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from the President...

Holly Decker-Carlson

by Holly-Decker-Carlson, MS, RN, CCRN,
INA President
Email: president@idahonurses.org

We are half way through our year and what a great year it has been! I would like to start by congratulating Kim Froehlich, INA's new Vice President as of July 1st. She comes with great leadership experience and passion for nursing. Thank you to all of the members of INA who voted!

Robert F. Kennedy* once stated,

> Few men are willing to brave the disapproval of their fellow men, their censure of their colleagues, the wrath of their society. Moral courage is a rarer commodity than bravery in battle or great intelligence. Yet it is the one essential, vital quality for those who seek to change the world which yields most painful to change.

In ANA's 2015 "Year of Ethics," many stories of moral courage and bravery amongst our peers are surfacing. This is important because it gives those who fear the disapproval of their fellow men and colleagues the added strength to act on behalf of their personal convictions, their profession, and, most importantly, their patient's. I thank all who continue to direct the true moral and ethical compass for our profession.

In this edition, I ask that you read Susan Trossman's article, "Conscientious Objection: When Care Collides With Nurses' Morals and Ethics," She is a senior reporter from ANA and clarifies the very important question, "Am I objecting because I truly do not believe in what is taking place, or am I objecting because of an ulterior motive?" Being able to differentiate between reasons for objecting to an action is vital to your patient's recovery and your professional longevity. It will either place you on the side of advocating for your patient, or put your job in jeopardy because your objection is unjustifiable.

I wish you all well and thank you for the care you provide to our patients.

*Retrieved from Robert F. Kennedy Quotes http://www.goodreads.com/author/quotes/98221.Robert_F_Kennedy

Conscientious Objection

When Care Collides with Nurses' Morals, Ethics

by Susan Trossman

Last winter, two high-profile — and very tragic — cases pitted family members against hospital administrations and stirred debates nationwide about brain death, policies and laws, and ethics. No matter where they practice, nurses may have wondered what they would do if they found themselves in similar circumstances — whether they could object to providing patient care. The answer is a qualified "yes."

Conscientious Objection continued on page 4

NEWS FLASH!

2015 National Nursing Workforce Survey

Will you be one of the 260,000 nurses chosen through a nationally randomized sampling to complete a national survey that will provide information critical to ensuring an adequate nursing workforce and high quality patient care? Be on the lookout for a postcard followed by a paper survey. The survey is being conducted by The National Council of State Boards of Nursing (NCSBN). The National Forum of State Nursing Workforce Centers is conducting the 2015 National Nursing Workforce Survey. If you receive the survey we encourage you to participate as your responses will contribute to a national study.

NATIONAL NURSING WORKFORCE SURVEY

Inside this issue

Guidelines for Submissions to RN Idaho

RN Idaho (RNI), the official publication of the Idaho Nurses Association (INA), is a peer-reviewed journal that is published quarterly. Views expressed are solely those of the authors or persons quoted and do not necessarily reflect INA's views or those of the publisher, Arthur L. Davis Publishing Agency, Inc. The *RNI* Editorial Board oversees this publication and welcomes nursing and health-related news items, original articles, research abstracts and other pertinent contributions of 200 to 800 words. Authors are not required to be INA members.

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www.idahonurses.org

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RN Idaho welcomes comments, suggestions and contributions. Articles, editorials and other submissions may be sent directly to the INA office via mail, fax or e-mail. Please call the INA office if you have any questions.

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Continuing Education - Patients Deserve Nothing Less

Robin Schaeffer, MSN, RN, CAE
Multistate Division Leader,
Western Multi-State Division

Health care is evolving quickly. During my 37 years as a nurse, I've seen our field change in ways I couldn't have imagined. Technology, protocols, specialization and much more – nurses today have greater challenges than ever before when it comes to staying current.

That's why Continuing Education (CE) is so important. The American Nurses Association has defined CE as "learning activities designed to augment the knowledge, skill and attitudes of nurses and therefore enrich the nurses' contributions to quality healthcare."[1] CE is a simple and effective way to keep current and acquire additional skills and knowledge that are essential to our everyday practice of nursing.

Organizations that sponsor CE benefit by demonstrating to the public, to nursing professionals and to state licensing boards the organization's commitment to high standards of performance and a well trained workforce. Ultimately, patients benefit most of all when nurses take it upon themselves to keep up-to-date with the latest in the nursing profession.

Nurse educators and trainers work hard to develop meaningful, needs based programs that merit approval to award continuing education credits.

Nurses who attend CE programs recognize their professional commitment to lifelong learning as well as fulfill their criteria for certification and re-certification in their specialty field of practice.

In 2014 the nurses associations of Arizona, Colorado, Idaho and Utah formed a nursing collaborative known as the Western Multi-State Division (WMSD). As an ANCC Accredited Approver of CE, the WMSD works across state lines to support nurses, educators, organizations and institutions acquire CE credits for their educational programs.

Ready to get started? Taking the next step is easy. Visit www.idahonurses.org/Education to determine if your program is eligible for CE.

Nursing professionals are in high demand. Nurture your craft and stay ahead of the curve when it comes to the latest innovations in health care. Our patients deserve nothing less.

[1] References available upon request.

Executive Director

Stepping Forward for Patient Safety and Our Profession

Robin Schaeffer

by Robin Schaeffer, MSN, RN, CAE
Executive Director of ANA Idaho
Email:ed@idahonurses.org

"Get to the table and be a player, or someone who does not understand nursing, will do that for you."
~ Loretta Ford, EdD, RN, PNP, FAAN, FAANP

Every nurse has advocated for his/her patients. Not every nurse has advocated for the nursing profession. What will it take to convince you to step forward, to get to the table, and to use your voice for the good of our profession and the safety of our patients? You already have advocacy skills but you may not know how to use those skills to focus on grassroots advocacy in your own workplace or in the policy environment of your state or nation.

Thankfully, resources are literally at your fingertips with a few keystrokes and clicks away! Make your way over to www.idahonurses.org and click on the Advocacy tab. Important local and national information will always be listed there. A sample of policy and advocacy topics available includes safe nurse staffing, workplace violence, and safe patient handling.

Now more than ever it is important for nurses to keep updated on policy issues, in fact, more and more schools of nursing are adding a health policy focus to their course of studies. The public needs the voice of nurses in every corner of our nation. Please step out of your comfort zone for a moment to access the advocacy portion of www.idahonurses.org and see how influential you can be.

Conscientious Objection continued from page 1

First, the Two Cases

According to published reports, Jahi McMath, 13, was admitted into a California children's hospital for surgical procedures to address sleep apnea. Following surgery, she developed a complication, went into cardiac arrest, and was declared brain dead by two hospital-associated physicians and ultimately a court-ordered physician. Her family fought to have her remain on a ventilator until she could be transferred to an undisclosed facility where she could be given additional "life-sustaining" measures.

Marlise Munoz was 14 weeks pregnant when she was found unconscious at home. She was declared brain dead and carrying a nonviable fetus; her family wanted her taken off life support, noting her wishes, the media reported. But this time, the hospital where she was admitted objected — citing a Texas law it believed required them to keep her on life support until her fetus could be delivered. Again, a legal battle ensued. A judge ultimately ruled that the hospital was misapplying the law, and the hospital removed her from life support.

