ethics that pervade everyday practice. Mabel concluded, “the facilities, they need a lot more, more education on ethics really.”

4.3.B Standalone modules/Itacit

Online training is commonly used to educate long-term care staff members in New Brunswick. Itacit is the learning management system used in all New Brunswick LTCF (J. Hall, personal communication, May 16th, 2017). Halabisky et al. (2010) expressed that e:learning is cost-effective, easy to manage, and can provide standardized training to numerous people who are located over a large geographical distance. They add that e:learning is flexible so staff members can access the modules in short-time intervals, revisit material, and work at their own pace which meets long-term care staff members’ needs.

The Chief Executive Officer of one LTCF is planning on integrating the ethics e:learning modules into the staff members’ current training curriculum. Every staff member at her facility could have the opportunity to engage with the material and may
develop a shared understanding of ethics and how to consistently address them in practice.

The modules were designed using Articulate Storyline, software which is compatible with Itacit, the learning management system used, to some degree, by all New Brunswick LTCF, for the distribution of educational materials (J. Hall, personal communication, May 16th, 2017). For privacy reasons Itacit would not permit me to access participants’ data. For the pilot of these modules, I uploaded them to a free learning management system. I had administrative access to the learning management system which enabled me to control how the modules were presented, monitor the participants’ progress, and access their results.

4.4 Threats to implementing the ethics e:learning modules

Threats are external circumstances that can negatively influence the execution of the ethics modules. The most prevalent threats evident from this study included available and functional equipment, the end-users’ ability to use the equipment, the motivation of the learners, and the workplace culture.

4.4.A Equipment

For the e:learning modules to work participants needed access to a computer with that had either Internet Explorer or Chrome installed and a reliable Internet connection. In most cases, participants had computer access, but in some cases, they did not have either of the compatible web browsers or chose not to use them. Consequently, two laptops were provided to four participants. One participant borrowed a laptop and then completed the e:learning course. I loaned the laptop that she used to a second
participant. A third participant that borrowed a laptop dropped out of the study. The laptop she used was loaned to a fourth participant.

In addition to having access to functional equipment, participants needed a reliable Internet connection. Gracie described having difficulty with one module due to a faulty Internet connection. It was Easter weekend at a peak time for Internet usage which caused service interruptions and ultimately prevented her from submitting her results.

4.4.B Technical ability and resistance

Although there was consensus that the modules were easy to use and navigate it is necessary to recognize that participants did require a level of technical skill to access and use the e:learning. Participants needed to turn on a computer, access a web browser, input a link, log in to the learning management system, locate the module, open the module, and navigate the module which required, at times, both the use of a mouse and keyboard. For a person who has never used a computer before or is unfamiliar with computers this process can be challenging intimidating as demonstrated by one participant, Janet, who asked for printed copies of the modules.

Janet requested a paper copy of each module after having spent over four hours (as opposed to thirty minutes) on one module while at work. At work, the computer was in the staff room and the number of people around was distracting. Janet explained that she did not have technical skill nor did she have a computer or the Internet at home. Thus, I printed the modules off for her and mailed them to her. She completed them and she returned them to me. Completing the modules on paper removed any interactivity
that would have been available in an online environment. On paper, everything was presented at once. Triggers that repeated content and audio features did not exist on paper. Janet could have had an advantage over other participants on the quizzes for questions relating to content; however, she did not hold an advantage on questions that required the application of abstract thought or theories as her grades were consistently lower in comparison to other participants. Janet was more comfortable completing the modules on paper. Although other participants completed the training online they did not go paperless.

Resistance to technology was evident through learners who chose to have handwritten notes and print the modules. Amber, Carrie, and Peach took notes. Amber had a full notebook, divided by module, that she could use later as a reference. Peach had a notebook that she used to initiate changes in the LTCF where she works. Sue printed the case study in module nine and Brooke printed the case studies from modules nine and ten, which enabled them to reference the case studies when responding to test questions. Carrie’s resistance was apparent through her desire to have a binder containing each module at the LTCF where she works so that they could be quickly referenced for ethical decision-making. Printing the modules to complete them encourages minimal engagement with the material resulting in shallow rather than deep learning (Donnelly & O’Rourke, 2007). Further, completing the modules on paper does not require active participation from the learner which modifies the learning process (Donnelly & O’Rourke, 2007) by eliminating interactive features built into the material.
4.4.C Learner motivation

Learner motivation can influence the success of the training. Out of the twelve people who agreed to participate in the research two participants did not complete the study. One participant was a student and one was a staff member.

The student participated in one focus group, agreed to complete the ten modules, but never accessed the modules. I contacted her by e-mail, but after failing to receive a response I contacted her by phone to uncover whether she was having issues with accessing the training. She told me that she had not tried to access the modules yet, but would complete the training before the deadline. She never did access the modules.

The staff member agreed to participate in the research, participated in the first focus group, and completed seven of the ten modules. A laptop was loaned to her to complete the modules. She e-mailed me explaining that she did not have enough time to complete the training; as a result, I offered to extend her allotted time by one week to complete the ten modules (giving her a total of thirteen weeks). Soon after, she e-mailed me again stating that she did not have enough time to finish the final three modules; therefore, with her permission, I asked the Chief Executive Officer of her LTCF if she could have time at work to complete the modules. The Chief Executive Officer allotted her twenty minutes per module. The participant then e-mailed me to express that the modules no longer worked and that she did not want to continue with the research, at which point, I collected the laptop. I tested the laptop, as it was being loaned to another participant, and the modules worked.
4.4.D Culture of care in long-term care facilities

The workplace culture defines the goals, values, and ethics of a company, but the staff members’ values and beliefs can influence the uptake of learned skills in practice. In LTCF the workplace culture can vary between facilities and the importance and extent that person-centred care is practiced can fluctuate. In LTCF there has been a culture shift; however, the focus of care predominantly remains on the completion of routines and tasks rather than that of providing person-centred care.

The participant’s values can influence whether she applies learned skills in practice. For instance, Janet believed that work-experiences are more valuable than education. She claimed that the modules are not useful for staff members who have worked in facilities long-term. To her, education is not as effective as the experience that she had gained from working in LTCF. She expressed that students going into the field of long-term care should have access to the modules, rather than current staff members. Janet suggested that, for a new staff member, the modules can answer the question, “What do I do?” Mabel also stated that the modules would have been more helpful at the beginning of her career, rather than at the end, and they should be included in the patient-care attendants’ curriculum.

In many LTCF work is centred around the completion of tasks. This was evidenced by participants who cited not having enough time to complete the modules and as the rationale for why strategies offered in the training materials could not be implemented in practice. Mabel claimed, “we tend not to let them make the decisions and things like that because they don’t have the time to do that.” Monica added: “sometimes you have a, a tendency to [uh] forget about certain ethical concerns and
considerations and you don’t, you don’t spend the time to be more self-aware.” The scarcity of time is one consequence of the staff shortages experienced in LTCF today.

Mabel explained that residents were not included in decision-making due to time constraints. She claimed that more funding ought to be dedicated to LTCF. Mabel described how staff members have an allotted amount of time to complete tasks and residents who were, for example, in a wheelchair, need assistance with things such as going to the washroom; therefore, they take more time and receive more attention.

4.5 Summary

This chapter explored the data using a SWOT approach. First, I described the strengths of e-learning which included positive staff perceptions of having control over the learning environment, the modules’ ease of use, changes in participants’ thoughts and behaviours, and support from management. Second, I explored the weaknesses of e-learning which involved technical issues and the participants’ recommendations for improvement. Third, I examined the opportunities, which were the need for ethics education and the infrastructures that support the modules. Finally, I discussed the threats to the ethics training, which included a lack of equipment, participants’ technical abilities and motivation, and the workplace culture. The implications of these findings will be discussed in chapter five.
Chapter five: Discussion

5.0 Introduction

This chapter is divided into two main sections. First, knowledge translation, defined by Heyland, Cahill, and Dhaliwal (2010) as the uptake of research findings into practice and how this relates to my research findings is discussed. Second, I examine the positive and negative, internal and external elements of implementing the ethics e:learning modules in New Brunswick LTCF and discuss the implications of each.

5.1 Knowledge translation

Due to the intended applied nature of the project and the aim to produce a useable ethics e:learning program, from the outset of the research, I was cognizant of the requirements of knowledge translation. Knowledge translation is not just a matter of working out how to translate research findings into practice, but informs all aspects of the design and implementation of the research.

Heyland et al. (2010) explain that knowledge translation is the process of applying clinical research findings into practice. In the literature to date, the terms “knowledge transfer” and “knowledge translation” are not clearly defined in many instances. One study by Lal et al. (2015) suggests that this is due to knowledge translation not being recognized as a distinct field and that many terms are used interchangeably. For Graham et al. (2006), these terms are often ill-defined leading to inconsistencies relating to their meaning. Consequently, I use the term knowledge translation as it is the term predominantly used in Canadian healthcare (Graham et al., 2006).
Heyland et al. (2010) describe knowledge translation as the process of incorporating research findings into practice. Failure to integrate research into practice can lead to the use of potentially harmful or unproven treatments and inadequate standards of care (Graham et al., 2006; Lang, Wyer, & Haynes, 2007; Van de Velde et al., 2016). Van de Velde et al. (2016) detail that when cost-effective treatments are applied in practice operational expenses can be reduced. Research demonstrates a “chasm” (Lang et al., 2007) between what we know and what we do (Lal et al., 2015) resulting in an ethical urgency for the effective translation of evidence-based research into practice (Bowen & Graham, 2013).

