Roberta Young MSN, RN
President NDNA

Greetings Colleagues,

North Dakota Nurses Association is proud to bring you a new refreshed look to the Prairie Rose, the “North Dakota Nurse.” The NDNA newsletter has had several looks and names over the years as our nurse leaders have strived to provide you valuable content. This newsletter is also providing you a CE offering on Advance Care Planning. We would really appreciate your feedback and so please post any comments on the NDNA Facebook page (ndna@ndna.org).

In April of this year, ANA published the first revision of the Code of Ethics of Nurses since 2001 and Guide to the Code of Ethics for Nurses and Interpretive Statements. (Both published by Nursebooks.org the publishing program of the American Nurses Association). These are key foundational documents for our practice. As defined by ANA this is our, “guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession.” (2015.nursingworld.org).

I encourage you to get your own copy and review the nine revised provisions for current nursing practice. It is our role to define the professional practice of nursing for our interdisciplinary partners and uphold our accountabilities to the public we serve. The Code of Ethics for Nursing provides us the structure for articulating just that. ANA describes the value of this work,

- Provides a succinct statement of ethical values, obligation, and duties of every individual who enters the nursing profession.
- Serves as the professional’s nonnegotiable ethical standard.
- Expresses nursing’s own understanding of its commitment to society.” (Nursingworld.org, About the Code. 2015)

As I have been reviewing the Code, I see the connection to the work many of us are doing to improve the culture of safety in our practice settings. The revision of the Code is the first to articulate more than reporting of errors but actual promotion for a culture of safety and is found in the 3rd Provision: The Nurse promotes, advocates for and protects the rights, health and safety of the patient. Although we all know the importance of speaking up when we see short cuts, unsafe practice, or non-adherence to safety practices such as vigilant hand hygiene, but what prevents us from taking action? Our clear accountability, according to the Code, is not only speaking up or reporting actual errors but also near misses so we can analyze and evaluate our practice and systems for improvement. Health care needs our passion and brains to be involved and engaged in this work.

Often in a day’s work the discovery to improve culture of safety starts with the thought of “this just doesn’t feel right.” Then we make a decision to follow that thread or not. Do we dig down to the...
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□ Medicare

□ Other

□ Type of Work Setting: (e.g. hospital)

□ Medicare

□ Other

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□ Medicare

□ Other

□ Employment Status: (e.g. full-time nurse)

□ Medicare

□ Other

□ Current Position Title: (e.g. staff nurse)

□ Medicare

□ Other

□ RN License #: State

□ Medicare

□ Other

Please note: 2014 membership dues begin at 50% of ANA membership dues for newly licensed RNs, students, and non-licensing bodies. Nurses must be licensed for at least one year in order to qualify for these reduced membership rates. Membership dues vary by state. Visit joinndna.org to check rates in your state.

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**Writing for Publication in The North Dakota Nurse**

The North Dakota Nurse accepts manuscripts for publication on a variety of topics related to nursing. Manuscripts should be double spaced and submitted electronically to MS Word to director@ndna.org. Please write North Dakota Nurse article in the address line. Articles are peer reviewed and edited by the RN volunteers at NDNA. Deadlines for submission of material for 2015 North Dakota Nurse are 3/19/15, 6/19/15, 9/18/15 and 12/18/15.

Nurses are strongly encouraged to contribute to the profession by publishing evidence-based articles. If you have an idea, but don’t know how or where to start, contact one of the NDNA Board Members.

The North Dakota Nurse is one communication vehicle for nurses in North Dakota. Raise your voice.

**The Vision and Mission of the North Dakota Nurses Association**

Vision: North Dakota Nurses Association, a professional organization for Nurses, is the voice of Nursing in North Dakota.

Mission: The Mission of the North Dakota Nurses Association is to promote the professional development of nurses and enhance health care for all through practice, education, research and development of public policy.
reason why or engage a peer in helping you look at the situation with new eyes?
I once worked with a group of expert oncology nurses. They knew firsthand the devastation of blood stream infections and how vulnerable the patients they cared for were. When the data showed an increased rate of hospital infections in the patients they served, the nurses started acting like detectives to dig down and ask why, why, why. They were open and creative enough to even look outside their normal practice area to their colleagues in NICU who had dramatically decreased their infection rate. Through the diligent, open eyes approach to creating a safer environment for their patients, they made a significant impact to lessen and sustain a very low infection rate.
This is also an example of care that follows the Code of Ethics. The Oncology nurses were not defensive, they didn’t throw up their hands and say that we can’t make an impact, nor were they limited by just looking at familiar literature. Really a practical example of ethical, conscientious, meticulous work that resulted in safer patient care.

The Code of Ethics for Nursing is an important way that ANA influences our profession. Are you a member? I hope so. Being a member enables you to contribute to and participate in important work such as this. The work of the revision was done under the structure of ANA’s Professional Issues Panels. Approximately 300 ANA members across the nation were part of an advisory group to review, advise and comment on the revisions to ensure the Code’s relevance for today’s practice. If you are not a member please go to www.ndna.org and click on the Join Now button. You will find value in this. Happy end of summer!
Completion Requirements:
1. After reading the article, go to https://www.surveymonkey.com/s/NDNA-ACP to complete test questions and evaluation questions.
2. Passing score for the posttest is 90%. If you achieve a passing score a Certificate of Completion will be emailed to you for 1.0 contact hour.
3. This program will be open until September 30, 2015. No contact hours will be awarded after this date.