Members of the American Nurses Association (ANA) Ethics and Human Rights Advisory Board were not aware of whether or not RNs objected to providing care in these specific cases. However, nurse ethicists did find it crucial to ensure that all RNs understand that they can conscientiously object to participating in interventions if certain criteria are met.

Confronting Difficult Decisions

Nurse ethicist Anita Catlin, DNSc, FNP, FAAN, followed the Munoz case in the national press. "Nurses have a right to conscientiously object to participate in technologically supported treatment of a brain-dead person," shared Catlin, a member of ANA's ethics advisory board. "Additionally, when a woman and her surrogate have made their wishes known, it is unethical to go against these wishes as stated in *ANA's Code of Ethics for Nurses with Interpretive Statements.*

"If members of the nursing staff wished to be excused from participating in this patient's care for anything other than palliative care and comfort measures, they have every right to do so."

When it comes to nursing practice, there are two broad categories in which RNs can conscientiously object to participate — based on provisions addressed in the *Code of Ethics*, according to Marsha Fowler, PhD, MS, MDiv, RN, FAAN, a member of the ANA's professional issues panel steering committee, which has been leading a revision of the *Code*.

Nurses can refuse to participate in all instances of an intervention — such as an abortion or sexual reassignment surgery — based on religious or moral grounds, said Fowler, an ANA\California member. RNs who hold these strong beliefs should make their objections to participate in these types of interventions or procedures known at the time of hiring, Fowler said.

"If that's not possible for some reason, the nurse should make her or his objection as timely as possible so the nurse manager can find a replacement," she said.

Vicki Lachman, PhD, MBE, APRN, FAAN, added that for nurses to ethically object to participating in an intervention, that intervention "must challenge their moral integrity — and not be based on false motivation. It really has to violate a deeply held conviction of what's right or wrong. A nurse might believe that the sanctity of life trumps all."

The *Code* does not allow nurses to refuse care based on prejudice, discrimination or dislike. For example, they can't refuse to take care of someone because the patient abuses alcohol or because the patient is homosexual, according to Lachman, chair of ANA's ethics advisory board.

To decrease the chances of having to object on moral or religious grounds, nurses ideally should practice in settings where they are less likely to be confronted with interventions — such as abortions, cardiac transplants or palliative sedation — that conflict with their beliefs, Lachman said.

The other broad category in which nurses can conscientiously object involves a specific intervention with a specific patient, Fowler said. A common example of this ethically sound objection is when a nurse is asked to participate in an intervention that goes against a patient's autonomy and expressed desires, as in the patient's not wanting a blood transfusion, antibiotics or other lifesaving measures.

Given the fast pace of technology and other advances, nurses may increasingly find themselves in ethically challenging situations, Lachman noted.

Additionally, many sensitive cases that might have been kept private in decades past are now being played out in the media, according to Fowler.

Parting Words

To make a conscientious objection, Fowler said nurses should follow the lines of authority and the structures that are in place in their facilities. They also can contact their organization's ethics committee or patient ombudsman.

And they must be aware of an obligation not to abandon a patient.

"Once a nurse begins treating a patient, she or he is legally bound to care for that patient until another nurse is available to assume responsibility for the patient," Lachman said.

And although it may take courage to conscientiously object — particularly given some workplace cultures — not doing so can have dire consequences for the individual nurse and for the nursing profession.

"Most of the time, nurses just remain silent and do not make their objections known. They also worry that their decision will place a burden on colleagues by giving them more work," Lachman said. "If nurses cannot move away from these situations, it becomes intolerable. They experience moral distress, emotional and physical fatigue, and burnout. Therefore, organizations must provide nurses with the staffing necessary to maintain their moral integrity, and nurses need to participate only in patient care that is not morally compromising."

Fowler added, "Nurses need to accommodate and support colleagues who conscientiously object and provide an environment that preserves professional integrity."

— Susan Trossman is the senior reporter for *The American Nurse.*

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Idaho Nurses Association 2015 Conference

Friday, November 6, 2015
St. Alphonsus Regional Medical Center
Boise, Idaho

ANA IDAHO
AMERICAN NURSES ASSOCIATION IDAHO

Completing Your Professional Puzzle

Where do **you** *fit in?*

Registration Information

$70 INA members
$100 non-members
$45 students

($15 late for for registrations on or after October 19)

visit:
www.idahonurses.org

Since its formation in 1909, the Idaho Nurses Association (INA) has made significant contributions to the nursing profession in the State of Idaho. INA, the only professional organization representing Idaho's 20,000+ registered nurses, exists to advances the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public.

Agenda

7:30am	Breakfast & Registration Opens
8.00am	Welcome & Announcements
8:15am	Keynote: "Nurses Transforming Healthcare" Marla Weston, PhD, RN, FAAN CEO, American Nurses Association
9:15am	"When Family Says 'Do Everything' and We Believe that the Requested Treatment is Futile" Alex Chamberlain, Ethicist
10:45am	Excellent Care Provided Presentation
11:45am	Lunch & Exhibits
12:45pm	"What is Your Personality Animal?" Rick Kerr, Chaplain
1:45pm	"Life Should be an Adventure: How to Overcome Change and Beat Stress" Sharon Lacey, Corporate Comedian
2:45pm	Break
3:00pm	"Elevating Your Efforts so That You Can Elevate Your Excellence" Brandon Kelly, Master at Triumphing Against All Odds
4:30pm	Closing & Evaluations

Featuring:

Marla J. Weston, PhD, RN, FAAN
CEO, American Nurses Association

Dr. Marla Weston is a distinguished and visionary leader for nursing, who has dedicated her career to improving the work and public policy environment for nurses and the quality of care for patients.

This focus has included leadership in a broad range of roles, including direct patient care in intensive care and medical-surgical units, nurse educator, clinical nurse specialist, director of patient care support, and nurse executive.

As a committed and influential leader for nursing, Dr. Weston's is not only helping to prepare and position nurses to improve the quality of health care in the United States, she is also making sure that policy makers understand and recognize the important contribution nurses make to quality health care.

Dr. Weston has been chosen as one of *Modern Healthcare's* 100 Most Influential People in Healthcare.

This activity has been submitted to the Western Multi-State Division for approval to award nursing contact hours. The Western Multi-State Division is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

WHAT HAPPENS WHEN YOUR PATIENT ASKS ABOUT DIABETES EDUCATION?

Almost one out of six
of your adult patients has or is at risk of developing diabetes. Diabetes control achieved through diabetes self-management education can improve health outcomes. Refer your patients to an ADA recognized or AADE-accredited Diabetes Self-Management Education (DSME) Program. With a referral, it's covered by Medicare, Medicaid, and most insurance plans.

There are DSME Programs statewide.
Find one near your practice:
diabetes.idaho.gov

IDAHO DIABETES
PREVENTION & CONTROL

IDAHO DEPARTMENT OF HEALTH & WELFARE

Supporting Safe Patient Care Through Cutting-Edge Vaccine Monitoring Technology: Nursing's Role and a Case Scenario

by Barbara McNeil, PhD, RN-BC (Informatics Nurse), Eagle, Idaho, Adjunct Graduate Nurse Faculty, Gonzaga University and Nova Southeastern University
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There are no declared conflicts of interest by the authors.