Straus, Tetroe, and Graham (2009) inform us that the Canadian Institute of Health Research defines knowledge translation as a dynamic and repetitive process of synthesizing, disseminating, exchanging, and ethically applying knowledge to improve the health care system through the provision of better health products and services. The Canadian Institute of Health Research accepts the knowledge-to-action cycle as a means of promoting the application of research into practice (Straus et al., 2009).

Heyland et al. (2010) claim that the action cycle is composed of two frameworks: knowledge creation and knowledge-to-action. Each framework consists of phases that can occur either simultaneously or sequentially. I focused on the seven-phased knowledge-to-action cycle: identifying the knowledge-to-action gaps, adapting knowledge to local context, assessing barriers/facilitators to knowledge use, selecting, tailoring, implementing interventions, monitoring knowledge use, evaluating outcomes, and sustaining knowledge use (Straus et al., 2009).
Phase one of the knowledge-to-action cycle, identifying the knowledge-to-action gaps, involves identifying the need for ethics training in New Brunswick LTCF (Heyland et al., 2010). Phase one is established by the collection of preliminary research data and the use of focus group and interview data (from the pre-intervention – see chapter three, methods) which identifies the need and desire for ethics education. A systematic review of the literature reveals that there is strong support and a need for continuing education on ethics in health care (Monteverde, 2014; Park, 2013). The need for ethics education in LTCF in New Brunswick is identified.

By establishing that the research can be adopted by local settings fulfilled phase two: adapting knowledge to a local context (Harrison, Graham, & Fervers, 2009). Phase two of this research is formed by implementing stand-alone, ethics education for New Brunswick long-term care staff members. In LTCF ethics is a relevant topic due to the quantity and range of ethical issues staff members encounter daily; yet, Dierckx de Casterlé et al. (2008) find staff members fail to engage in critical reflection on these ethical dilemmas. MacDonald et al. (2008) report that e:learning is a cost effective and flexible method of providing standardized education to staff members who span over large geographical distances. New Brunswick is a predominantly rural province.

Identification of the elements that can impede or enhance the uptake of knowledge in a local context is phase three, barriers and facilitators to knowledge use (Heyland et al., 2010). In this study, I accounted for this by investigating circumstances that can hinder or improve the implementation of the training material. For instance, one element that can impede knowledge translation is the reportedly high illiteracy rates in New Brunswick (New Brunswick literacy rates, 2017). To address this limitation,
audio narration is embedded in the modules and the content does not exceed an eighth-grade reading level. Additional facilitators and barriers are discussed later in this chapter under, “Strengths of the ethics e:learning modules” and “Weaknesses of the ethics e:learning modules” respectively.

Choosing appropriate methods to implement the training is phase four, selecting, tailoring, and implementing interventions (Heyland et al., 2010). A stand-alone e:learning training program is the selected method to deliver ethics education to long-term care staff. Articulate Storyline software was used to design the training as it is compatible with Itacit the learning management system that delivers, to some extent, education in every LTCF in New Brunswick. The e:learning is tailored to the participants’ needs by offering flexibility and control over the learning environment. The modules are designed to be highly interactive with minimal variability to ensure that they captivate participants. These topics are further discussed in detail later in this chapter.

I did not reach phase five of the knowledge-to-action cycle, which focuses on monitoring knowledge use (Heyland et al., 2010). LTCF managers can monitor whether staff members apply the content they learned from the modules and can assess shifts in practice. In this research, I did not observe the participants’ behaviours on-site.

A SWOT analysis is applied to the implementation of the e:learning modules for phase six, assessing the results by evaluating outcomes (Heyland et al., 2010). Two sets of focus groups, interviews, quizzes, written responses, and written feedback from the e:learning course are evaluated in order to identify participants’ perspectives of the
ethics modules. This information provides some insight to the degree that knowledge translation was achieved (Heyland et al., 2010).

The measurement of whether learned skills are applied in practice over time, which is phase seven of the knowledge-to-action cycle, sustaining knowledge use, fell outside of the scope of this study. This, however, could be explored through evaluating the participants’ progress by conducting an observational or a longitudinal study to examine the long-term impact of the training.

5.2 Applying a SWOT analysis

A SWOT analysis is used to examine the elements that have an effect upon the implementation of the e:learning program. The internal strengths and weaknesses and the external opportunities and threats are reviewed (Montalban et al., 2014). Here, I examine the implications of the strengths, weaknesses, opportunities, and threats of implementing the ethics e:learning course in New Brunswick LTCF.

5.2.A Strengths of the ethics e:learning modules

Berge and Giles (2008) state that the strengths are the internal positive elements that can influence the ethics e:learning modules. Moreover, they assert that e:learning is a fiscally prudent and flexible method of educating long-term care staff members as it is both physically and conceptually accessible. A sizeable audience with standardized education can be reached using e:learning. Supportive management positively impacted some participants.

The facilities that participated in this study did not have any upfront costs with implementing the e:learning. The indirect cost to one facility was through the time
allotted to staff members to complete the modules on-site. There can be costs associated with implementing e:learning, but these are lower than those incurred from traditional teaching methods (Berge & Giles, 2008). E:learning can be integrated into existing infrastructures. In this case, the modules were designed using Articulate Storyline which is compatible with Itacit, the learning management system used to distribute educational materials in all New Brunswick LTCF. Instructor-led courses incur travel costs, instructor fees, tuition fees, facility overheads, and publishing costs (Berge & Giles, 2008). Minimizing costs can promote the use of the ethics training from the LTCF perspective; while creating a positive learning environment can promote the e:learning for participants.

Amber enjoyed having control over the learning process. She worked on the modules in her office. She explained:

The fact that [um] I could do it at my own pace. That was most important. [um] If I needed to redo the module I did it two or three times. Redid the modules because a) either was not happy with my results or I wasn’t quite sure I had grasped what it was that was intended for that module. It was, I was able to do that and again make notes. I’m a very visual person to go back and re-read.

The modules are accessible twenty-four hours a day, seven days a week, can be fully or partially completed, and can be completed in any location with a laptop/computer and Internet connection. Further, Articulate Storyline software offers the option of producing the modules as standalone packages by copying them onto a disc. Consequently, learners would not need Internet access to complete the training;
thereby, providing increased flexibility and opportunities for use. In contrast, instructor-led courses halt facility operations to train numerous people in a synchronous environment (Berge & Giles, 2008). A space needs to be provided for the session to occur, scheduling conflicts may arise, and it is difficult to organize sessions when one or more people cannot attend.

Forty-percent of the participants indicated that they appreciated having the ability to control the pace of the training. Staff members noted that they skipped familiar content and focused on learning new information and one staff member turned off the audio features to complete the modules faster. Only one staff member reported that she would repeat modules when needed. Both teachers noted that they liked having the ability to progress through the modules at their own pace, repeat content as needed, and return to the modules without losing their progress. One teacher also discussed how the audio features helped with her preference of auditory learning. This emphasized differences between the staff members and the teachers in their approaches to the e:learning.

The combination of multi-media approaches (audio, images, and text) incorporated into the design of the e:learning modules was intended to engage learners. Roy (2006) describes interactivity as a strategy of encouraging learners to produce thoughtful responses to the material. The participants who said that they appreciated the different levels of interactivity and formats of the e:learning were teachers. Teachers might be more inclined to appreciate the interactivity due to their professional backgrounds, familiarity with pedagogical goals, and course development. They might focus on different learning strategies. Moreover, they might approach the e:learning
differently than staff member as they will use the material in different contexts. For example, teachers may focus on applying theoretical concepts to situations in LTCF rather than focusing on the provision of choice when helping a resident bathe as they may be limited in what they do in LTCF. Staff members had a tendency to dislike the interactive course features which is discussed later in this chapter. There is thus a tension between the preference for interactivity on the part of teachers, for pedagogical reasons, and the preferences of learners.

Instructor-led training sessions are not always conceptually accessible for learners. If learners enter late, leave early, or are interrupted during the session learners may not have access to missed content. Additionally, learners cannot control the pace that material is delivered. Learners can ask questions in classroom-led sessions, but can be hesitant or unwilling when the content is on sensitive/controversial topics such as, ethics. In instructor-led sessions some staff members may be forced to sit through familiar content due to the varying degrees of education levels which wastes their valuable time and can be frustrating. Monica’s feedback supported this since she was familiar with some of the content, but she could choose what she wanted to focus on.

Registered Nurses are required to have a four-year university degree (Butcher & MacKinnon, 2015; Cruttenden, 2006), Licensed Practical Nurses obtain college certificates averaging two-years (Gould et al., 2013), and Resident Attendants have little to no formal education and may receive on the job training Registered Nurses provide approximately 20% of the hands-on care to residents while Licensed Practical Nurses and Resident Attendants each provide approximately 40% of the hands-on care to residents (Cruttenden, 2006; Surviving - Sustaining - Thriving - New Brunswick
E-learning is an effective method for providing uniform education to every staff member. New staff members can easily receive training and all staff members may have shared a common language with which to discuss the ethical issues they encounter.