Disclosure
The planners, authors and content reviewers have reported no conflicts of interest. No commercial support or sponsorship was received for this program. The North Dakota Nurses Association is a member of the Midwest Multistate Division.

The Midwest Multistate Division is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Questions?
If you do not receive your Certificate of Completion or have problems completing the posttest and evaluation, please contact NP@minotstateu.edu or have problems completing the program. The North Dakota Nurses Association, 2006.

Definitions
Advance Care Planning – (ACP) – is a person-centered, engaging process of communication that facilitates individuals’ understanding, reflection and discussion of their goals, values and preferences for future health care decisions (Hammeres & Briggs, 2011).

Agent/Health Care Agent/Surrogate Decision Maker – an adult to whom authority to make health care decisions is delegated under a health care directive for the individual granting the authority (ND Century Code, 2015). As a health care agent makes decisions and takes actions that a patient would make or do, if able (American Bar Association Commission on Law and Aging & North Dakota Department of Human Services Aging Services Division, 2006).

CPR – Cardiopulmonary resuscitation. This includes chest compression, shock, vasopressors, and invasive and non-invasive respiratory support.

DNR/DNAR/AND – Do Not Resuscitate/ Do Not Attempt Resuscitation/Allow Natural Death (ANA, 2012). A code status that directs that CPR not be attempted or performed.

End-of-life – Although there is no formal definition for end of life (EOL); evidence supports the inclusion of several components: the presence of a chronic disease(s) or symptoms or persistent functional impairments though these may fluctuate; and theses symptoms or impairments require either supportive or palliative care (clinical or informal) or informal (unpaid) care and can lead to death (NIH, 2004). Note: there is no time frame, thus end-of-life may be imminent or months to years, usually the last year of life. NCP 2013 guidelines term serious or life-threatening illness is assumed to encompass populations of patients at all ages within the broad range of diagnostic categories, living with a persistent or recurring medical condition that adversely affects their daily functioning or will predictably reduce life expectancy.

Health Care Decision – consent to, refusal to consent to, withdrawal of consent to, or request for any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition including: a. Selection and discharge of health care providers and institutions; b. Approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; c. Directions to provide, withhold, or withdraw natural nutrition and hydration and all other forms of health care; d. Establishment of an individual’s abode within or without the state and personal security safeguards for an individual, to the extent decisions on these matters relate to the health care needs of the individual (ND Century Code, 2015).

Case Study Overview with Questions
The position will remain open until filled.

Competitive Salary
Please contact:
Bruce Pritschet, Division of Health Facilities Surveyor.
Immediate Openings Available
For info: 858.3101 or 1800.777.0750
www.minotstateu.edu/nursing
or email nuring@minotstateu.edu

Be seen. Be heard.
ACP is an ongoing process that may be informal or formal, comprising the development of a plan of care with appropriate legal documentation regarding the patient's desired life-sustaining interventions and the designation of a healthcare agent. ACP discussions are important to the delivery of comprehensive care across the life span and should be implemented while the patient is healthy and able to make decisions. Yet often, these discussions do not occur until serious illness or declining frailty with aging occur (Levi et al., 2010, Hinkley, 2011, Keeney, 2012, Heale, 2014).

Among seriously ill patients, prior communication about preferences for life-sustaining treatment is uncommon. A majority of patients have not discussed preferences for end-of-life care. Unspoken and undocumented preferences for care exist in a conflicted family with some members believing that “doing everything” is the only acceptable choice and all life-sustaining interventions are unnecessarily family distress when the patient is in need of emotional and spiritual support (Dahlin, 2014, IOM, 2014, Joyner & May, 2015).

However, ACP is not just for people who are aging or dying. “Every competent adult has the right and responsibility to make the decisions relating to the adult’s own health care, including the decision to have health care provided, withheld, or withdrawn (ND Century Code, 2015).” Ideally, ACP should occur over time with patients expressing and clarifying their preferences verbally and in writing before a healthcare crisis occurs. At any age, a medical emergency could leave someone too ill to make his or her own health care decisions. (Dahlin, 2014, IOM, 2014, Joyner & May, 2015).

Levi et al (2010) identified four distinct reasons why patients engage in ACP:

1) To be in control of their major life decisions;
2) Concern for the wellbeing of others;
3) Expectations about the efficacy of ACP related to trust in the medical system as well as predicted and proven effectiveness of treatment(s); and
4) Anecdotes, stories and experiences they had previously, in the past and the emotional responses to caregiving.


The second aspect of ACP is creating the health care directive reflecting the patient’s preferences for future health care if he/she is not able to speak for himself/herself. Health care directives express how patients would want to be treated, based on their values and beliefs, when they are unable to speak for themselves. Many people, including some health care professionals, believe that the requirements of ACP are satisfied by the patient completing a health care directive. While documents are important care decision-making tools at the end of life, they are ideally the end product of a process of conversations and decisions that the patient has made.