Nurses working in all care environments including hospitals, public health clinics, private health clinics, and employer work settings have a responsibility for competently administering all types of medications including temperature-sensitive medications such as vaccines. A key aspect of medication safety is the nurse's oversight of the proper storage and handling of the vaccines to guarantee medication potency and effectiveness. Nursing education curricula today may not include content about the best practices for proper storage and handling of vaccines.

The purposes of this article are to 1) explain nursing's role in promoting a culture of safety in the "vaccine cold chain" process and 2) to examine features and implications of the cutting-edge vaccine monitoring technology of PharmaWatch™ applied to an actual nursing scenario.

Vaccine Cold Chain

The Centers for Disease Control and Prevention (CDC) estimate that among children born in the last 20 years vaccinations will prevent more than 21 million hospitalizations and 732,000 deaths (CDC, 2014b). However, those impressive numbers would be even higher, says the CDC, if vaccines were better monitored and protected during storage (CDC, 2014a). In a major report of a study involving 45 providers in five states who offered free immunizations as part of the Vaccines for Children (VFC) Program, the researchers found that 76 percent of providers stored their vaccines at temperatures that were either too hot or too cold (Department of Health and Human Services [DHHS], 2012, p. 14). According to that report (pp. 14-15), a percentage of vaccine doses were at risk due to inappropriate storage temperature and consequently "may not provide children with maximum protection against preventable diseases."

Vaccine cold chain, or cold chain, is a system that is designed to "protect and maintain vaccine viability" (Rogers, Denison, Adepoju, Dowd, & Uedoi, 2010a). In vaccination programs, this process (as shown in Figure 1) requires vaccines to be stored properly from the time of manufacture to the time of administration. An effective

vaccine cold chain requires that optimal temperatures be maintained continuously along every link of the cold chain. The CDC (2014c) states that effective cold chain management of vaccine storage and handling depends upon:

- Well-trained staff,
- Use of the right storage and transport equipment, and
- Efficient management procedures.

Cold chain violations or "excursions" are the primary reason for vaccine waste. Excursions include storing vaccines outside of the minimal and maximal temperature range, unsafe monitoring of temperatures, incorrect storage containers or improper storage within a refrigerator, equipment failure, and inadequate staff training (Rogers et al., 2010b, p. 341). For example, during the 2009 H1N1 (Swine flu) pandemic, a refrigerator malfunction causing temperatures to fall dramatically over a weekend in a Pennsylvania public school resulted in thousands of lost doses of vaccine (WPXI News, 2009). Rogers et al. (2010b) noted that all agency participants in the Vaccines for Children program were "mandated" to replace unreliable dormitory-style refrigerators because of vaccine damage caused by this type of refrigerator.

Nursing's Role in the Vaccine Cold Chain Process

CDC Guidelines. CDC's (2014c) comprehensive guidelines comprise 109 pages of recommendations and best practices to ensure vaccine storage and handling safety. For example, the CDC specifies that a vaccine coordinator and a backup staff person should be assigned to oversee adherence to the cold chain process from transport to shipping to receipt of the vaccines. In some settings, the vaccine coordinator and the staff's backup coordinator may be registered nurses e.g., an occupational or environmental health nurse working in an employer setting. Detailed instructions and written guidelines for the vaccine coordinator are found in the CDC's (2014c) comprehensive, best practices document, *Vaccine Storage & Handling Toolkit*.

Vaccine Coordinators and Staff Training. Vaccine coordinators should be knowledgeable about routine and emergency policies and procedures. However, all staff handling vaccines should have ongoing training on proper vaccine storage and handling using the latest authoritative guidelines. Detailed training guidelines and resources for all vaccine personnel are included in the CDC's (2014c) *Toolkit*.

Vaccine Storage Temperature Monitoring and Documentation. CDC (2014c) guidelines require that vaccine storage temperatures be monitored twice a day with those readings recorded and maintained for three years. Excursions must be corrected promptly with documentation of both the nature of the excursion and the corrective action taken. To comply with such regulations, many health care providers still use paper, pen and thermometer and respond to audits by gathering together paper-based logs and notes. However, these tedious, labor-intensive manual efforts by nursing staff can often involve human error, confusion and frustration.

New Technology Features for Vaccine Monitoring

New technology is beginning to dramatically simplify and streamline the process of monitoring vaccine safety. Automated "continuous monitoring" systems are available to provide highly accurate readings every five minutes—a tremendous advantage when trying to determine with a vaccine manufacturer the extent to which a vaccine inventory may be damaged.

In the event of a temperature excursion or deviation from the optimal temperature range, cutting-edge systems can immediately alert staff by text, email, smartphone or pager. Newer cloud-based systems are able to store data indefinitely, providing all documentation needed for an audit at the touch of a key and enabling administrators to view all data anywhere and anytime via laptop, tablet or smartphone.

The new cloud-based vaccine monitoring systems are fully secure and use encryption technology. Users can easily access raw data and reports showing temperature trends and documenting compliance with CDC requirements. For example, PharmaWatch™ developed by a local Boise-based company, AmericanPharma Technologies, LCC, may be the industry's most advanced system. The PharmaWatch™ system allows users to view all refrigeration units at all facilities on one web page and satisfy the twice-a-day CDC requirement of recording and documenting storage temperatures by simply clicking a box in the top right corner of the computer screen.

Idaho Success Cases. In Idaho, the most advanced vaccine storage monitoring systems have demonstrated benefits. For example, a faulty refrigerator at a local pediatrics unit was briefly but repeatedly subjecting its polio vaccines to freezing temperatures, rendering them useless – a fact that a more traditional monitoring process would not have detected. Fortunately, their newly installed state-of-the-art monitoring solution caught the excursion. The bad vaccine was disposed of and patients were protected.

In another case, a local clinic that was excluded from the state-funded Vaccines for Children (VFC) program, after losing over $60,000 worth of vaccine due to temperature excursions, installed a new-cloud based system. The facility was allowed subsequently to re-join the VFC program and its temperature-monitoring activities are now considered "Best-In-Class."