Six LTCF in New Brunswick participated in this research. While every LTCF agreed to allot staff members the time to complete the modules during their shifts, only one facility upheld that arrangement. Participants were from two LTCF and one educational institution. Supportive leadership is necessary to cultivate change for long-term care staff members (Stolee et al., 2005). Berge and Giles (2008) assert that leaders need to promote the use of the training and encourage staff members to participate in its use. A facilitator to the uptake of knowledge is support from management. Augustsson et al. (2013) suggest that management needs to be willing to encourage, provide support, direction, and guide staff members to apply learned skills in practice.

Support from management encourages participants to complete the modules (Janes et al., 2009). For example, learners being given adequate time, resources, and space to complete the modules. Amber explained,

And I took the time. I was able to come in here in this office and take the time and I was very fortunate my, my employer who was on board with this was very willing and understood that in order for this to be completed I needed that time. And I took as much time as I needed for that, which was very, very good.

Behavioural support stems from management practicing and engaging in the desired learned behaviours. Janes et al. (2009) uphold that when managers participate in
and promote the use of training, staff members may be more receptive to changing their behaviours. In contrast, Augustsson et al. (2013) contend that if management does not support educational initiatives staff members might experience frustration as they cannot use learned skills. LTCF managers may influence the culture within the facility. 

Castle and Lin (2010) maintain that managers, who rarely provide care to residents, make decisions related to the facilities underlying structures and care processes that directly affect staff members and residents. These decisions include how resources such as, money, staffing, health, information technology, and equipment are distributed within the facility. High attrition rates of management can be problematic in the provision of care in LTCF as new managers focus on learning routines and processes rather than on the quality of care being delivered (Castle & Lin, 2010). Pijl-Zieber et al. (2008) assert that creating a relational environment where nurses can openly communicate about their experiences can help them feel supported in decision-making. Both staff members and residents can benefit from relationship-oriented care practices.

Toles and Anderson (2011) claim staff members are responsible for information sharing, problem-solving, and providing feedback to each other to ensure the complex care needs of residents are met. They argue that relationship-oriented care practices that encourage staff members’ participation in decision-making produces positive outcomes relating to improved resident behaviour, increased satisfaction, and individualized care. When nurses are partners in developing policies and practices they are empowered to be active partners in decision-making rather than passive recipients (Pijl-Zieber et al.,
2008) resulting in lower job strain, increased satisfaction, and better staff retention (Toles & Anderson, 2011).

The modules provide a common language that staff members can use to communicate about ethics. The modules’ scenarios helped participants develop a clearer understanding of the resident’s experiences, and could also help them to accept troubling situations (Olson et al., 1991). To illustrate, if a resident falls repeatedly she could die if it happens again, yet she insists on walking unassisted. Participants may have been more willing to accept her decision to walk and set aside their own values if they understood how walking increased her quality of life and contributed to her well-being. Additionally, e:learning provided insight on topics one which participants had not previously reflected.

Hsu (2011) asserts that nurses need to know what they do and do not know, and need to be aware of multiple approaches that can be used to make decisions in practice. The training materials introduced new information to participants, elaborated on information that they already knew, and encouraged them to approach topics from different viewpoints. Participants translated these skills into practice in different ways. For instance, Amber modified her approach to information sharing to respect the residents’ right to privacy. Gracie developed the language to describe diagnostic overshadowing which prepared her to respond to a situation that arose in practice resulting in individualized care being provided to one resident. Further, Ella learned about assent which could improve the experiences of non-verbal residents if she provides them with opportunities to assent (or not). Ella acknowledged the importance
of considering points-of-view other than her own which might increase her willingness to collaborate with others or be more understanding of other people’s perspectives.

To utilize the strengths of e:learning the modules can be uploaded to the current infrastructure, Itacit, or copied onto compact discs and made available to all staff members. Management needs to be willing to promote the use of the training both instrumentally and behaviorally by shifting the focus from routine to person-centred care. To illustrate, a manager would not reprimand a staff member who did not clean up a wash-basin and dirty towels immediately, if, instead, she was socializing with a resident to alleviate his loneliness.

5.2.B Weaknesses of the ethics e:learning modules

Although the benefits of e:learning are clear, it is vital to identify the internal, negative, weaknesses (Berge & Giles, 2008) that can influence the ethics e:learning program. These include the technological infrastructure and the staff members’ abilities to access the required software, hardware, and have a designated space to complete the training. Further, staff members also require support for technical issues. The participants’ thought processes continued to focus on sensational ethical dilemmas rather than microethical issues.

Berge and Giles (2008) identify one weakness that can affect the adoption of e:learning: the technological infrastructure at the facility. It is crucial that processes exist to support changes (Dirksen, 2012) and that staff members have consistent access to the software (Berge & Giles, 2008). Further, staff members are required to have
working relationships with the information technology department so that they can reach out to them when they need assistance (Berge & Giles, 2008).

The Internet is a tool that many organizations use for immediate access to collect and share information (Barnett, 2000; Bernaschi, Aiutolo, & Rughetti, 1999). Barnett (2000) explains that it provides benefits to an organization through connecting internal and external users worldwide; however, challenges can also arise with its use. An organizations’ network can be subject to internal and external threats including viruses, the interception of sensitive data, the misuse of resources, and network infiltration (Barnett, 2000; Bernaschi et al., 1999). Consequently, information technology departments are responsible for both passively managing the network by observation and actively managing the network by controlling access, using user authentication, and developing data encryption to minimize threats (Barnett, 2000). The size of the LTCF can influence the amount and type of support available.

Larger LTCF tend to have dedicated information technology departments that manage their equipment and networks; whereas, smaller facilities may not have dedicated information technology departments. Larger facilities may have a lot of equipment such as computers which can be dedicated to training initiatives; whereas, smaller facilities may have minimal equipment made available to staff members. As a result, in smaller facilities staff members may not have access to a computer, be required to share the computer(s) with several other people, and/or have outdated equipment which creates challenges in accessing training.

Moreover, larger facilities may exert more control over access to the Internet, specific websites or domains; however, they may be better prepared to address technical
challenges that arise. In contrast, smaller facilities may offer greater flexibility in accessing websites, but may not have a dedicated technical support team. Consequently, in a larger facility staff members might not have access to outside resources such as, “Google” or may not want to dedicate time to gaining access to the websites needed to complete the training. At one for-profit LTCF it took more than two months and several requests from the Chief Executive Officer to gain access to the learning management system website on-site as the information technology department restricted access to that website. In contrast, in smaller facilities staff members may be able to access external resources, but may not have a dedicated information technology team available to address technical problems that might arise. When staff members experience technical issues, they may quit the training since they have no one to contact for support.

Staff members need access to working hardware (i.e., laptop/computer) (Berge & Giles, 2008). Four of the ten participants in this study borrowed laptops in order to complete the training. Participants need access to equipment to use the training. One participant suggested that the modules be printed out and kept in binders so that they can be referenced quickly at the facility. After having completed the modules online participants could have access to paper copies of the modules if they needed to revisit a topic during their shifts.

Participants need an environment that is conducive to learning when engaging with the e:learning material. In this study, one participant explained that the computer at her LTCF was housed in a staff room where staff came and went for various reasons. She was unable to complete the modules at work due to the traffic in and out of the
room, the socializing, and the distractions. Participants needed a private space when using the e:learning to ensure that they could absorb the material, listen to the audio (when needed), and were free from distractions. This dedicated space needs to have the contact information for the information technology department so that staff members know whom to contact if issues arise.

When participants encountered technical issues they generally sought help immediately without troubleshooting on their own. For instance, participants would sometimes attempt to use an incompatible web-browser, and when there were problems accessing the materials would often demand immediate results rather than trying to resolve it herself first. On more than one occasion I was told to “fix it now,” or, “I will quit,” and “I don’t have time for this.” Although, it was reasonable for participants to expect working modules participants were clearly instructed to use a compatible web-browser. Problems relating to the learning management system were understandably very frustrating, but, again, participants wanted immediate resolutions, reflecting the immediacy of the care-culture, the task-based mind-set, and the social conditions of their work. Ethics was viewed as a task to be completed rather than understood as a process in which to engage. Ethics is a continuous process of enhancing understanding rather than a task with a definite beginning and endpoint which might conflict with how work can be organized in LTCF.

Task-oriented mindsets were also apparent in Mabel’s desire to have the questions appear immediately following the content. This suggested that she found it troublesome (i.e., too time consuming) to take notes, but preferred an immediate response to the question to complete the module (a task). The task-oriented mind-set
was also reflected in other participants who only wanted to respond to multiple choice rather than short-answer format questions.

The participants’ task oriented and time-limited approach to the ethics modules might reflect the realities of the organizational structure. Long-term care staff members often work in environments subject to chronic under-staffing (Pijl-Zieber et al., 2008). Bowers et al. (2003) found that in United States Certified Nursing Assistants are responsible for delivering high-quality, efficient care under labour-intensive circumstances while receiving little remuneration. In this study, the Certified Nursing Assistants reported that they would leave their current roles to work in equally demanding, low-paying positions to obtain positions where they felt they were valued and/or felt that their suggestions were taken into consideration.