The third and final step is translating the patient’s wishes into medical orders. This can be done through tools such as the Provider/Physician Orders for Life Sustaining Treatment (POLST), Medical Orders for Life Sustaining Treatment (MOLST), or SAPO (State Authorized Portable Orders) forms. These orders translate the patient’s shared decisions into actionable medical orders. The POLST and similar forms enable all health care professionals, including trained emergency medical personnel, to provide the treatments that the patient wishes to receive. These documents have also demonstrated the ability to decrease the frequency of medical errors (ANA, 2010, VA, 2012, IOM, 2014).
Understanding Patient Preferences for Treatment and Care

Patients frequently do not know what treatments are available and how their values and beliefs can be reflected in their health care decisions. Families may not understand the meaning of life support measures and continue to withhold or withdraw options with the patient’s direct input or request. The patient’s wishes may change when a patient is actively dying. The patient’s goals of care could be to be cured, to live longer, or simply to improve or maintain their current level of function, quality of life, or be kept alive. The patient’s goals of care may change when a patient is actively dying. The patient’s willingness to have ACP conversations, some cultures and beliefs of patients are not receptive to discussing ACP; therefore, it is imperative that nurses lead the discussion. Many patients feel they do not have control over their care. The family and patients may be like; (Gross, 2006, Garner et al., 2013).

Table 1: Nurse Rated Communication Skills

1) Inform patients how their illness may affect their lives;  
2) Supply enough information so that patients understand their illness and treatment;  
3) Talk with patients and families about what their dying experience may be like;  
4) Discuss ACP in an honest and straightforward way;  
5) Deliver bad news in a sensitive way;  
6) Be sensitive to when patients are ready to talk about death;  
7) Be willing to talk about dying if or when the patient is ready to talk (Reinke et al., 2010).

Nurturing education and training are critical to the knowledge, skills, and attitudes that current and future nurses bring to the clinical care of patients with life-limiting conditions and must include content on ACP. With education and practice nurses can facilitate the components of advance care planning by:

1) initiating conversations;  
2) providing information and assistance to patients;  
3) facilitating patients’ determination of their preferences;  
4) assuring patients’ advance directives are properly stored and readily available once they are completed; and  

There is a need for nursing interventions to focus on improving communication at the bedside and in transitions of care with the development of ACP. ACP may be like; (Gross, 2006, Garner, Goodwin, McSweeney, & Kirchner, 2013).

The extent to which patients want to engage in ACP is variable, thus requiring support and training of health professionals to initiate such discussions at the right time, in the right place (Barnes & Barlow, 2011, Carpenter, 2013, Baudo, 2014).

Not only are nurses uniquely positioned to positively understand and influence patient desires and abilities to initiate and continue ACP discussions, it is part of their role (ANA, 2010). They are often the “constant” in a patient’s health care journey through a frequently fragmented health care system (Gross, 2006). Providing a continuous advocate for patients is important to the patient’s experience, especially as patients face serious and life-limiting conditions. (Peereboom & Coyle, 2012, Hall & Grant, 2015).

Patient Challenges and Obstacles to Advance Care Planning

The Role of the Nurse continued on page 7

Often, patients and their families consult nurses for advice, education and support when facing their decisions and options with the patient confronting serious or life-limiting illness. Nurses are ideally appropriate to facilitate goals-of-care discussions with patients, their health care agents and families. Respect for patient autonomy is imperative for effective ACP, thus positioning in the care of patients with serious and chronic illnesses, there are several options for quality end-of-life care. (Peereboom & Coyle, 2012, ANA 2010, ANA, 2012). Caring for others is the basic principle of nursing upon which patient advocacy is grounded (Seal, 2007) and patient advocacy is essential for quality end-of-life nursing care and it is part of their role (ANA, 2010). They are often the “constant” in a patient’s health care journey through a frequently fragmented health care system (Gross, 2006). Providing a continuous advocate for patients is important to the patient’s experience, especially as patients face serious and life-limiting conditions. (Peereboom & Coyle, 2012, Hall & Grant, 2015).

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When to Initiate Advance Care Planning Discussions

ACP discussions are optimally initiated in the outpatient setting when a patient is healthy and not in distress or crisis. However ACP occurs more typically for patients with advanced chronic illness in an outpatient setting some point during their last year of life. Transition points throughout the...
progressive illness trajectory provide opportunities to revisit the patient’s illness. These include prognosis, goals of care, treatment options, risks, benefits, burdens and anticipated outcomes specific to the individual. The nurse is often in the best position to alert the team to such opportunities. Major transition points include the time of initial diagnosis, disease progression, functional decline, and when disease-focused treatments are likely to cause risk greater than benefit. These transition periods can be times of psychological and existential crisis for the patient (Peereboom & Coyle, 2012, Dahlin & Wittenberg, 2015). Nurse specialists (those who are trained and specialize in palliative care and hospice) and generalists must be equally engaged and not have the expectation that one or the other is responsible for providing such discussions. Conversations with certain patients may be delivered primarily in any practice setting (Lorenz et al, 2005). Coordination of ACP efforts is especially important with patients suffering from serious illness or life limiting conditions. Patients and families often do want to have ACP conversations when initiated by a health care provider. Significant opportunities for ACP discussions include times when the patient asks about the future, talks about wanting to die or is experiencing serious or chronic illnesses(e) (ANA, 2010, Carpenter, 2013).

With hospital and long term care admissions, facilitated conversations about the ACP includes initiating conversations, providing information and assistance to patients, facilitating patients’ determination of their preferences, making sure patients’ advance directives are properly completed, stored and readily available and encouraging clinicians to follow advance directives (AAN, 2010).