Vaccine Monitoring continued on page 8

Vaccine Monitoring continued from page 7

Figure 1. Vaccine Cold Chain Flow Chart*

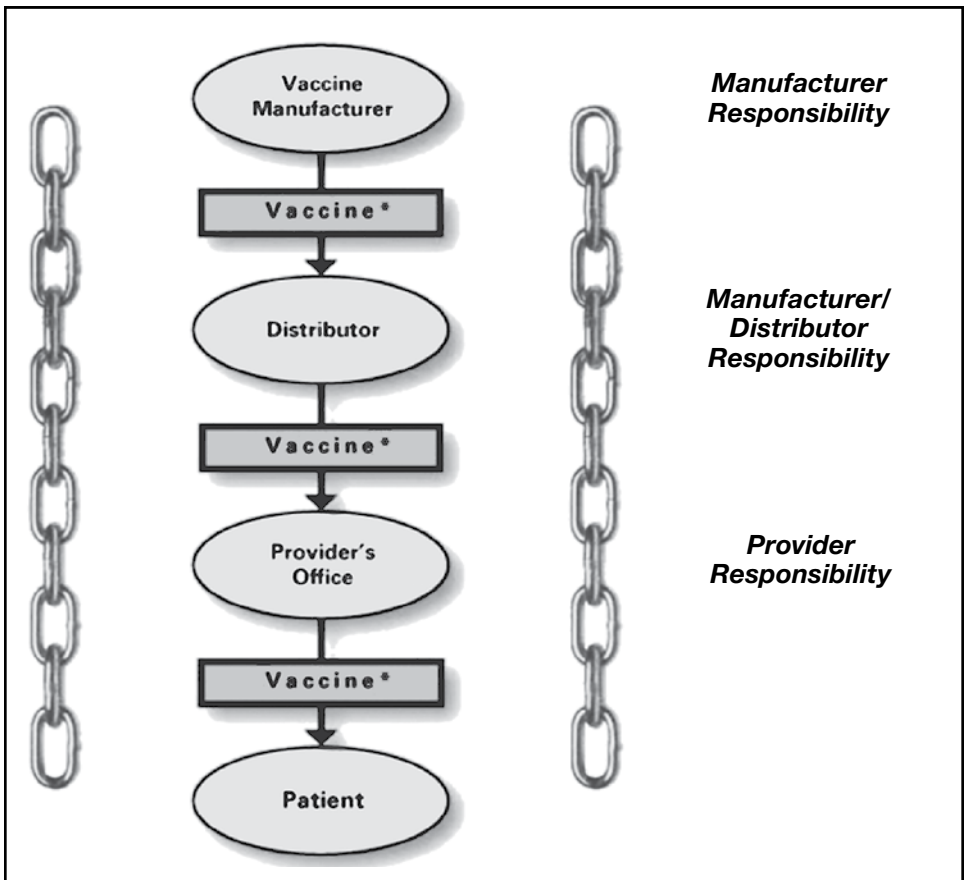

***Figure 1. Adapted from: CDC (2014c). Vaccine storage & handling toolkit, p. 11.**

Retrieved from http://www.cdc.gov//vaccines/recs/storage/toolkit/storage-handling-toolkit.pdf.

Nursing Case Scenario: Cutting-Edge Continuous Vaccine Storage Monitoring with PharmaWatch™

Scenario

On a Friday evening, after closing the pediatrics clinic, the lead RN received **an alert on her cell phone** from PharmaWatch™. The RN returned to the clinic to discover the door of the refrigerator was not fully closed and latched. The RN **immediately acknowledged the alert on the PharmaWatch portal via her Smartphone** and **quarantined the inventory.**

On Monday, the RN **called the vaccine manufacturer**. Using the data provided by the **PharmaWatch™ Alert History Report**, the manufacturer determined that the vaccines were still good and could be used that day. The clinic saved over $40,000 in inventory by **not disposing of the vaccines mistakenly**. In addition, the **engineering department was notified** of the situation, the spring tension on the refrigerator door was adjusted and the unit was placed back in operation.

All events for this incident including corrective **actions were easily documented** on the PharmaWatch portal **with time stamps** for each action. The actions taken for remediation of this incident are now available as a **permanent record** if needed.

Analysis: In this scenario, the nurse took appropriate actions in line with CDC guidelines. The clinic utilized **PharmaWatch™** which is a wireless, cloud-based 24/7 service to continuously monitor vaccine storage temperature and other environmental factors such as light, humidity and pressure that might damage vaccines. As noted in the scenario, after leaving the clinic, the nurse was alerted via her smartphone to a temperature excursion at her clinic. The nurse did not have to be physically on-site for the alert and was able to take quick, corrective actions. Using her smartphone, she accessed the PharmaWatch™ portal through the Internet and took immediate action to quarantine the vaccine and to notify other staff and engineering of the incident. In analysing the PharmaWatch™ report data, the vaccine manufacturer could determine that the vaccine was viable. The nurse followed standard policies and procedures for ensuring vaccine storage safety. In doing so, the nurse also complied with the most recent *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association [ANA] Provision 33.4, 2015):

> Nurses must participate in the development, implementation and review of and adherence to policies that promote patient health and safety, reduce errors and waste, and establish and sustain a culture of safety. (p. 11)

Conclusions

Knowledge about vaccine storage best practices, prevention of temperature excursions, and actions to take when discovering emergencies and breaks in the vaccine cold chain are essential for all nurses as well as staff involved with handling of vaccines. Guidelines from the CDC present current recommendations and training resources for healthcare staff and providers.

New technology is now available for more complete and accurate real-time, continuous vaccine storage monitoring. Alerts to deviations from optimal vaccine storage temperatures can take place off-site and via smartphone, text, email or pager. Nurses are quickly alerted to cold chain problems and can take essential actions to report and remedy problems. Instead of labor-intensive monitoring and documenting of vaccine storage temperatures, nurses can focus on the important client and patient needs and core operations. Today's new technological innovations in continuous temperature and environmental monitoring such as with PharmaWatch™ will ensure the ability of nurses to provide patients with viable vaccines that have been stored and protected according to the highest safety standards.

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Update from the Idaho Board of Nursing

by Sandra Evans, M.A.Ed, RN, Executive Director
Email: Sandra.evans@ibn.idaho.gov

"The Board of Nursing believes continuous measurement of performance fosters achievement of desired outcomes and demonstrates respect for the public's trust" (from the Board's Philosophy of Governance, adopted 1/09/15 as revised). Consistent with this belief, at their April 9-10, 2015, meeting, the nine Governor-appointed Board members completed their annual self-assessment in which they determine how well they accomplished benchmarks related to strategic goals and objectives; acted consistent with their values of accountability, collaboration, integrity, leadership and respect; and adhered to elements of their governance philosophy.

Board Actions

In addition, Board members Susan Odom, RN, Moscow, Chair; Vicki Allen, RN, Pocatello, Vice Chair; Jill Howell, RN, Jerome; Whitney Hunter, consumer member, Boise; Christopher Jenkins, RN, Homedale; Jan Moseley, RN, Coeur d'Alene; Carrie Nutsch, LPN, Jerome; Rebecca Reese, LPN, Post Falls; and Clay Sanders, APRN, CRNA, Boise:

- Granted initial LPN licensure conditioned on terms of an agreement whereby the applicant agreed to a formal reprimand, fine of $500 and completion of specific related courses for providing false information on an application for licensure;
- Reinstated a previously disciplined LPN license to include conditions for monitoring for up to five years;
- Revoked two RN licenses based on substantiated findings of violations of the Idaho Nursing Practice Act;
- Upheld the January 2015 Board action denying reinstatement of a license previously disciplined by the Board;
- Adopted the revised Board core belief statement related to Practice;
- Affirmed the Board's 2010 "Interpretive Statement Regarding Midwifery" in which the Board concludes that a licensed nurse (RN, LPN) who is also a licensed midwife (L.M.) "will, either intentionally or unwittingly, exceed the scope of his/her nursing practice while performing as a midwife because of inherent disparities between the two disciplines;"
- Endorsed the "Multi Board Statement of Understanding: Regarding the Prescribing of Controlled Substances in Idaho" developed by a subcommittee of the Office of Drug Policy Prescription Drug Abuse Workgroup;
- Accepted notice from Eastern Idaho Technical College of revision of the PN program curriculum; and
- Granted continued provisional approval to the RN program administered by ITT Technical Institute, Boise, for the period ending June 2016.

