Introduction

As technology applications in acute care multiply, the ethical implications of utilizing them can be difficult to anticipate. Because technologies differ, issues that nurses face may be different, resulting in an under-reporting of concerns. Additionally, when an information system is meeting a hospital’s goals, there may be a reluctance to expose “hidden” dilemmas. There are situations in acute care where professional and ethical values conflict with organizational goals (protocols). Ethical drift is described as “an almost indiscernible move toward cutting corners when making the best of a bad situation”. Moral drift is a behavior “whereby the choice between the lesser of two evils somehow makes it right” (Kleinman, 2006). Conflicts of interest occur when competing interests influence the motivation of the nurse.

The Study

This dissertation study was a mixed methods survey conducted in collaboration with American Association of Critical Care Nurses and approved by The University of Texas Health Science Center IRB. A sample of 297 AACN Registered Nurse Members voluntarily responded to an email survey and described the problems and workarounds encountered using information technology at the bedside. These Ad Hoc findings were not part of the dissertation research questions but emerged from the qualitative data. Data was analyzed using MAXQDA software and nurse narratives characterizing moral and ethical drift were simply categorized as such.

87% of respondents were female, 13% male (n=296). 58% of the nurses were 45 years old or greater. Almost 50% of the nurses had a bachelor’s degree in nursing, while 19% had an associate’s degree (n=296). 58% of the nurses had a bachelor’s degree in nursing, 20.6% an associate degree and 19.9% had a masters degree. Nurse experience was midway between a proficient and expert level. 42% of the nurses worked in mixed intensive care units, 11 % in surgical intensive care units, 10.5% in coronary care and 9.5% in medical ICU units. PICU and NICU was represented. The acuity of the patients were reported as: 61.8% critical, 28.7% guarded and 9.2% stable. PICU and NICU was represented. The acuity of the patients were reported as: 61.8% critical, 28.7% guarded and 9.2% stable.

Results

Ethical Drift: Incremental deviation from ethical practice that goes unnoticed and is justified as acceptable. Ethical drift occurs over time and the actions rationalized as reasonable given the set of circumstances or challenges in the workplace (Kleinman, 2006). 1. “When bar code of an insulin bottle will not scan, I can take several barcodes off the multi-use vial and tape them securely to my badge” 2. “Frequently computer bogs down and unresponsive for 5-10 minutes. Triple check and administer meds without scanning…then scan in empty drug wrappers when system comes back up.” 3. “I will not list all my IV medication titration changes that I made just to keep from having tobeg someone to put in their password several times for each change” 4. “Scan barcodes and all meds outside of room, especially if patient is on contact precautions” 5. “Verification of IV pump settings for analgesic and sedative drips requires finding a 2nd RN who must also enter their info two and sometimes three different times for each patient. We found we can enter settings to be verified throughout shift (without needing a witness) and then at the end of shift the witnessing RN enters their info once and all the fields fill in automatically”

Moral Drift: A behavior whereby the choice between the lesser of two evils somehow makes it right (Kleinman, 2006). 1. “Doctors unable to enter orders correctly; particularly medication orders. I put the order in myself” 2. “When initially signing into computer a blocked screen comes up and the RN has to enter a height and weight. To get past that you have to enter any number no matter what then change it later” 3. “Titrating drips to fit the order, even if actual titration different” 4. “Many places on assessment have only certain choices and no place to free text what is not on the list. You must either leave it blank (and get in trouble) or put what is closest to the assessment and this is not right either.”

Results

Moral Drift: Continued….. 5. “Nurses check badges instead of medications when obtaining a double verification—the computer and administration are happy but the medication does not get double checked.” 6. “I frequently need to complete documentation that is "required" by institution policy but is not available from the patient or truly assessed.” 7. “for instance if a patient is on a vent they must be on peridex mouth care Bid. The assessment only has a 'yes' for peridex mouth care. If MD does not order or patient refuses we have no way to chart that and the get told we have to fill out our assessment completely” 8. “Change the real administration time. Otherwise the system wants an explanation why medication wasn’t given on time. Set yourself up for an investigation”

Conflict of Interest: A conflict between the private interests and the official responsibilities of a person in a position of trust 1. “If barcode not readable give med without scanning and chart reason as ‘other patients care’ whether it is true or not. Borrow meds from other patient.” Could chart as “Barcode not readable” but this means counselling from management for each non-scan (and an e-report MUST be completed or else it is another counselling event” 2. “Our scan rate percentages on our end of year evaluations must be greater than 95% so if we follow full documentation by saying med was given but not scanned we are dinged.” 3. “I could not scan one medication. If you do not scan your medications it will reflect in your personal scan rates.” 4. “Another barcode mismatch option is to trick out by choosing "not given" with a reason code like "schedule adjust", then proceeding to next screen where you are supposed to scan the patient. At this point you can change it back to “given” and proceed with the patient scan. Apparently this does not count against your scan rates.” 5. “Organization is using computer charting as audit and disciplinary tool.”

Conclusions

The purpose of this work was to present nurses’ narrative descriptions of moral and ethical drift when utilizing health information technology (HIT) protocols in acute care. Raising awareness of dilemmas faced by nurses utilizing HIT can help to inform future studies. These ad hoc findings were part of a dissertation which examined nursing workaround behaviors. These narratives describing nurses’ workarounds when using technology are indicative of a larger pattern. As is found frequently in the literature, ethical dilemmas and moral distress can negatively impact a nurse’s well-being and the healthcare workplace environment. As the use of technology in acute care expands, hospitals, vendors, administrators and informaticists have a responsibility to evaluate when professional and ethical values might conflict with organizational goals (protocols) Anticipating potential ethical mismatches during workflow analysis and post implementation could provide an opportunity to reduce their occurrences and improve the health of the nurses work environment.

Bibliography