Mabel, Peach, and Monica all preferred multiple choice questions rather than short-answer written ones. For Monica, the written responses were too time consuming and could: “be grueling at times.” Although Peach took notes she commented that she would: “much rather have a more detailed question with an answer or a multiple choice.” She explained: “for me to write it out I tend to lose my train of thought.” These suggestions reflect pragmatic thought processes. These participants wanted to finish the task of answering the question rather than viewing the e:learning as an opportunity to engage in the process of ethical reflection to enhance their ethical awareness. The weaknesses that can influence the implementation of the ethics e:learning program can be addressed through careful planning.
To address the weaknesses of implementing the ethics e:learning program the information technology department can complete extensive testing to ensure the training materials function as intended on the LTCF equipment prior to giving participants access. This includes ensuring all features such as, triggers and audio are functioning. Additionally, participants need to be provided simple, clear instructions on accessing the modules. A quiet, dedicated space needs to be made available for participants to progress through the modules. Additionally, a process for staff members to report technical problems that arise to the information technology department needs to be in place. Reported problems need to be addressed within a reasonable time-frame.

5.2.C Opportunities for implementing the ethics e:learning modules

Opportunities are the external, positive factors (Berge & Giles, 2008) that can influence the ethics e:learning initiative. External factors affecting the successful uptake of the ethics e:learning program can include New Brunswick’s rapidly aging population, the complexity of care required in LTCF, the culture shift that promoted person-centred, individualized care in LTCF, and the rapid growth of e:learning.

New Brunswick is a small, mainly rural province located in Atlantic Canada. According to the New Brunswick Association of Nursing Homes (2014), New Brunswick has the second oldest population in Canada and has the highest percentage of individuals over the age of sixty-five per capita. Youth in New Brunswick migrate for employment from rural areas to larger cities (NBANH, 2014). New Brunswick LTCF provide care for 3-4% of the aging population, a population that is expected to increase from 122,000 to 188,750 by 2039 (NBANH, 2014). Although the population
growth places higher demands on New Brunswick LTCF so too does the complexity of care required by residents.

Individualized care contributes to residents’ well-being, but the provision of individualized care requires recognition of the problems arising in LTCF. Janet stated: “the tone of your voice, it’s your personality that can set a resident off or somebody can go in who has no problem with them, but if you’re very perky and some of them like quiet.” Janet’s statement emphasizes that people have individual preferences, but time and effort need to be dedicated to uncovering these to ensure care that suits the resident is provided. Further, awareness on how to appropriately care for people with varying medical circumstances needs to be raised.

Mabel described how a diagnosis can shape care practices, “when you just say that someone has dementia or Alzheimer’s or something like that we do, we do tend to, just to say, “He has dementia” and that’s it. You know and, and make the choices for him.” Diagnostic overshadowing connects people’s behaviours to diseases with which they are living, such as dementia, and discounts other circumstances that could contribute to that behaviour (Hassiotis et al., 2003). Residents should not be denied the opportunity to make choices due to having dementia. Education can give priority to this type of issue and promote change.

Augustsson et al. (2013) claim that staff members need to develop new competencies since residents have increasingly complex medical and psychiatric problems. People who reside in LTCF have varying needs. They require twenty-four-hour supervision and need assistance with personal and medical care. Many residents experience comorbidities, meaning that they have two or more chronic diseases or
conditions, which increases their dependency on staff members. Additionally, increasing numbers of residents have some form of dementia (Knopp-Sihota et al., 2015). Cruttenden (2006) asserts that staff members require specialized knowledge and skill sets to ensure that they provide holistic care and meet residents’ psychosocial as well as physical needs. Janet concluded: “you really have to know your resident to know how to care for them.” Enabling staff members to provide better care can be accomplished by the provision of adequate resources.

Participants perceived residents as more dependent on staff members than they were in the past and suggested that there were fewer staff members available to provide care. Mabel explained:

Years ago, we had five full-time RN’s, no, patient-care attendants, and now we’re down to three. So, you can tell we have lots of part-times and things, but we didn’t need it thirty-seven years ago, because people coming in the nursing homes were people that were in their sixties, seventies, and eighties, and nineties and they were [um] driving their own cars really couldn’t stay alone. That was the only thing. And now it’s like totally different. The people that we’re, we’re admitting are like so, so much worse. The, the level of care is so bad and [uh] it’s not only just dementia, but it’s like people are in wheelchairs a lot worse. They can’t get around and things like that so, you know, it’s just, it’s a lot heavier workload.

In other words, while the workload is heavier the number of available staff members decreased leaving staff members caught in the middle of providing care to
residents who need their help within the constraints of the organization – an ethical crisis for them to navigate on a daily basis.

Koren (2010) informs us that the culture change movement seeks to modify LTCF from paternalistic health care institutions to home-like environments that provide services to individuals in need. According to Buchanan (1978), paternalism, the historically dominant approach to care, involved physicians exerting control over patients by: lying to, withholding information from, or engaging in decision-making on their behalf. He explains that this approach was justified since physicians sought to act in the best interests of the patients. Gervais (1998), however, suggests people wanted decision-making to reflect their personal values and beliefs, which contributed to shifting care practices that emphasized the patient’s autonomy.

The goal of the culture-change movement in LTCF is to improve quality of life and quality of care for residents (Zimmerman, Shier, & Saliba, 2014). The LTCF culture change movement encourages the creation of homelike atmospheres in which residents have choice through collaborative decision-making, and empowering staff members (Koren, 2010). The culture shift from paternalism to person-centred care emphasizes the need for well-trained staff members to achieve these outcomes.

McGilton et al. (2012) claim that providing person-centred care does not eliminate clinical responsibility to residents; rather the primary goal is to respect the person’s autonomy and use a collaborative approach to include the resident in his/her care which vastly differs from previous approaches to care (such as, paternalism). Elements of these goals can be accomplished through the ethics e:learning program, an innovative method of educating long-term care staff members.
Web-based learning has received increased attention over recent years (Santally & Alain, 2006) due to the expansive growth of Internet usage from forty million users in 1996 to over one billion users in 2006 (Davis & Wong, 2007). Companies and educational institutions use e-learning to educate people who might not otherwise be able to participate due to: being employed full-time, having family responsibilities, and/or living at a distance (Davis & Wong, 2007). E-learning addresses these challenges. Ruiz et al. (2007) suggest e-learning through the Internet provides portability over numerous sites.

Opportunities that promote the use of ethics e-learning include the increasing number of long-term care residents who have complex needs that require staff members who have specialized knowledge and skill-sets (Cruttenden, 2006). The culture-change movement encourages LTCF to shift away from routine-centred care and provide person-centred care to residents by promoting improved quality of life and well-being. Additionally, e-learning is a useful method of educating staff members and can eliminate challenges associated with traditional teaching methods. Although several factors positively influenced the success of the e-learning program a number of threats have also been identified.

5.2. D Threats to implementing the ethics e-learning modules

Threats are the external factors (Berge & Giles, 2008) that can negatively affect implementing the e-learning program into LTCF. Im and Chee (2003) assert that empiricism influenced the development of nursing resulting in black or white answers and dismissing gray areas. They describe that, as a discipline, nursing was dominated
by pragmatism which involves “action.” The lines of thought that influence care-practices are examined relative to my findings.

Healthcare ethics discourse was formed as a sub-category of medical ethics which led to the discourse focusing on highly-charged ethical dilemmas (Varcoe et al., 2004). Im and Chee (2003) assert that academic nursing also inherited positivism which promotes objectivity and diminishes subjectivity. Carrie explained:

I’ve worked in long-term care for almost thirty years and I’m a nurse so I can say this, that we are, in healthcare, very task-oriented. As much as we think we’re not, you know, we need to get the beds made, we need to, you know, get all these things done that we believe have to be done in our shift versus really paying attention to the resident.

Such pragmatic, task-oriented thought processes influenced participants’ perceptions of the modules. Clinical nursing is dominated by pragmatic philosophies (Im & Chee, 2003) which refer to: “action” or “doing” (Doane & Varcoe, 2005, p. 82). Monica’s comments outlined this regarding her work in LTCF:

I felt that some of the questions were really broad … you would really have to put a lot of thought, and time, and effort into being [um] [um] just covering everything that you’d want to cover that it just, it just, it’s a matter of time and [um] I, you know, I felt time constraints were kind of the issue.

The e:learning modules were designed to be interactive and engage participants; however, three participants, all of whom were staff members, suggested that the modules needed to get to the point faster rather than require the participants to explore
options and draw their own conclusions. This suggested that staff members viewed the modules as another task to be completed rather than perceiving them as a process of learning in which to engage. As a parallel to completing the modules Mabel described providing care for residents as: “it’s just the time that they’re allotted and some people only take a few minutes to do up and then that’s it. You don’t see that person again for the rest of the day.” It could be inferred that if staff members take the same approach to the e-learning then after completing a module they would move on to the next one and would not reflect on the content.