How to Discuss Advance Care Planning

Nurses have the unique opportunity to engage patients in ACP. They have the opportunities through day-to-day interactions such as caring for the patient utilizing small talk, discussion of basic treatment issues, activities of daily living (ADLs), or personal care, which are more of a neutral level. A second opportunity would be with the treatment assessment, benefits and burdens, which allows the patient to be honest and direct. Equally important is to assess the burden of the patient’s distress or suffering. The final level of patient communication opportunity is the existential, where the patient is at the most personal sense of self. This is the most sensitive and distinct level of communication that includes disclosure, searching for meaning, and shared meaning (Peereboom & Coyle, 2012, Dahlin, 2014, Dahlin & Wittenberg, 2015). Whenever ACP discussions are initiated, regardless of the care setting, the first step is to utilize good listening skills, a skill in which most nurses excel. This listening phase can provide insight into the patient’s values and goals. This may include their understanding of the risks, benefits, burdens and anticipated outcomes specific to that patient. Along with treatment goals is the consideration of options for treatment and care based on the person’s goals and condition. This will promote shared decision-making and improved communication (see Table 2) (Dahlin, 2014, IOM, 2014).

Obtaining essential information about the patient’s background will stimulate values, family relationships, understanding of illness, goals of care and hopes for the future. All of these elements are essential in guiding patient and family-centered discussions regarding disease status and consideration of options for treatment and care based on the person’s goals and condition. This will promote shared decision-making and improved communication (see Table 2) (Dahlin, 2014, IOM, 2014).

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A comprehensive assessment of patient readiness, barriers to planning, and existing end-of-life plans is the next step. Even if exact plans are unknown, nurses can revisit the patient’s ideas and concerns over time, educating as needed (Carpenter, 2008, Keeney, 2012).

After assessment, the patient’s treatment goals should be explored. This may include their understanding of the risks, benefits, burdens and expected outcomes specific to that patient. Along with treatment goals is the identification of specific medical interventions patients decline because of burden or discomfort. This may require further inquiry based on the patient’s knowledge, experience and situation. A third component affecting treatment

<table>
<thead>
<tr>
<th>Table 2: Opening Statements/Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) “I am here to learn how to best help you and your family understand what is involved in ACP.”</td>
</tr>
<tr>
<td>2) “I need to ask you several questions to find the best way to help you plan for future medical needs.”</td>
</tr>
<tr>
<td>3) “We assist all adults to plan for unexpected events.”</td>
</tr>
<tr>
<td>4) “We like to be prepared, in case you cannot make your own healthcare decisions.”</td>
</tr>
<tr>
<td>5) “We think it is your right to know what your choices are and give you time to reflect and discuss.”</td>
</tr>
<tr>
<td>6) “This is a work in progress and today is only a beginning. We will take this at your pace.”</td>
</tr>
<tr>
<td>7) “Have you known anyone who became suddenly ill or injured? What was that experience like for you?”</td>
</tr>
<tr>
<td>8) “Help me understand what you know and believe about advance care planning (ACP) and/or healthcare (advance) directives.”</td>
</tr>
<tr>
<td>9) “One important decision we encourage all adults to make is who they would want to make decisions for them if something happened to them and they were not able to communicate their own wishes. Do you have someone you might consider asking to take on this responsibility?”</td>
</tr>
<tr>
<td>10) “Has anyone asked you about ACP in the past?”</td>
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<tr>
<td>11) “Have you ever helped someone with ACP?”</td>
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<tr>
<td>12) “Can you tell me what you understand about your health condition?”</td>
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<tr>
<td>13) “Have you thought about the future, if something was to happen to your health?”</td>
</tr>
<tr>
<td>14) “What is your understanding of CPR/DNR?”</td>
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<tr>
<td>15) “Do you have any religious, cultural or personal beliefs that might influence your preferences for life-sustaining treatments?”</td>
</tr>
<tr>
<td>16) “When you think about the last phase of your life, what’s most important to you?”</td>
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<tr>
<td>17) “How would you like the last phase of your life to be?”</td>
</tr>
<tr>
<td>18) “If you were near the end of your life, what kinds of aggressive treatment would you want (or not want)?”</td>
</tr>
<tr>
<td>19) “What is your understanding of options for treatment, testing, interventions and comfort you can receive?”</td>
</tr>
<tr>
<td>20) “What is most important for you to live well? What Matters Most?” (Hammes et al, 2015, Hammes &amp; Briggs, 2015)</td>
</tr>
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The American Nurses Association endorses nurses to actively participate in potentially difficult and emotionally charged conversations. (See Table 3 for some examples of these communication tools).

Table 3: Communication Tool Examples

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Benefit</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Ask-Tell-Ask</td>
<td>Method which allows nurses to carefully assess concerns before discussing information and education</td>
<td>Ascertains how much patient knows, wants to discuss, and want to know.</td>
<td>A: You ask What is CPR? They respond only what is on TV and they ask, does it work? T: You tell them about witnessed out of hospital versus in-hospital. A: You ask them what they understand and they repeat back what was said.</td>
</tr>
<tr>
<td>Tell Me More</td>
<td>Encourages dialogue in challenging situations</td>
<td>Often after patient/family conference, questions arise, opportunity to explore more regarding facts, explanations, meaning.</td>
<td>You: Mr. Johnson it sounds like it caught you by surprise. Can you tell me more how this illness is affecting you and your family?</td>
</tr>
</tbody>
</table>

Situation-Background-Assessment-Recommendation (SBAR) Standardized prompt that structure concise and focused information

S: You report to Nurse Nancy that Mr. Johnson is thinking about a healthcare agent. A: Mr. Johnson’s cancer has advanced to stage IV and hospice has been discussed. R: You state you have had a frank and open discussion with Mr. Johnson about having a healthcare agent and he is going to talk to his wife and children about it. Y: You recommend Nurse Nancy explore his understanding and if he has made a decision, wanting to complete a healthcare directive.