Board Appointments

At the April 2015 meeting, the Board appointed APRN Advisory Committee Members Allie Gooding, APRN-CNS, Betty Brosh-Schoenecker, APRN-CRNA and Charlotte Salinas-Wilkes, APRN-CNM to continuing 3-year terms; and appointed Heather Nasker, APRN-CRNA to an initial 3-year term on the PRN Advisory Committee.

Other Board Actions

The Board reviewed and provided comments on the revised NCLEX-RN® Test Plan in anticipation of its presentation to the National Council of State Boards of Nursing 2015 Delegate Assembly for adoption.

The Board also considered potential legislation and administrative rules for presentation to the 2016 Idaho Legislature. As a result of that discussion, "Notice of the Intent to Promulgate Rules-Negotiated Rulemaking" and draft rules were posted on the Board's website at www.ibn.idaho.gov. Proposed rules include:

- Define the term "active practice" and clarify where practice occurs.
- Clarify requirements for nurses functioning in RN nursing specialty areas.
- Require demonstrated continuous professional development/lifelong learning for renewal of LPN/RN licensure, establish standards and criteria, and establish methods by which nurses can comply.

The Board also plans to introduce legislation to adopt the newly revised Nurse Licensure Compact which, when implemented, will replace the current Nurse Licensure Compact (NLC) adopted and implemented in Idaho in 2001. The "new" NLC includes changes needed for participation by more states than the current 25 states. Changes address:

- Uniform Licensure Requirements for greater consistency between states, e.g. fingerprint-based criminal background checks, demonstrated English proficiency for foreign applicants.
- Governance of the NLC governing body (Commission).
- Rule-making processes.
- Provisions for grandfathering nurses licensed under the current NLC.
- Transition from the current NLC to the "new" NLC, for current member states.

On the Board's legislative agenda is adoption of the Advanced Practice Registered Nurse (APRN) Compact, an interstate contract similar to the NLC but specific to multistate regulation of APRNs.

New and Retiring Board Members

The Idaho Board extends appreciation to Jill Howell, RN, Jerome, who 'retired' from the Board after twelve years of service, including eight years as Chair of the Board's PRN Advisory Committee. The Board extends congratulations to Rebecca Reese, LPN, Post Falls, and Clay Sanders, APRN-CRNA, Boise, both appointed by Governor Otter to continuing four-year terms on the Board; and to Merrilee Stevenson, RN, Wendell, appointed to an initial four-year term.

Other Board News

Of note, Shasta Kilminster-Hadley, JD, the Board's prosecuting attorney, presented "Beyond Appropriate Boundaries: Why Boards Need Clarity in Rules Prohibiting Sexual Misconduct" at the 2015 National Council of State Boards of Nursing Discipline Case Management Conference in Indianapolis.

Next Board Meeting

The next meeting of the Board is tentatively scheduled for October 1-2, 2015, in Boise at a location to be determined. For further information, visit the Board's website at www.ibn.idaho.gov or contact Lyn Moore at lyn.moore@ibn.idaho.gov or 208.577.2500.

As always, the Board invites the public to attend scheduled Board meetings and participate in the Open Forum held on the second day of each meeting. The Open Forum provides the opportunity to dialogue with the Board on issues of interest that are not necessarily included on the published agenda. The Board will not take action on issues introduced during the Forum, but may choose to address them at a later scheduled Board meeting.

Evidence Summary: Hand Hygiene Compliance Studies Validate Only Short-Term Effectiveness of Strategies to Decrease Nosocomial Infection Rates

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At any given time, about one in every 25 inpatients has an infection related to hospital care (U.S. Department of Health and Human Services, 2015, page 1 para 3). Simple measures such as handwashing may reduce the frequency of healthcare-associated infections (HAIs) by 50% (World Health Organization, [WHO], 2015). Although hand hygiene is effective for preventing infection, rates of compliance with the established recommendations are poor and intervention outcomes are short-lived (Gould, Moralejo, Drey, & Chudleigh, 2012). According to Erasmus et al., (2010), infection rates in hospitals demonstrate that healthcare professionals are not complying with professional standards and guidelines.

Non-compliance with hand hygiene protocols differs from the ability to wash hands effectively to remove pathogens. According to Cherry, Brown, Bethell, Neal and Shaw (2012, p. e407), hand hygiene compliance is the healthcare professional's "ability to wash their hands at the recommended points of clinical contact." Non-compliance with evidence-based protocols may result in increases in hospital-acquired infections, costs, extended length of stay, morbidity, and mortality. The Joint Commission has challenged hospitals to decrease healthcare-associated infections through improving hand hygiene compliance (White et al, 2012). Provider compliance with proper hand hygiene is essential for improving patient safety (Shekelle et al., 2013).

While there is research evidence supporting clinical guidelines on effective hand hygiene methods, less is known about ways to effectively promote and sustain hand hygiene compliance among healthcare professionals. This evidence summary was initiated to determine if increased hand hygiene access by healthcare providers in the ICU would improve hand hygiene compliance and subsequently lead to reduced nosocomial infection rates.

Overview of the Evidence Search Process

After generating a PICOT (population, intervention, comparison, outcome and timeframe) statement and conducting a comprehensive and systematic literature search (strategy available by contacting the author), eight studies were reviewed. The reviewed studies were chosen with pre-set inclusion criteria as shown in column two in Table 1. The eight studies included two systematic reviews (Gould et al., 2010; Cherry et al., 2012), two randomized controlled trials (Fisher et al., 2013; Martin-Madrazo et al., 2012); two quality improvement project reports (White et al., 2012; Helder, Brug, Looman, van Goudoever, & Kornelisse, 2010); and two cohort studies (Garus-Pakowska, Sobala, & Szatko, 2013; Yin et al., 2014). Further, current clinical practice guidelines were reviewed to compare findings and supplement the eight studies.

Study Characteristics and Findings

Overall, the eight studies had similar findings (see column three in Table 1) and recommendations. All showed improved hand hygiene compliance after interventions were applied, but only for the short term. Those that evaluated infection rates concluded that compliance with hand hygiene practices decreases nosocomial infections (Cherry et al., 2012; Garus-Pakowska et al., 2013; Helder et al., 2010; White et al., 2012; & Yin et al. 2014). When comparing infection rates pre and post-hand hygiene, there was a decrease in infection rates with the increase of hand hygiene compliance. Across studies, there were variations in the nature of groups, interventions, and products used for hand hygiene (see Table 1). Several authors recommended further longitudinal research on hand hygiene compliance and the use of larger sample sizes.