If the modules were merely understood as tasks to be completed, participants would have missed the opportunities to engage with and critically reflect on the material. In doing so they risked rushing through the content to complete the task rather than absorbing the information and thinking about ways to utilize techniques arising in their daily practice. This might reflect why participants, after completing the modules, still said that they did not have the time to do things such as provide choice to residents. Mabel claims that staff members: “tend not to let them make the decisions and things like that because they don’t have the time to do that.” Many of the suggestions offered in the modules were not time-consuming, for instance, asking a resident if she would prefer taking a shower instead of a bath or identifying whether the water temperature in the bathtub was comfortable for the resident. Providing this choice can be meaningful to the resident and promote her well-being.

When education is perceived as a task to be completed it can compete with the other tasks staff members have in their daily roles. As such, education could be deprioritized. Ethics training requires dedicated time for staff members to engage with
and reflect on the material rather than feeling pressured to get it finished to move on. The modules were designed to be interactive for participants.

The modules were designed with high-levels of interactivity and low levels of variability to engage learners and avoid having to constantly reorient themselves to ever-changing formats (Dirksen, 2012). Additionally, they were designed to avoid habituation which occurs when same image appears repeatedly causing the learner to no longer notice or ignore that image (Dirksen, 2012) - for instance, if the coloured markers appeared on every slide in the same place participants would habituate and no longer click on them. Therefore, these markers only appeared on some slides and in different locations to draw the participants’ attention to them.

Some content was repeated to promote retention. For example, assent was defined. Next, a slide displayed an example of assent. Following this, the definition of assent reappeared. This format encouraged retention in two ways: First, through repetition, and second through the creation of information networks using examples that can help the learner recall information at a later time (Dirksen, 2012). Frequent exposure to the information under different circumstances can help learners retain information.

During the second focus group Sue claimed that: “it really doesn’t take a whole lot of time to make somebody feel like they’re important.” For Sue, time was not used as an excuse for why ethical action could not occur in practice unlike other participants who felt time pressures were the biggest obstacles to providing choice. Ella explained: “It’s just you know doing what you can in an allotted amount of time basically. You don’t really think too much outside the box.” Another element that affected the
participants’ engagement with the e:learning were their preconceived notions of ethics as demonstrated by the content participants suggested should be added to the modules.

Participants who made suggestions for additional content focused on dramatic ethical issues (Varcoe et al., 2004). Not one participant suggested the inclusion of microethical or “everyday” issues (Hasselkus, 1997) encountered in her daily role. This was interesting as such daily or minor concerns were predominantly discussed in the modules. This may reflect how biomedical discourse influences ethics in LTCF (Varcoe et al., 2004).

Participants suggested topics such as, Medical Assistance in Dying, helping family cope with end-of-life care, violence towards staff members, and residents forming relationships. Each of these are relevant topics that require serious critical reflection, but they present as highly-charged, ethical dilemmas. While these topics can be integrated into the current content or developed as modules, some of these topics are not decisions most staff members encounter in daily practice. Also, they are not decisions that a staff member would typically make alone. The goal of the training was to provide concrete methods for daily ethical decision-making rather than to explore uncommon sensational topics. I am not diminishing the importance of these topics, but some of these materials would be less pertinent to some staff members than others. For instance, a Resident Attendant does not make decisions regarding Medical Assistance In Dying but, the same Resident Attendant does make decisions on whether she provides the resident a choice on what he would like to wear, eat, and the activities he will participate in. The relevance of the topics can impact learner motivation.
Each participant needed to take responsibility for enacting learned behaviors. Dirksen (2012) informs us that participants can be intrinsically motivated or extrinsically motivated. She explains that intrinsically motivated learners seek out information for self-development; whereas, extrinsically motivated learners are mandated to participate and comply due to external reward or punishment. Motivation influences whether or not learners use the content they learn. Dirksen (2012) believes an externally motivated learner can be changed into an intrinsically motivated learner by ensuring materials are designed to be relevant to them. For instance, scenarios that resonated with staff members’ experiences were integrated into the e:learning. Staff members have a finite amount of time to engage in decision-making; therefore, they may rely on their experience or intuition.

Often nurses tend to make decisions based on their experiences since they can decide without taking a lot of time to process or reflect on the information (Thompson et al., 2005). My findings support these claims in two ways. First, Ella stated:

I feel like in some cases the best interests, if they’re not competent, are like physical health benefits. … you could meet their nutritional requirements or you could decrease their risk of falling or things like that, like it’s, it’s less of meeting their mental needs, unfortunately, and more of a meeting their physical needs.

Here, when residents are not competent (i.e., are living with dementia) measurable tasks to meet their physical needs are prioritized and their mental needs are set aside even though this can negatively affect the quality of life and well-being for people who are not “competent.”
The second was from one participant who dropped out of the study. She was allotted an additional week, given time while at work to complete the modules, had already finished seven of the ten modules, and at the time she left the research had five weeks to complete three modules, but still felt that the time pressures were too much. In this instance the training might have been neglected to ensure other tasks were accomplished at work.

In LTCF there are social, political, economic, and institutional factors that influence the delivery of care (Beagan & Ells, 2007). Each stakeholder has a different goal that is being sought after. Health care is entwined with corporate ideologies and the need to maximize efficiency has created barriers against staff members from being able to perform person-centred care (Beagan & Ells, 2007). Since the focus in LTCF tends to be on physical care, the work becomes both task-oriented, and time-determined. It is not surprising, therefore, that participants transferred this approach to the ethics training.

In Canada, each province is responsible for designing and maintaining the LTCF system that governs funding, regulation and legislation (Laxer et al., 2016). In some provinces, such as Ontario, full-time staff members receive benefits; however, part-time and casual staff members are excluded from this (Laxer et al., 2016). In LTCF a significant portion of staff members are either part-time or casual and they do not receive benefits (Laxer et al., 2016). Many staff members, especially at these lower levels, have second, or even third jobs, which impacts on their ability and energies to
engage in what might be seen as additional to the requirements of the job such as additional training.

For Knopp-Sihota et al. (2015), staff members delivered routine-centred physical care to residents. Work is organized around routines and structures that ensure efficiency (Allen, 2004). Organizational constraints and staffing shortages contribute to problems in the efficient delivery of care (Knopp-Sihota et al., 2015; Pijl-Zieber et al., 2008). Consequently, residents’ psychosocial needs might go unmet and may be deprioritized so that tangible tasks are completed (Allen, 2004; Knopp-Sihota et al., 2015; Pijl-Zieber et al., 2008). Gracie explained:

I know I couldn’t work in a nursing home. I know I couldn’t because I would not have the time to do what I wanted to do and to meet all of the needs. Right? And so when it comes down to it, we have to prioritize and yes, we have to meet those physical needs first, so I understand it, but I don’t think I could do it and sleep at night because it’s, it’s I don’t know how you guys do that. It’s, I just, it’s too hard on so many levels.

A tension exists between the concrete tasks such as lifting a person or helping a person eat and conceptual, abstract ethical thought. Abstract thought involves forming ideas based on something that is not tangible such as, happiness, freedom, or love. Happiness exists, but the feeling is not observable or measurable. Woods (2005) found that most nurses did not confront situations that threatened their values, a finding supported by Sue’s statement:
I haven’t really had any ethics come up since I’ve done it, but [um]
just the you know, I will keep, I always keep it in mind now when
I’m working with my dementia patients.

Sue worked full-time in a LTCF. She encountered ethical decision-making every
day, yet, she distanced herself from her role as a decision-maker.

A possible threat of these modules is that they enhanced the participants’ ethical awareness, but organizational constraints might have prevented them from enacting ethical behaviour. This could heighten rather than reduce the moral distress experienced by participants. Ageist attitudes and underfunding perpetuates a cycle where staff members are forced to work in environments that do not meet their own personal standards of care (Rees et al., 2009).

Some participants avoided the ethics of the situation. For instance, Ella disagreed with the following question: “Kali has dementia, but would like to wear a tank top in December. Kali does not go outside. The staff member, Sheryl, gives Kali a sweater to wear. Should Kali’s capacity be considered in this decision?” In Ella’s immediate written feedback, she disagreed with this question since the facility she worked in was so cold that the: “resident would be freezing if they were wearing a tank top.” Ella’s response avoided the ethical issue about Kali’s autonomy and instead raised another ethical issue. Why was the facility where Ella works so cold that she described it as “freezing?” Thompson et al. (2005) suggest learners may avoid applying new skills due to resistance of changing proven methods. In Woods’ (2005) view, staff members may ignore or comply with the ethical issues that they encounter to fit in with their colleagues.
The ability to identify ethical dilemmas is not enough to ensure ethical practice. Nurses have felt as though they cannot act, are unclear as to what to do, or feel overruled by other staff members when responding to ethical issues (Woods, 2005). For Allen (2004), a discrepancy between the organizational values and the nurses’ values is prevalent in LTCF. Management promotes operational efficiency while front-line staff members want to provide care that aligns with their personal and moral values.