(Shannon et al, 2011, Peereboom & Coyle, 2012)

Overall, using communication tools and strategies, nurses should assess for any ACP documentation including the presence of a written health care directive. Once the fact of a written health care directive has been determined, the validity of the document must be established. Is it available, relevant, and up to date. (Hammes et al, 2015, Hammes & Briggs, 2015)

CPR and DNR/AND Discussions

One specific life sustaining treatment discussion outlined by the ANA is the do not resuscitate (DNR) order. Difficulties and confusion about these orders are common among patients, families, and healthcare providers. CPR is unique among medical interventions, since it is the only intervention where there is a presumption to provide the intervention exists, unless there are written medical orders not to attempt CPR (ANA, 2012).

Thus, by default, until the order changes, all adults are considered full code with CPR attempts to be initiated. Language matters and family members often misinterpret DNR orders as do not treat and thus giving permission to terminate an individual’s life as with other (non-life sustaining) interventions. Nurses often reflect on CPR discussions and conversations of benefits versus the burdens of treatment, comfort and symptom palliation and when aggressive attempts to sustain life with the understanding that life-sustaining technology will be withdrawn if it does not meet the goals agreed upon by the medical team, patient, agent, or family.

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choices is what specific treatments the providers have determined are within the framework of the patient’s care objectives.

The nurse is often the person who de Briefs the patient and/or family after the provider has delivered a new diagnosis or prognosis. Nurses then have the opportunity to reinforce the next steps in the plan of care including ACP. Some communication tools found in the literature have been found to be most useful for ACP. These tools offer nurses new strategies for approaching potentially difficult and emotionally charged conversations. (See Table 3 for some examples of these communication tools).

Case Study Discussion / Possible Solutions

Thomas Jones is 47-year-old gentleman with stage III metastatic colon cancer has had surgery and is now admitted in your facility and will be having chemotherapy. You personally have taken care of him in the past and have now been assigned to him again (not his current oncologist). He has a full code (CPR attempted), full treatment (all medical testing and interventions offered/implemented) without any documented discussion of life-sustaining care. His wife appears distraught and has said no one has explained anything to them—they do not know what is ahead.

1. What is your responsibility?

Response: First, let’s establish, truth, open communication and rapport with the patient and family. Establish an appropriate time for discussion. Identify and assess what their understanding is of the 1) medical diagnosis and condition, 2) prognosis, 3) CPR vs DNR/AND, 4) treatment options, risks, benefits, burdens and expected outcomes based on Thomas’s situation/conclusion.

2. What actions will you take?

Response: Answer questions, if unknown, acknowledge you do not know but find the answers for them. Elicit questions for the health care team. Involves other team players-chaplain, social worker, primary providers, both privately and with Thomas and his family. Establish if the plan of care reflects Thomas’s wishes, preferences, beliefs. Consider a family conference. Consider a facilitated conversation about values, beliefs, preferences discussed on Thomas and his family. Engage in a CPR/DNR/AND discussion. Speak privately to Thomas and then with his permission, with his family. Adopt communication strategies that work best for you and your working setting.

Summary

The nurse is an integral and trusted member of the health care team. Nurses have always been at the bedside of patients who are seriously ill, with life limiting conditions or dying. Nurses remain in the forefront as leaders and advocates for patients and their families. They are prepared to provide compassionate assistance and support for patients and their families in making quality of life choices throughout the lifespan, especially those pertaining to serious illness and life limiting conditions.

The role in providing the highest quality care, focusing on comfort, communication and support at the end of life for patients and their families is established, accepted, and expected. The nurse’s devotion and commitment to the patient requires the provision of comfort and includes expertise in the relief of suffering, whether physical, emotional, spiritual, or existential. To meet these needs, nurses must be educated, competent, and committed to ACP.

“We people need most on this journey is not the promise of the next technology but rather a guide to help navigate this dark forest in which they will undoubtedly find themselves.”

“Nurses need competence and commitment to supporting patients in ACP. Nurses serve as advocates for patient choices and interpreters of the many aspects of serious illness.”

Ferril, 2015

Advance Care Planning-Role of the Nurse Part III References


American Nurses Association (ANA). (2013). The American Nurses Association Endorses Nurses to actively participate in timely and frequent discussions on changing goals of care and initiate DNR/AND discussions with patients and their agents and families, confirm the agent’s and/ or family’s understanding that written and/or verbal documentation is reflected using the Patient’s condition. ANA supports methods that encourages nurses to more fully participate in end-of-life discussions with patients and families, including discussions surrounding DNR orders. ANA states that all nurses must enable that when respondents, the DNR decision is a subject of explicit discussion between the health care team, patient, and family (or designated surrogate), and that actions taken are in accordance with the patient’s wishes.“ (ANA, 2012).

Volandes, 2015

“The Role of the Nurse continued on page 9
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A nurse was named in a lawsuit after a 20-year-old male she saw in an urgent care clinic later died from one of the most dangerous forms of bacterial meningitis.

Case summary:

• The nurse attended to the patient and determined that he needed to go to the ER within 5 minutes of the patient arriving at the clinic.