Table 1.
Author's Inclusion Criteria for Selecting Studies and Characteristics of Reviewed Studies

PICOT Elements	Pre-Set Search Inclusion Criteria	Characteristics of Reviewed Studies
(P) Populations and Settings	Nurses, physicians, respiratory therapists, and healthcare students providing care in the ICU.	Populations addressed in all studies. Settings were critical care units and the hospital.
(I) Intervention	Hand hygiene practices pre and post patient contact. Per protocol use of hand sanitizer or sinks available in each patient room, outside patient rooms, and in general use areas in the ICU.	Single or multiple hand hygiene practices per unit protocol before and after patient care with or without provision of hand hygiene education. Studies reported use of aqueous and/or alcohol-based solutions, hydro-alcohol solutions with education, reminder posters, alcohol gel or wipes, and use of technology alert reminders.
(C) Comparison Intervention	Hand sanitizer and sinks available in patient rooms only.	Not addressed in studies.
(O) Outcomes	Hand hygiene compliance rates, infection rates, length of stay, and cost of care re: compliance.	Hand hygiene compliance rates and infection rates.
(T) Timeframe	At least one year follow-up.	10 weeks, several months, six months, and over one year.

After reviewing the studies, this author was surprised to find that hand hygiene compliance levels were alarmingly low at baseline and then after short-term improvements following varied interventions. The health professional's behavior, attitude, and hand hygiene habits seemed to be factors associated with decreased hand hygiene compliance. Unexpectedly, infection prevention was not the motivating factor for healthcare professionals to increase hand hygiene compliance rates.

Best Practices for Hand Hygiene Compliance

In itself, hand hygiene is a best practice standard in WHO guidelines (WHO, 2015) and is included in the *Healthy People 2020* (2014) initiative to decrease hospital-associated infections. According to Martin-Madrazo et al. (2012), the Centers for Disease Control and Prevention (CDC) promote using alcohol solutions and multimodal strategies for improving hand hygiene compliance. The use of alcohol solutions in conjunction with hand hygiene protocol compliance are the best practices as confirmed in six of the studies reviewed.

According to the National Institute for Health and Care Excellence (NICE, 2012, pp. 2-3), the guidelines for prevention of health-care associated infections include: "hand hygiene: hand washing technique using decontamination agents, including liquid soaps and alcohol handrubs, which should occur before patient contact or care and after patient contact or care." The CDC (2011) also published guidelines that promote hand hygiene programs with the use of alcohol-based products, which were initiated in the reviewed eight studies. The guidelines were published to increase hand hygiene compliance among healthcare workers and to decrease nosocomial infection rates.

These national practice clinical guidelines directly support the importance of hand hygiene, yet the findings in this review of studies show that healthcare providers are not compliant with the recommendations. As reported in the study by Garus-Pakowska (2013) of 188 physicians and nurses at three hospitals, there was an overall average baseline rate of 5.2% hand hygiene compliance (handwashing before patient contact) using CDC and WHO guidelines. Nurses were observed and found to be less compliant with CDC and WHO hand hygiene protocols than physicians.

Implications for Practice

This author's research reaffirmed the known difficulty in measuring true hand hygiene compliance of healthcare workers. The Hawthorne effect (a tendency to change behavior in response to being observed) was suspected in many studies; it was difficult to observe the behavior of workers covertly over a long period. This research also revealed that despite guidelines and recommendations from the CDC, WHO, and *Healthy People 2020*, hand hygiene compliance continued to be alarmingly low. While the initial PICOT question for this evidence summary was focused on the outcome of decreasing infection rates, a new starting point for understanding hand hygiene compliance should focus on the individual worker's behavior, attitudes, and habits of hand hygiene. Although the evidence shows that increased compliance will decrease infection rates, there is no current evidence that identifies a single or multimodal method that maintains continuously high hand hygiene compliance rates over time. This is a safety concern for all patients receiving care.

As recommended in several studies, a multifaceted approach was the most successful strategy for increasing hand hygiene compliance. Examples of multifaceted approaches included the combined use of educational sessions with feedback, reminders, or audits. Hospitals should promote and implement follow-up strategies for hand hygiene. There are several strategies or "continuous interventions" (Cherry et al., 2012) that should be considered for implementation in order to sustain increased hand hygiene compliance among all healthcare workers. Some of these strategies include regularly scheduled, short inservices; awareness campaigns planned throughout the year; and placement of reminders or alerts in patient care areas. Hospitals must ensure that adequate hand hygiene products and sinks are available for all their employees. In addition, there is a need to monitor hand hygiene compliance rates on a regular basis. All healthcare workers are personally accountable for adhering to clinical practice guidelines, which will decrease nosocomial infection rates.

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Evidence Summary continued on page 15

An Introduction to Palliative Care

Alys Falcone, RN, BSN, MHS, Palliative Program Manager, St. Luke's Medical Center, Boise/Meridian, Idaho
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Palliative care is an interdisciplinary field whose goal is to provide quality of life for patients. It addresses the physical, psychosocial and spiritual dimensions of care. Sometimes confused with hospice care, which is usually utilized only in the last six months of life, palliative care may occur during any point in an illness trajectory to alleviate suffering. Patients receiving palliative care span the perinatal stage of life to the end of a lifespan. Palliative care can include care of the dying and follow-up bereavement, but also serves those with serious illnesses that do not have a terminal diagnosis. A good way to remember the difference between palliative care and hospice care is that **all hospice care is palliative care, but not all palliative care is hospice care**.

The Role of the Palliative Care Team

Palliative care teams provide services in a variety of settings such as inpatient hospital stays, skilled nursing facilities, long-term acute care facilities, in the home, and in outpatient settings. A key component to providing quality palliative care is excellent clinical skills, but outstanding communication skills are as important. Communication with the patient and loved ones requires the ability to allow expression of emotions, fears, and questions about the patient's illness and potential outcomes. Specialized education and training are crucial requirements for members of a palliative care team.

Benefits to Patients and Families

Palliative care teams have the time and resources to hold family conferences or engage in other modes to communicate, which allow patients and their loved ones to discuss the plan of care for the patients. Palliative care does not decide for the patient what the best plan of care is, but rather determines with the patient and loved ones what the patient desires. Often times it can come as a relief for family members to hear what the patient wants. This allows the family to determine what the patient would want for care if unable to express what he/she wants in the future.

Palliative care increases patient satisfaction with care (Parker, Remington, Nannini, & Cifuentes, 2013) Palliative care also has been found to be a cost saving in the inpatient setting, especially when utilized early in the patient's hospital stay (McCarthy, Robinson, Huq, Philastre, & Fine, 2015). Palliative care is about patient choice and self-determination as exemplified in the following scenario.

An 88 year old patient with chronic anemia due to a non-obstructive colon cancer was seen by the palliative care team. The patient had previously seen a colorectal surgeon who said that surgery was not an option and the patient had declined chemotherapy and radiation as a treatment option. Through talking with the patient, the palliative care team discovered that she was experiencing fatigue, shortness of breath, and vision problems. The patient discussed her goals with the team, which were to live as long as possible as long as some of her symptoms could be alleviated.

The MD on the palliative care team ordered blood and iron transfusions for the future, which alleviated the patient's fatigue. Her shortness of breath was not alleviated and she was started on an inhaler, which she said helped. Her vision problems were found to be due to glaucoma and the social worker from the team contacted the assisted living center where the patient lived. An assessment of her room was initiated to determine safety issues and the needed community resources for someone with impaired sight.