Mabel, who worked as a front-line staff member, identified that she was not aware of the role ethics played in LTCF and, after completing the modules, “it really has made me think of working there for all those years and me doing the things that, that your scenarios were and not, not thinking anything about it and not giving them the choice.” Front-line staff members worked one-on-one with residents and needed access to ethics education; yet, some people have worked in LTCF for decades and have had little or no exposure to ethics. This can have significant implications for residents who may: have their rights infringed on, be denied choice, and have their psychosocial needs neglected.

During the pre-intervention thirty participants agreed to participate in the intervention. Of those thirty participants, three people participated, all of which were from non-profit LTCF. During recruitment, staff members from the for-profit facility cited time constraints as the reason why they would not participate. One staff member claimed that she was, “all about ethics,” but “didn’t have time” [to dedicate to training]. One not-for-profit LTCF did not allot time to staff members to complete the training, but two people continued on to the intervention. The second LTCF was a not-for-profit
and allotted time for participants to participate in focus groups and the training. Forty percent of the participants were from this LTCF.

Every for-profit facility failed to deliver on the agreement to allot time for staff members to work on the training. The modules were slightly longer than originally anticipated; however, the not-for-profit facility allotted a time-frame for completion (twenty minutes per week) while the for-profit facilities did not allot any time. Further, when addressing the technical accessibility of the modules the turnaround time at one for-profit facility was over two months and had to be requested several times by the company’s Chief Executive Officer before access was granted.

To mitigate these threats nursing practice needs to be reimagined by shifting the focus from task-based, routine-centred care to the provision of person-centred care in practice. It is necessary to demonstrate that person-centred care can be achieved while completing other work, for example, having a conversation with a resident while completing another chore such as, putting laundry away or including residents in activities, for example, asking a resident to distribute drinks or fold towels alongside staff members. It is helpful to note that it is acceptable for a task to go unfinished.

Carrie explained:

    if they’re having an off day, well who cares if the bed is made?
    Someone will make it eventually or you know what? I’m sure
    some of us have gone to work or gone to school and haven’t made
    our bed and we’ve crawled into bed the same way we left it that
    morning… if we can continuously add staff who are task-oriented
    that’s all we’re going to get…
Carrie went on to explain that residents’ mental health is commonly dismissed. She asserted that hiring additional care aides may not be as effective as hiring full-time social workers to meet residents’ emotional needs. Tasks are objective and easily measurable from an operational perspective, but this does not provide a holistic model of care. Residents are people who have social, emotional, and mental health needs that ought to be recognized and addressed rather than cast aside.

5.3 Summary

This chapter was divided into five sections. In the first section I described knowledge translation, the process integrating research findings into practice. Next, I analysed participants’ experiences with the ethics e:learning program using a SWOT analysis, looking for the internal strengths and weaknesses, and external opportunities and threats, to implementation. The strengths included cost-effectiveness, accessibility, consistency, and the positive influence leadership may have; weaknesses included accessibility to materials, the learning environment, technical support with minimal turnaround time; opportunities included the New Brunswick population growth, complexity of care, culture change movement, and the growth of e:learning; and threats involved the development of nursing discourse and how ethics are perceived in LTCF. The final chapter, “concluding remarks” summarizes the research and makes recommendations for future research.
Chapter six: Concluding remarks

6.0 Research Goals

Fleming (2007) warns that ethical dilemmas arise in everyday practice in LTCF, yet few concrete methods exist to address these problems. Additionally, there are no standardized educational requirements on ethics for those working in health care settings (Cline et al., 2012; Fleming, 2007). Staff members have varying degrees of experience and education and they provide care to individuals who have complex medical and psychosocial needs (Cheston and Bender, 1997). Ethics is a continual process of enhancing understanding to reach greater depths and is an important skill set that can be taken for granted in care settings. Cruttenden (2006) asserts that staff members need specialized knowledge and skill sets to provide care to residents. In response to the need for ethics educational materials, I designed an ethics e:learning program, asked long-term care staff members, students, and teachers to use it, and interviewed participants to gain their perspectives on their experience in using the program. I then applied a SWOT analysis to examine the internal strengths and weaknesses and the external opportunities and threats that could influence the implementation of the program in New Brunswick LTCF.

My findings corroborated claims made by Harrington and Walker (2002) and Kontio et al. (2011) who described one strength of e:learning was the participants’ abilities to control the learning environment. In this study, over 50% of the participants expressed that they enjoyed controlling the pace and the features of the learning environment. Some shifts in the participants’ ethical reasoning occurred; however, it
was unclear how this knowledge could translate into practice. I also found that participants focused on dramatic ethical issues (Varcoe et al., 2004), and the everyday ethical issues (Hasselkus, 1997) were still not receiving sufficient attention. While some findings were supported by the literature, disagreement also emerged between the literature and the participants’ experiences of using the ethics e:learning.

The pre-intervention demonstrated a need for ethics education in long-term care environments and my findings endorsed this. Half of the participants expressed that they gained new knowledge about the role of ethics in long-term care, or learned details about concepts they were aware of, but not to the degree that was needed in practice. New Brunswick LTCF had the infrastructure in place to distribute these modules, but pragmatic thought processes served as a barrier to implementing the ethics education.

Harrington and Walker (2002) suggested interactivity could enhance the learning environment and motivate learners by creating a stimulating and engaging environment. My findings contradict this since three participants, all of whom were staff members, wanted less interactivity in the e:learning. Thus, reflected the commonly-held pragmatic, task-oriented thought processes existing in long-term care environments. This research showed parallels between staff members’ perceptions of the training and their task-oriented care practices.

Changes within the organization need to occur to support the ethical development of long-term care staff members. The workplace culture needs to place value on educational initiatives to support staff members. LTCF need to support a “learning organization” which combines both the “adaptive learning” and the “generative learning” to enhance the current situation (Senge, 2006). “Generative
“learning” (Senge, 2006, p. 192) seeks to accomplish a goal while “adaptive learning” (Senge, 2006, p. 14) seeks to simply maintain the status quo. By combining both a “learning organization” (Senge, 2006, p. 14) can continually transform itself. In LTCF continual growth could meet the needs of staff members by, hiring more staff members, providing time and space for staff members to complete training, and promoting a holistic model of care for residents. LTCF need to promote a shift away from task-centred, efficiency-driven care and instead place value on ensuring that the psychosocial needs of the residents as well as the physiological needs are met and, more importantly, are equally valued. While task-oriented care practices exist, there are opportunities for future research.

6.1 Further research

The findings from this research into ethics e:learning in LTCF provide insight on the strengths, weaknesses, opportunities, and threats of implementing an ethics e:learning course in New Brunswick LTCF. Increasing participants’ ethical sensitivity might not lead to enacting learned skills in practice due to the organizational constraints and work place culture. Beliefs about ethics education need to be reframed away from tasks needing to be completed toward understanding ethics as a process of enhancing and promoting individualized, person-centred care.

To evaluate whether knowledge translation can occur in clinical settings a longitudinal, observational study on ethical decision-making could be conducted. First, participants will be observed in practice and how they identify, approach, and resolve ethical dilemmas they encounter will be examined. Following this, participants will
engage with ethics e:learning training for three to six months. I would recommend the inclusion of video clips in the training to enhance the e:learning environment. During and following the six-month period participants will be observed to identify whether changes in practice occur. The goal of this research will be to explore whether knowledge translation can take place in practice and to identify the barriers and perceived constraints that prevent long-term care staff members from engaging in ethically sound practice. Methods to overcome the real and perceived barriers will be developed.

6.2 Summary

It is evident that LTCF in New Brunswick need a systematic method of approaching and resolving ethical issues in practice; however, the task-oriented model that currently exists in LTCF is a barrier to the implementation of ethics e:learning education. Ethics is a continuous process of reflection, enhancing, and refining skill-sets. Heightened ethical sensitivity can ensure staff members deliver high standards of care which can increase the resident’s quality of life. When staff members can act ethically they might experience reduced moral distress which in turn can increase job satisfaction. Some participants had heightened ethical awareness and sensitivity after completing the modules; however, many participants viewed the training as a task to be completed and felt that they could not enact learned skills in practice which puts them at risk of experiencing moral distress. Although task-oriented care practices are still prevalent in LTCF in New Brunswick the ethics e:learning program does provide current and future long-term care staff members with strategies to resolve the difficult
ethical dilemmas that they encounter in their daily roles and may help LTCF achieve the goal of providing person-centred care.
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Appendix A: Long-term care facilities cover letter

August 2016

Dear Participant

Thank you for taking the time to read the information provided in this pack. Here you will find details of a research project we are undertaking on the difficult decisions faced by long-term care staff. If you have participated in an individual interview and focus group please read the information provided in the “returning participants envelope A” package enclosed. If you have not participated in an individual interview and a focus group please read the information provided in the “new participants envelope B” package. Please read the information in the package that applies to you and discard the package that does not.

If you have any questions about the research before deciding whether or not to participate please contact me on 506.206.2004. If I am not in please leave a message and I will get back to you as soon as I can. Alternatively, you can email me at jestey1@unb.ca.

I look forward to hearing from you.

Yours

[Signature]

Jennifer Estey, BA

Brian Mulroney Hall, St Thomas University, Fredericton, New Brunswick, Canada E3B 5G3
Tel: 506.206.2004 Email: jestey1@unb.ca
Appendix B: Long-term care facilities new participants contact information

August 2016

Dear Participant

Thank you for taking the time to read the information provided in this pack. If you have not participated in an individual interview and a focus group please read the information provided in the “new participants envelope B” package and discard the “returning participants envelope A” package.