• The patient’s girlfriend took him directly to the hospital, where he was triaged but showed no fever and normal blood pressure. The patient began showing signs of delirium nearly two hours later, and an hour afterward began to be treated for meningitis even though a diagnosis had not been confirmed.

• The patient was definitively diagnosed with Neisseria meningitis, Group B, the next day. He died less than 24 hours after arriving at the urgent care clinic.

The nurse was named, along with the clinic where she worked, the physician working at the clinic, the ER physician and the hospital, in a lawsuit brought by the parents of the patient. The parents alleged that if the nurse would have triaged the patient and the physician would have seen him, they would have recognized the symptoms of meningitis and administered antibiotics in time to save his life.

Defense experts supported the actions of the nurse in referring the patient to the ER immediately. Discovery also confirmed that the patient had been ill for several days before seeking help, and the defense concluded that no treatment could have reversed the course of the illness.

Despite this, her defense costs topped $125,000.

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1. Advance Care Planning (ACP)
   a. Is the completion of a healthcare directive
   b. Should be initiated when someone is seriously ill.
   c. Is a process of involving communication to discuss and plan for future healthcare decisions.
   d. Should be done with an attorney to make it legal.

2. When facing injury or serious illness,
   a. It is easier to identify stressors and make decisions.
   b. It can make healthcare decisions difficult.
   c. ACP should be delayed until the patient recovers.
   d. ACP should be initiated immediately.

3. Among seriously ill patients, prior communication about preferences for life sustaining treatment is
   a. Uncommon.
   b. Commonly initiated.
   c. Commonly completed.
   d. Dismissed.

4. Four distinct categories that explain patients’ reasons for engaging in ACP include being in control, concern for others, expectations of ACP efficacy and
   a. Comfort.
   b. Dialogue.
   c. Cultural norms.
   d. Past experiences.

5. The three major aspects of ACP are
   a. Conversations about options, completing a healthcare directive.
   b. Completing a healthcare directive, the attorney’s will, and medical order.
   c. Conversations, documenting preferences and wishes, translating to medical orders.
   d. Assigning treatment and comfort options using the POLST, MOLST and SAPO.

6. Patient’s preferences should include their values, beliefs, and preferences based on informed choices for
   a. Any and all treatment options.
   b. Only those treatment options that are effective.
   c. Treatment and comfort options for future.
   d. What their insurance will cover.

7. Nurses face challenges with ACP. These include their position/scope of practice, inadequate preparation and
   a. Disagreement with the physician’s prognosis and treatment plan.
   b. Agreement with the physician’s prognosis and treatment plan.
   c. Comfort in discussing the patient and family.
   d. Mentoring and multiple experience with ACP.

8. Nurses are in a unique position to advocate for patients and family. They should
   a. Have issues with listening attentively to physician’s discussions with patients.
   b. Confuse treatment options with patient’s preferences.
   c. Limit information and counsel with patients and families.
   d. Value communication skills as an important dimension of care.

9. In ACP, nurses have a duty to educate, encourage, support, ensure and communicate and
   a. Advocate.
   b. Arbitrate.
   c. Admonish.
   d. Acquire.

10. ACP discussions should be initiated during a crisis.
    a. In the ICU.
    b. In the ED.
    c. In the outpatient setting.

11. Nurses can engage patients in ACP with day to day neutral interactions as well as
    a. When the patient is in distress and suffering.
    b. With burdens of treatment assessments.

12. During the delivery of a new diagnosis, prognosis or family meeting, the nurse can
    a. Reinforce the patient’s preferences.
    b. Question the patient’s preferences.
    c. Reinforce the family’s preferences.
    d. Question the family’s preferences.

13. CPR and DNR discussions are
    a. Easy and straightforward conversations.
    b. Unique since CPR is presumed without an order.
    c. Only held in ER or ICU.
    d. The same as do not treat discussions.

14. The American Nurses Association (ANA) recommends that nurses
    a. Avoid confrontation about DNR orders.
    b. Actively participate in timely and frequent discussions.
    c. Refrain from participating in DNR discussions.
    d. Ensure the DNR decision is made by the family.

15. In the case study, Thomas and his wife were
    a. Accepting all treatment and full code without any reservations.
    b. Satisfied with the documentation of his goals of care.
    c. Comfortable with the explanations and decisions.
    d. Distraught without having explanations about the future.
illness in the healthcare industry, the U.S. most common causes of workplace injury and Department of Labor’s Occupational Safety and Health Administration announced the agency is expanding its use of enforcement resources in hospitals and nursing homes to focus on: musculoskeletal disorders related to patient or resident handling; bloodborne pathogens; workplace violence; tuberculosis and slips, trips and falls. U.S. hospitals recorded nearly 58,000 work-related injuries and illnesses in 2013, amounting to 6.4 work-related injuries and illnesses for every 100 full-time employees: almost twice as high as workplace violence; tuberculosis and slips, trips and falls. Emphasis placed on musculoskeletal disorders, bloodborne pathogens, workplace violence, tuberculosis and slips, trips and falls.

WASHINGTON — Targeting some of the most common causes of workplace injury and illness in the healthcare industry, the U.S. Department of Labor’s Occupational Safety and Health Administration announced the agency is expanding its use of enforcement resources in hospitals and nursing homes to focus on: musculoskeletal disorders related to patient or resident handling; bloodborne pathogens; workplace violence; tuberculosis and slips, trips and falls.