Conclusion

Palliative care is a growing part of many healthcare settings and meets the needs of patients across the lifespan. Its role in improving the quality of life, not only for patients but also for their families and other loved ones, is integral to delivering holistic care. As a nurse, if you are encounter a patient who need symptom control or a discussion about goals of care for their health situation, determine if palliative care is available in your healthcare setting and then seek out how to refer the patient for this type of valuable care.

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Idaho Nursing Action Coalition: Outcomes from a June Summit on How Idaho Can Move to a Better-Educated Nursing Workforce

by Margaret Wainwright Henbest, MSN, RN, Executive Director of the Idaho Alliance of Leaders in Nursing; Co-Lead of the Idaho Nursing Action Coalition
and
Randall Hudspeth, PhD, MS, APRN-CNS/CNP, FRE, FAANP, NEA-BC, INAC SIP-3 Grant Manager

The Idaho Nursing Action Coalition (INAC) sponsored a two-day Robert Wood Johnson Foundation (RWJF) and Idaho Board of Nursing grant-supported summit in Boise during June 3-4. The purpose of the summit was to strategize how Idaho can best offer nurses the opportunity to engage in lifelong learning. The two-day agenda included an overview of national workforce trends and how those trends relate to Idaho. Two national speakers and a variety of Idaho leaders presented at the summit including nurse leaders in acute and community practice, higher education, labor, and regulation; nurses from all across Idaho were represented.

National Nursing Workforce Trends

Five emerging national nursing trends were identified:

(1) The Affordable Care Act requires nurses to develop skills to practice acute care nursing outside of traditional institutions.
(2) There is a national movement by accreditors and certifying bodies, as well as the Department of Education, to cap associate degree education at 60 credits.
(3) Academic progression in nursing is slow due to personal motivation, costs and time, even though opportunities are available to continue to a BSN.
(4) For the first time in history, the national nursing BSN population is at 55.2% of all RNs.
(5) Diversity in the nursing workforce is difficult to achieve and sustain.

Idaho Nursing Workforce Data

Bob Uhlenkott, from the Idaho Department of Labor, presented the January 2015 nursing workforce data. **Following the national trend for more BSN-prepared nurses, 53.4% of RNs in Idaho have a BSN or higher nursing degree.** The job market maintains near equilibrium with the number of Idaho graduates, almost 800, meeting the annual job demand of about 600. Idaho continues to see about 65% of new graduates seeking employment in Idaho. While Idaho seems to be doing well today, the next five years could pose some issues because 9.3% of nursing faculty intend to leave their positions, more Idaho licensed nurses today (14.7%) practice outside of Idaho than in 2010 (10.6%), and almost 50% of the nursing workforce is over 45 years old, with the greatest number of RNs over the age of 55.

State Implementation Grant (SIP-3)

Information on the current Robert Wood Johnson Foundation (RWJF)/AARP State Implementation Grant (SIP-3) was presented with respect to three major goals: (1) establish a work plan for career-long education to meet future workforce needs, (2) create resources that facilitate educational progression and life-long learning, and (3) create opportunities for lifelong learning among underrepresented populations. Mary Dickow, MPA, FAAN, who is the Statewide Director for the California Action Coalition for RWJF's Future of Nursing initiative, reported on the California experience and how they are driving the workforce to meet the target of 80% BSN preparation by 2020 and identified the new roles nurses will take on in a changing healthcare environment. Maureen Sroczynski, DNP, RN, presented the Massachusetts experience, which identified competencies in nursing and supported academic progression. A general discussion followed that examined how Idaho could learn from the experiences of these two states, as well as other states that have similar issues and barriers to academic progression in nursing and that have developed state based strategies to meet the 2020 BSN goal of 80%.

Program facilitator Marsha Bracke guided the group through a formative process that explored options, identified barriers and resulted in strategies for Idaho to meet statewide goals. The goals included integrating the IOM recommendations, promoting academic progression in order to achieve the IOM report recommendation of 80% BSN by 2020, defining the roles of nursing in a changing healthcare environment, and improving diversity in nursing.

Next Steps

Regional meetings in Idaho will be held beginning in September to broaden stakeholder engagement and to facilitate and support regional opportunities for academic progression and lifelong learning. Please contact Randy Hudspeth (rhudspeth@nurseleaders.org) or Margaret Henbest (mhenbest@nurseleaders.org) if you are interested in participating in these regional planning sessions.

We want to thank the attendees of the summit for their presentations, attention, and recommendations, which have become the blueprint for action as we move forward.

In Memoriam

INA is pleased to honor deceased registered nurses who graduated from Idaho nursing programs and/or served in Idaho during their nursing careers. Included, when known or when space allows, will be the date when deceased and the Idaho nursing program. The names were submitted to the American Nurses Association for inclusion in a memoriam held in conjunction with the ANA House of Delegates. Please enable the list's inclusiveness by submitting information to rnidaho@idahonurses.org.

Dickey, Melva "Jeanine" Holfeltz, 6/23/2015. Jeanine worked at St. Luke's Medical Center. One of her strong traits was her ability to "quietly take care of people."

Erickson, Tana Dawn, 6/26/2015. Tana graduated from Idaho State University and worked at the California Men's Prison and then St. Luke's Hospital in Boise. Her passions were caring for the elderly and her career in nursing. She was a compassionate and loving family member and friend.

Gardner, Anna Louise, 4/29/2015. Anna obtained her R.N. license in 1944 and joined the U.S. Army Nurse Corps. She was stationed on the hospital ship, Marigold, the first ship entering into Japan just prior to the Japanese signing of the treaty to end World War II in the Pacific. During her service on the hospital ship and in Japan, she assisted in the repatriation of Allied prisoners and toured the devastation in Hiroshima. Contracting TB and remaining seriously ill, Anna traveled back to the U.S. Although she then had to take an early medical retirement from nursing, Anna continued her spirit of adventure and interest in healthcare. She was generous and kind towards everyone she met and will be greatly missed.

Mayerka, Sharon L. Van Curen, 5/28/2015. Sharon attended Boise Junior College and cared for others for several years at the Ada County Nursing Home. She loved family and the outdoors.

Miskin, Virginia Crooks Palmer, 6/5/2015. A 1944 graduate of the LDS Hospital in Idaho Falls, Idaho, Virginia worked as an office nurse, a special-duty nurse in Idaho Falls and as a school nurse until her retirement. Her hobbies included gardening and ham radio operator. She was devoted to her family

Nevin, Catherine Prickett, 6/3/2015. Catherine received her nursing degree from Deaconess Hospital after completing one year at the College of Idaho. She worked for many years at Good Samaritan Hospital in Portland, Oregon, and engaged in mission fieldwork in Thailand and in ministering at her church. She cultivated beautiful roses and many friendships throughout her 104 years.

Olsen, Alice Olavarria, 2/18/2015. Alice graduated from St. Teresa's Academy in Boise with her degree in nursing. She worked for 29 years at St. Alphonsus Medical Center and in 1975, she humbly accepted the "Employee of the Year" award. Her dedication to nursing was recognized.