Enclosed in the “new participants envelope B” you will find, an information sheet and a focus group consent form. If, after reading the information sheet, you would like to take part in the research, please return the consent form and the slip from the bottom of this letter with your contact details using the return envelope and we will be in touch to arrange a time to come and speak with you. If you have any questions about the research before deciding whether or not to participate please contact me on 506.206.2004. If I am not in please leave a message and I will get back to you as soon as I can. Alternatively, you can email me at jestey1@unb.ca.

I look forward to hearing from you.

Yours

Jennifer Estey, BA
I am interested in participating in the research project “Evaluating ethics training in long-term care”.

Name: 
Tel: 
Address: 
Email: 

Best days/times to contact you:

Brian Mulroney Hall, St Thomas University, Fredericton, New Brunswick, Canada E3B 5G3
Tel: 506.206.2004 Email: jestey1@unb.ca
Appendix C: Long-term care facilities returning participants contact information

St. Thomas University
CANADA RESEARCH CHAIR IN NARRATIVE STUDIES
CENTRE FOR INTERDISCIPLINARY RESEARCH ON NARRATIVE

August 2016

Dear Participant

Thank you for taking the time to read the information provided in this pack. If you have participated in an individual interview and a focus group please read the information provided in the “returning participants envelope A” package and discard the “new participants envelope B” package.

Enclosed in the “returning participants envelope A” package you will find, an information sheet, a focus group consent form and an interview consent form. If, after reading the information sheet, you would like to take part in the research, please return the two consent forms and the slip from the bottom of this letter with your contact details using the return envelope and we will be in touch to arrange a time to come and speak with you. If you have any questions about the research before deciding whether or not to participate please contact me on 506.206.2004. If I am not in please leave a message and I will get back to you as soon as I can. Alternatively, you can email me at jestey1@unb.ca. I look forward to hearing from you.

Yours

Jennifer Estey, BA
I am interested in participating in the research project “Evaluating ethics training in long-term care”.

Name: ____________________________ Tel: ____________________________
Address: ____________________________

Best days/times to contact you:

______________________________ ____________________________

BRIAN MULRONEY HALL, ST THOMAS UNIVERSITY, FREDERICTON,
NEW BRUNSWICK, CANADA E3B 5G3
Tel: 506.206.2004 Email: jestey1@unb.ca
Appendix D: Long-term care facilities focus group consent form

St. Thomas University
School of Social Work, Fredericton, NB CANADA E3B 5G3

EVALUATING ETHICS TRAINING IN LONG-TERM CARE

FOCUS GROUP CONSENT FORM

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I agree to participate in the focus group for the purposes of the research described in the information sheet.

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I understand that I do not have to answer a question if I do not want to and can stop participating in the focus group at any time.

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I agree to the focus group being audio recorded.

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I understand that the discussion within the group is private and not to be shared with anyone outside of the group.

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I understand that participation is voluntary and that I may withdraw from the research at any time up until the final report and that if I choose to withdraw all information (audio, text and personal information) will be destroyed.

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Agreement:

I understand that by signing this consent agreement I am not giving up any of my legal rights.

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EVALUATING ETHICS TRAINING IN LONG-TERM CARE

You are being asked to participate in a research study. Before you decide, it is important that you read the following information and ask as many questions as you want so that you are clear what will be asked of you.

What is the research about?
The proposed research is about how people working in long-term care (long-term care) facilities make decisions concerning the care they provide and the people with whom they work. We are interested in the difficult decisions that people working in long-term care facilities face, how they deal with these, what support they receive and what might be done in order to help them.

Why have I been invited to participate?
You have been invited to participate because you work in a long-term care facility.

Who is conducting the research?
Dr. Clive Baldwin is leading the research. He is Canada Research Chair in Narrative Studies at St Thomas University (STU). The research has been approved by the Research Ethics Board of STU.

If I am interested in participating, what should I do?
If you are interested in participating, please contact Jennifer Estey indicating your interest and to ask any questions you might have. You can do this by phone, e-mail, or regular mail:

Jennifer Estey, Rm 313, Brian Mulroney Hall
St Thomas University, Fredericton, NB  Canada E3B 5G3
Phone:  506.206.2004          Email: jestey1@unb.ca

What does participating in the research involve?
In agreeing to participate in the research you are agreeing to four things. First, to participate in a focus group where you will be asked to discuss a number of situations in which people working in long-term care facilities might be faced with difficult decisions as to the right thing to do. These situations will be based on interviews we have conducted but will not be taken from any particular participant’s experience. The purpose of the focus
group is to generate discussion as to how difficult situations might be resolved. The focus groups will be audio recorded.

Second, to use online ethics training materials over a period of approximately three to four months. The materials are broken up into short sections so you won’t be asked to spend more than 20 minutes at any one time looking at them. There will be approximately 10 sections – so this works out to about one each week, though you can do them at any time.

Third, you will be asked to take part in a short interview, (approximately 45 minutes long) about your experiences of using the materials. The interview will be arranged at a time convenient to you. You can be interviewed at a place of your choosing – at home, at the University or in a room where you work. The interview will be audio recorded with your consent.

Fourth, you will be asked to join a focus group to discuss a number of situations in which people working in long-term care facilities might be faced with difficult decisions as to the right thing to do. These situations will be based on the interviews we conduct but will not be taken from any particular participant’s experience. The purpose of the focus group is to generate discussion as to how difficult situations might be resolved. The focus groups will be audio recorded.

We will also ask you for a small amount of personal information (for example, age, gender, ethnicity) that will help in the research – all of which will be kept completely separate from the interview material.

Any expenses incurred as a result of participating (for example, travel costs to interview) will be met by Dr Baldwin.

**What will happen to the information I provide?**

Interviews and focus groups will be typed word for word (transcribed) and all identifying personal information removed. The information will then be analysed and used in reports, journal articles, conference presentations and educational materials. All information will be edited so as to minimize the possibility that you could be identified. All information will be stored in locked filing cabinets and/or password protected computer files and will be destroyed seven years after completion of the research.

**Will the information I give be confidential?**

Yes. Only the research team will have access to the information you give us. Transcribers will be required to sign confidentiality agreements. All information will be treated in confidence, unless you told us about another person being harmed or at risk of being harmed, or about an unresolved or future crime.

All identifying information will be removed from the information you give us.

We ask participants to agree to maintain the privacy of what is discussed in the focus groups. While we expect that everyone will respect this, we cannot guarantee that they will do so.

**What are the benefits of participating in the research?**

While you might find it interesting to participate in the interview and focus group it is unlikely there will be any direct benefits to you individually as a result of participating in the research. At this stage, the purpose of the research is to evaluate the effectiveness of online learning in ethics education.
What are the risks of participating in the research?

There are no particular risks involved in participating in the research. Everything you say in the interview will be confidential and we will not share with your employer any information that could identify you.

We are aware that discussing difficult decisions might prompt some uncomfortable feelings, in which case you will be asked whether you need a break or would like to stop the interview. The interviewer will be able to point you towards sources of support if you so wish.

Can I change my mind about participating in the research? And what will happen if I do?

You are free to withdraw at any stage without having to give a reason. If you decide to withdraw then all information you have supplied and can be attributed to you will be destroyed.

Will I be able to see the outcomes of the research?

Yes, you can ask to be put on the list to be sent a summary when it is available. When the research is completed a report will be available on the website.

Who do I contact if I have a question or want further information?

Please contact Jennifer Estey at the address above.

If you have questions regarding your rights as a participant in this study, you may contact the Chair of the St. Thomas University Research Ethics Board, reb@stu.ca

If during your participation you have any concerns about the conduct of the research or want to make a complaint, please address these, in the first instance, with Miss Estey. If you are not satisfied with the response, you may contact:

Chair, Research Ethics Board, reb@stu.ca
Appendix F: Long-term care facilities interview consent form

St. Thomas University
School of Social Work, Fredericton, NB CANADA E3B 5G3

EVALUATING ETHICS TRAINING IN LONG-TERM CARE

CONSENT FORM (INTERVIEW)

CODE:

Initial to indicate agreement

I would/would not (delete as appropriate) like to receive a summary of the research findings.

I have read and understood the information sheet and have had the opportunity to ask questions which have been answered to my satisfaction.

I agree to the interview for the purposes of the research described in the information sheet.

I understand that I do not have to answer a question if I do not want to and can stop the interview at any time.

I agree to the interviews being audio recorded.

I understand that participation is voluntary and that I may withdraw from the research at any time up until the final report and that if I choose to withdraw all information (audio, text and personal information) will be destroyed.

Agreement:

I understand that by signing this consent agreement I am not giving up any of my legal rights.

Name of Participant (please print)    Signature of Participant    Date

Signature of Investigator    Date
Appendix G: Educational institution cover letter

St. Thomas University

CANADA RESEARCH CHAIR IN NARRATIVE STUDIES
CENTRE FOR INTERDISCIPLINARY RESEARCH ON NARRATIVE

January 2017

Dear Participant

Thank you for taking the time to read the information provided in this pack. Here you will find details of a research project we are undertaking on the difficult decisions faced by long-term care staff. Please read the information provided in this package.