“Workers who take care of us when we are sick or hurt should not be at such high risk for injuries — that simply is not right. Workers in hospitals, nursing homes and long-term care facilities have work injury and illness rates that are among the highest in the country, and virtually all of these injuries and illnesses are preventable,” said Dr. David Michaels, assistant secretary of labor for occupational safety and health. “OSHA has provided employers with education, training and resource materials, and it’s time for hospitals and the health care industry to make the changes necessary to protect their workers.”

OSHA has advised its staff through a memorandum that all inspections of hospitals and nursing home facilities, including those prompted by complaints, referrals or severe injury reports, should include the review of potential hazards involving MSD related to patient handling; bloodborne pathogens; workplace violence; tuberculosis; and slips, trips and falls.

“The most recent statistics tell us that almost half of all reported injuries in the healthcare industry were attributed to overexertion and related tasks. Nurses and nursing assistants each accounted for a substantial share of this total,” added Dr. Michaels. “There are feasible solutions for preventing these hazards and now is the time for employers to implement them.”

For more information; to obtain compliance assistance; file a complaint or report amputations, losses of an eye, workplace hospitalizations, fatalities or situations posing imminent danger to workers, the public can call OSHA's toll-free hotline at 800-321-OSHA (6742).

Under the Occupational Safety and Health Act of 1970, employers are responsible for providing safe and healthful workplaces for their employees. OSHA’s role is to ensure these conditions for America’s working men and women by setting and enforcing standards, and providing training, education and assistance. For more information, visit http://www.osha.gov.
ANA Commends Introduction of the Registered Nurse Safe Staffing Act

Legislation Presents Balanced Approach to Protect Patients and Nurses

SILVER SPRING, MD – The American Nurses Association (ANA) commends Senator Jeff Merkley (D-OR) and Representatives Lois Capps (D-CA) and David Joyce (R-OH) for introducing the Registered Nurse Safe Staffing Act. This bill presents a balanced approach to ensure adequate RN staffing by recognizing that direct care nurses, working closely with managers, are best equipped to determine the staffing level for their patients. Without the necessary nurse coverage, patients risk longer hospital stays, increased infections, avoidable medication errors, falls, injuries and even death.

The bill’s sponsors chair Congress’ Nursing Caucus, Merkley in the Senate and Capps and Joyce jointly in the House. The Nursing Caucus educates lawmakers on issues significant to the profession and patients, and the impact of nurses on the health care system.

“Optimal nurse staffing could mean the difference between a patient surviving or dying,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “Research tells us it’s that crucial. If you or your loved one were in the hospital, you’d want to be certain that the hospital was continually setting, evaluating and adjusting its nursing coverage to meet your changing needs and the conditions of all patients. That is what this legislation seeks to ensure.”

Research has shown that higher staffing levels by experienced RNs are linked to lower rates of patient falls, infections, medication errors and even death. One study showed the likelihood of overall patient mortality (in-hospital death) and mortality following a complication increases by 7 percent for each additional patient added to the average RN workload.

When anticipated events happen in a hospital resulting in patient death, injury, or permanent loss of function, inadequate nurse staffing often is cited as a contributing factor.

In setting staffing plans, the Registered Nurse Staffing Act considers:

• RN educational preparation, professional certification and level of clinical experience.
• The number and capacity of available health care personnel, geography of a unit and available technology.
• Intensity, complexity and stability of patients.
• It also includes these patient protection, reporting, investigation and enforcement provisions:
  • RNs would not be forced to work in units where they are not trained or experienced without orientation.
  • Procedures for receiving and investigating complaints.
  • Potential for civil monetary penalties imposed by the Secretary of Health and Human Services for each known violation.
  • Whistleblower protections.
• Public reporting of staffing information.

ANA Lauds Supreme Court Decision Upholding Affordable Care Act Tax Credit Subsidies

We are gratified that the Supreme Court ruling will avoid the loss of subsidies that have allowed millions of people to get healthy and stay healthy,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “The Supreme Court has spoken. Now it’s time to finish the work of ensuring Americans get the health care they need by expanding Medicaid.”

The share of adults without health insurance dropped to its lowest level in seven years in 2014 as the ACA took full effect. Without the tax credits, many people would have been unable to obtain health insurance, thus limiting their access to routine preventive care and causing insurance costs to rise due to a sicker population.

ANA has been a steadfast supporter of the Affordable Care Act (ACA) by preserving tax credits that have allowed more than 10 million Americans to obtain health insurance coverage.

Alarmed by the growing numbers of uninsured individuals and families, rising costs, and quality-of-care concerns, ANA has advocated for health care reform since the early 1990s and contends health care is a basic human right and that all deserve access to essential health care services.

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The Year of Ethics Commences with First Revision of Code since 2001

ANA Plans Ethics Educational Activities for 2015 to Highlight Importance in Nursing Practice

In December 2014, the Gallup survey ranked nurses as the top profession for honesty and ethical standards for the 13th consecutive year. In recognition of the impact ethical practice has on patient safety and the quality of care, the American Nurses Association (ANA) has designated 2015 as the “Year of Ethics” highlighted by the release of a revised code of ethics for the profession.

“The public places its faith in nurses to practice ethically. A patient’s health, autonomy and even life or death, can be affected by a nurse’s decisions and actions,” said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. “ANA believes it’s important that all nurses practice at the highest ethical level, and therefore, we will be offering a full range of activities to inform and support nurses to achieve that goal in a stressful and ever-changing health care environment.”