Enclosed in the package you will find an information sheet, a focus group consent form, and a prepaid return envelope. If, after reading the information sheet, you would like to take part in the research, please return the consent form and the slip from the bottom of this letter with your contact details using the return envelope and we will be in touch to arrange a time to come and speak with you. If you have any questions about the research before deciding whether or not to participate please contact me at 506.206.2004. If I am not in please leave a message and I will get back to you as soon as I can. Alternatively, you can email me at jestey1@unb.ca.

I look forward to hearing from you.

Yours

Jennifer Estey, BA

I am interested in participating in the research project “Evaluating ethics training in long-term care”.

Name: 
Address: 
Tel: 
Email:

Best days/times to contact you:

Brian Mulroney Hall, St Thomas University, Fredericton,
New Brunswick, Canada E3H 5G3
Tel: 506.206.2004 Email: jestey1@unb.ca

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EVALUATING ETHICS E: LEARNING MATERIALS FOR USE IN LONG-TERM CARE ENVIRONMENTS

You are being asked to participate in a research study. Before you decide, it is important that you read the following information and ask as many questions as you want so that you are clear what will be asked of you.

What is the research about?
The proposed research is about how people working in long-term care (long-term care) facilities make decisions concerning the care they provide and the people with whom they work. We are interested in the difficult decisions that people working in long-term care facilities face, how they deal with these, what support they receive and what might be done in order to help them.

Why have I been invited to participate?
You have been invited to participate because you are a personal care assistant or nursing student.

Who is conducting the research?
The research is being conducted by Dr. Clive Baldwin, Canada Research Chair in Narrative Studies at St Thomas University (STU), and Jennifer Estey, a Master’s student at the University of New Brunswick (UNB). The research has been approved by the Research Ethics Boards of STU and UNB.

If I am interested in participating, what should I do?
If you are interested in participating, please contact Dr. Baldwin indicating your interest and asking any questions you might have. You can do this by phone, e-mail, or regular mail:

Dr. Clive Baldwin, Rm 313, Brian Mulroney Hall
St Thomas University, Fredericton, NB Canada E3B 5G3
Phone: 506.452.9596 Email: baldwin@stu.ca
What does participating in the research involve?

In agreeing to participate in the research you are agreeing to three things. First, to use online ethics training materials over a period of approximately three to four months. The materials are broken up into short sections so you won’t be asked to spend more than 20 minutes at any one time looking at them. There will be approximately 10 sections – so this works out to about one each week, though you can do them at any time.

Second, you will be asked to take part in a short interview, (approximately 45 minutes long) about your experiences of using the materials. The interview will be arranged at a time convenient to you. You can be interviewed at a place of your choosing – at home, at the University or in a room where you work. The interview will be audio recorded with your consent.

Third, you will be asked to join a focus group to discuss a number of situations in which people working in long-term care facilities might be faced with difficult decisions as to the right thing to do. These situations will be based on the interviews we conduct but will not be taken from any particular participant’s experience. The purpose of the focus group is to generate discussion as to how difficult situations might be resolved. The focus groups will be audio recorded.

We will also ask you for a small amount of personal information (for example, age, gender, ethnicity) that will help in the research – all of which will be kept completely separate from the interview material.

Any expenses incurred as a result of participating (for example, travel costs to interview) will be met by Dr Baldwin.

You will receive a $50 gift certificate for completing the training modules and participating in the interview and focus group. This will be mailed to you following the focus group.

What will happen to the information I provide?

Interviews and focus groups will be typed word for word (transcribed) and all identifying personal information removed. The information will then be analysed and used in reports, journal articles, conference presentations and educational materials. All information will be edited so as to minimize the possibility that you could be identified.

All information will be stored in locked filing cabinets and/or password protected computer files and will be destroyed seven years after completion of the research.

Will the information I give be confidential?

Yes. Only the research team will have access to the information you give us. Transcribers will be required to sign confidentiality agreements. All information will be treated in confidence, unless you told us about another person being harmed or at risk of being harmed, or about an unresolved or future crime.

All identifying information will be removed from the information you give us.

We ask participants to agree to maintain the privacy of what is discussed in the focus groups. While we expect that everyone will respect this, we cannot guarantee that they will do so.
What are the benefits of participating in the research?
While you might find it interesting to participate in the interview and focus group it is unlikely there will be any direct benefits to you individually as a result of participating in the research. At this stage, the purpose of the research is to evaluate the effectiveness of online learning in ethics education.

What are the risks of participating in the research?
There are no particular risks involved in participating in the research. Everything you say in the interview will be confidential and we will not share with your employer any information that could identify you.

We are aware that discussing difficult decisions might prompt some uncomfortable feelings, in which case you will be asked whether you need a break or would like to stop the interview. The interviewer will be able to point you towards sources of support if you so wish.

Can I change my mind about participating in the research? And what will happen if I do?
You are free to withdraw at any stage without having to give a reason. If you decide to withdraw then all information you have supplied and can be attributed to you will be destroyed.

If you withdraw before participating in the focus group, you will not be eligible for the $50 gift certificate.

Will I be able to see the outcomes of the research?
Yes, you can ask to be put on the list to be sent a summary when it is available. When the research is completed a report will be available on the website.

Who do I contact if I have a question or want further information?
Please contact Dr Clive Baldwin at the address above.

If you have questions regarding your rights as a participant in this study, you may contact the Chair of the St. Thomas University Research Ethics Board, reb@stu.ca

If during your participation you have any concerns about the conduct of the research or want to make a complaint, please address these, in the first instance, with Dr Baldwin. If you are not satisfied with the response, you may contact:

Chair, Research Ethics Board, reb@stu.ca
Appendix I: Educational institution focus group consent form

St. Thomas University
School of Social Work, Fredericton, NB CANADA E3B 5G3

EVALUATING ETHICAL LEARNING MATERIALS FOR USE IN LONG-TERM CARE ENVIRONMENTS

CONSENT FORM (FOCUS GROUP)

CODE:

I have read and understood the information sheet and have had the opportunity to ask questions which have been answered to my satisfaction.

I agree to participate in the focus group for the purposes of the research described in the information sheet.

I understand that I do not have to answer a question if I do not want to and can stop participating in the focus group at any time.

I agree to the focus group being audio recorded.

I understand that the discussion within the group is private and not to be shared with anyone outside of the group.

I understand that participation is voluntary and that I may withdraw from the research at any time up until the final report and that if I choose to withdraw all information (audio, text and personal information) will be destroyed.

I understand that if I withdraw prior to participating in the focus group, I will not be eligible to receive the $50 gift certificate.

I understand that by signing this consent agreement I am not giving up any of my legal rights.

Name of Participant (please print)  Signature of Participant  Date

____________________________________  ___________________________
Signature of Investigator  Date

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Appendix J: Educational institution interview consent form

St. Thomas University
School of Social Work, Fredericton, NB CANADA E3B 5G3

EVALUATING E-THOSE: LEARNING MATERIALS FOR USE IN LONG-TERM CARE ENVIRONMENTS

CONSENT FORM (INTERVIEW)

CODE:
I would [ ] not [ ] (delete as appropriate) like to receive a summary of the research findings.

I have read and understood the information sheet and have had the opportunity to ask questions which have been answered to my satisfaction.

I agree [ ] to the interview for the purposes of the research described in the information sheet.

I understand that I do not have to answer a question if I do not want to and can stop the interview at any time.

I agree [ ] to the interviews being audio recorded.

I understand that participation is voluntary and that I may withdraw from the research at any time up until the final report and that if I choose to withdraw all information (audio, text and personal information) that can be attributed to me will be destroyed.

I understand that if I withdraw prior to participating in the focus group, I will not be eligible to receive the $50 gift certificate.

I would [ ] not [ ] (delete as appropriate) like to receive a summary of the research findings.

Agreement

I understand that by signing this consent agreement I am not giving up any of my legal rights.

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Appendix K: Indicative questions

Indicative questions

What was your experience of using the e:learning material?

What was helpful/unhelpful about the e:learning material? And why?

Were there additional topics that need to be covered in the material?

Is there anything you would like to see excluded from the material?

Was the material easy to navigate?

Were the objectives of the material clearly communicated to you?

What would you change about the e:learning material?

Have you continued to use the e:learning material?

Has the e:learning material changed how you approach difficult decisions? (e.g. more confident, more knowledgeable)

If yes, can you provide an example of this?

If no, can you explain why not?

Is there anything we have not covered that you think is important for us to know about your experience of using the e:learning material?
Curriculum Vitae

Candidate’s full name: Jennifer Lindy Estey

Universities attended: St Thomas University, Bachelor of Arts with Honours in Sociology, May 2015

Publications:


Conference Presentations: Canadian Association on Gerontology Hotel Bonventure August, 2016 Montreal, QC
Island Multi-disciplinary conference University of Prince Edward Island August, 2016 Charlottetown, PE
Graduate Research Conference University of New Brunswick April, 2016 Fredericton, NB
Student Research and Ideas Fair St Thomas University March, 2016 Fredericton, NB