The foundation of the 2015 ethics initiative is the revised Code of Ethics for Nurses with Interpretive Statements, which was released Jan. 1 and now available on nursingworld.org under ANA publications. Several thousand registered nurses submitted comments during a four-year revision process for the new Code of Ethics, which was last updated in 2001. The update ensures that the Code reflects modern clinical practice and evolving conditions, and fully addresses transformations in health care.

Activities emphasizing the importance of ethics in nursing practice include:

2015 Designated as Year of Ethics
- The National Nurses Week (NNW) theme, “Ethical Practice. Quality Care,” was May 6-12.
- The 2015 ANA Ethics Symposium designed to facilitate dialogue across the nursing spectrum, was June 4-5 in Baltimore, Maryland.

In 2014, ANA participated as a strategic partner in the National Nursing Ethics Summit convened by the Johns Hopkins University’s Berman Institute of Bioethics and School of Nursing to strengthen ethics in the profession. The Summit resulted in the blueprint for 21st Century Nursing Ethics: Report of the National Nursing Ethics Summit. Summit leaders are encouraging individuals and organizations to adopt and implement the ethics blueprint to “create and support ethically principled, healthy, sustainable work environments; and contribute to the best possible patient, family and community outcomes.”
North Dakota Celebrates the Recruitment and Retention of American Indians into Nursing (RAIN) Program

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North Dakota (ND) has many reasons to celebrate during this landmark year of 2015. The ND Board of Nursing completed an exciting event on May 21st in Bismarck to mark the 100th year of nursing titled “100 Years of Nursing Excellence: Past, Present and Future.” It was also twenty-five years ago in 1990 that the University of North Dakota (UND) College of Nursing initiated a program specifically tailored to the education and support of American Indian Nurses. Little did UND faculty and staff know that the program would go on to celebrate 25 years of student achievements, federal funding, and the award of 240 undergraduate and graduate degrees to American Indian nurses with a BSN, master’s or doctorate degree. These graduates are well prepared to serve the tribal communities of North Dakota and beyond.

As nursing continues to be an advocate for population health and improved family health outcomes, the U.S. demographic and persistent health disparities require us to rethink our way of making nursing education more culturally responsive and diversifying the healthcare workforce. Phillips and Malone (2014) reported that while the need to diversify the workforce is not new, “the need to successfully address this issue has never been greater” (p 45). The RAIN program at UND is one example of a strategic initiative in nursing education to strengthen opportunities for American Indian students to succeed as nursing students and to decrease health disparities in their native communities following graduation.

What are the hallmarks of RAIN and other higher education programs that improve academic performance and retention of minority students in primarily Caucasian nursing programs? The University of North Dakota RAIN program utilizes the mentor model. The RAIN staff are deeply connected to the tribal communities and travel frequently to the areas where students reside visiting high schools and tribal colleges to maintain networks, build relationships, and increase recruitment of students interested in nursing. The RAIN program provides mentoring, academic advisement, financial resources and scholarships, a supportive learning and social environment, tutoring for test taking skills, and role modeling from faculty, alumni, administrators, and community members participate in the meal, honor ceremony, and traditional dance.

Prior to the initiation of the RAIN program in 1990, UND had 19 BSN graduates. In the twenty-five years of the UND RAIN program the outcomes include:

- 181 American Indians have received BSN degrees
- 52 American Indian nurses have earned master's degrees
- 5 RAIN alumni have earned doctorate degrees and one has been awarded a Juris Doctorate at other institutions
- The first RAIN DNP student will graduate in summer 2015
- Of the 154 American Indian Registered Nurses in North Dakota, 87 are RAIN program graduates

The lack of diversity in nursing programs and the academic success of minorities of varied racial backgrounds is very complex (White & Fulton, 2015). Faculty and staff may have unconscious racial biases which are likely to be ambient, or absorbed from society (Hall & Fields, 2013). To address this RAIN has provided professional development and regular presentations to the College of Nursing and Professional Disciplines (CNPD) that have been essential in examining some of the deeply rooted biases in the learning environment. Some objectives to advance the RAIN program at UND through the next 25 years include:

1) Revising the CNPD Strategic Plan based on a model by Rosenberg & O’Rourke (2011) which includes measurable objectives for the entire college to respond to the commitment for educational excellence and support of student diversity,

2) Establishing stronger linkages in the curriculum between practice, research, and social determinants of health,

3) Increasing interprofessional clinical experiences in the rural American Indian communities for all CNPD students, and

4) Maintaining a pipeline of grant funding to ensure continued stability of the RAIN services which are 95% grant funded at present.

This year at UND’s Homecoming event in October, the College of Nursing & Professional Disciplines (CNPD) is celebrating RAIN’s 25 years of success by hosting a traditional meal to honor those who have contributed to the RAIN program during the past quarter of a century including tribal elders, alumni, students, faculty, staff, and community leaders. We invite each of you to share your thoughts and ideas to bring further success to North Dakota by deepening the commitment to diversity of nursing education and the healthcare workforce over the next 25 years. As Dean at the UND CNPD, I pay tribute to all the unsung heroes and heroines who have made the RAIN program as vibrant and successful as it is today and as dynamic as it will be in the next 25 years. The RAIN program at the University of North Dakota CNPD should be considered a gold standard program for increasing the diversity of nursing education and the healthcare workforce in North Dakota.

References
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