Perecz, Mary "Susan" Chantrill, 6/30/2015. Susan graduated from Ricks College with a nursing degree and became the youngest applicate accepted into the Treasure Valley School of Anesthesia. She worked as a registered nurse at St. Luke's Hospital in Boise. She was selfless in giving to others.

Raney, Cindi Kay, 5/26/2015. Cindi received her BSN from Boise State University and began her career at Mercy Medical Hospital (now Saint Alphonsus Medical Center). She was devoted to nursing, earned a "Forever Fighter" button, and completed the 2015 Komen Race for the Cure. Her family, friends, and patients recognized her strength.

Thomas, Marianna G. Boehmer, 01/13/2015. Marianna enlisted in the Army Nurse Corps and served as an Army officer in World War II. She later worked as a school nurse and at several Veterans Administration hospitals. Later in her career, she worked at the Boise Veterans Administration Medical Center in Boise, Idaho. Her dedication to nursing and serving others was unwavering.

Tibbs-Wideau, Mary Lee, 4/24/2015. Mary Lee completed the St. Luke's Nursing Program in 1962 and work at St. Luke's Medical Center, Boise, Nampa's Mercy Hospital, and the Idaho State School and Hospital. She is remembered for her kindness, strength and courage throughout her life. She was dedicated to nursing and to her family and is missed by all she touched.

Ward, Tamara Louise, 6/12/2015. Tamara graduated from Boise State College and worked in nursing for over 35 years until her retirement in 2010 from Saint Alphonsus Medical Center in Boise. She nurtured her family and those around her and will be remembered for her kindness, acceptance, and welcoming nature.

Dealing with Moral Distress and Ethical Dilemmas in Nursing

by Rick Bassett, MSN, APRN, ANCS-BC, CCRN
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In today's increasingly complex clinical environment, we more frequently encounter moral distress and ethical dilemmas. Regardless of the workplace such as acute care, rehabilitation, long-term care, surgery center or ambulatory clinics, our patients and clients present with unique issues. In some circumstances, these issues present healthcare professionals, the patient/client and their families with difficult decisions for which the resolution seems unattainable. Whether the patient is the child with cancer or a father who has had a devastating head injury or a grandmother who has struggled with end stage disease and now faces imminent death, nurses are there to provide care and support for these patients, their families and for each other.

Complex situations create a challenging work environment that can lead to moral distress or ethical dilemmas. Andrew Jameton (Epstein & Delgado, para 2, 2010) first defined moral distress as "a phenomenon in which one knows the right action to take, but is constrained from taking it." This state of moral distress can result when nurses experience numerous challenging clinical situations. According to the American Association of Critical Care Nurses [AACN], moral distress is a critical issue in nursing which contributes to feeling a loss of integrity and dissatisfaction with their work environment (para 1, 2008). The AACN further cites studies demonstrating that moral distress is a major contributor to nurses leaving the work setting and the profession.

Moral distress is not an uncommon occurrence in critical care and other intense workplace care settings. However, as nurses, we have resources to help confront the feelings of moral distress and find an acceptable resolution. In the role as a Clinical Nurse Specialist and Clinical Ethics Consultant for St. Luke's Hospital, the author has encountered many nurses and other healthcare colleagues struggling to deal with these feelings. It is important that these feelings be shared with colleagues in order to facilitate a resolution. Nurses should identify resources that are in their organizations such as Spiritual Care providers, nursing and physician colleagues, leaders, ethics committee members and others. Many professional organizations also have online resources that identify and present solutions to dealing with moral distress.

In addition to experiencing moral distress in the work environment, nurses may also have encountered an ethical dilemma(s). Most ethical issues in healthcare today involve the core ethical principles of *autonomy (right to choose), beneficence (to do good), non-maleficence (to do no harm)* and *justice (the moral obligation to act).* Some of the most frequent ethical dilemmas arise in settings where patients have complex disease processes and are unable to provide their input into treatment decisions. As a result, health professionals encounter difficulties or disagreements in determining which treatments are in the best interest of the patient. Inadequate communication or incomplete information is often at the core of these difficulties or disagreements. Identifying and addressing the ethical issues early can improve patient outcomes, reduce staff stress, decrease avoidable complex ethical dilemmas, and change potentially irreversible outcomes.

Dealing with moral distress and ethical dilemmas is not infrequent in healthcare today. With an ever-growing number of patients, an increasing patient acuity, and a nursing shortage, nurses need to take action for self-care, must support the health of our workforce and improve our relationships with our patients by proactively addressing moral distress and ethical dilemmas in the workplace. Continually educating ourselves and utilizing our resources will help us to be better patient advocates and more effective healthcare professionals.

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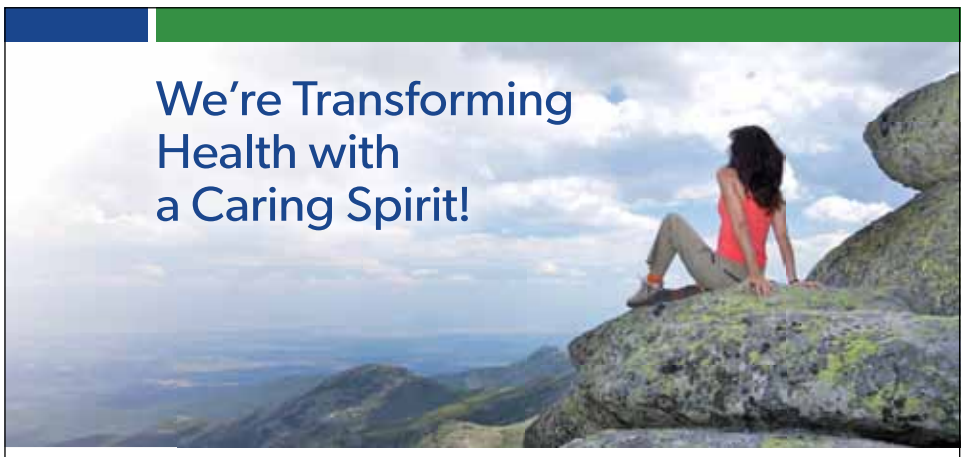

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SCL Health offers a myriad of career choices at Holy Rosary Healthcare (Miles City), St. James Healthcare (Butte), St. Vincent Healthcare (Billings) and within five other hospitals in Colorado and Kansas. There is a setting for every career and lifestyle as our facilities are located near numerous quality-of-life activities for you and your family to enjoy.

All of our locations offer competitive pay, excellent benefits and relocation assistance for qualified positions. RNs may participate in Shared Governance, Pathways to Excellence and other quality-focused programs to augment patient care. In addition, RNs are encouraged and rewarded to continue education or obtain national certifications to enhance their own careers. With so many settings and locations, we offer both career mobility and advancement opportunities.

For details on desired positions, hospital locations of choice, and other questions, please call **Kate Christmas**, RN, Senior Sourcer, at **919-977-6186** or email **Kathryn.Christmas@sclhs.net**. Please enter this code to apply online: **http://bit.ly/1EjaxcL** or visit our website at **sclhealth.org/careers**.

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SCL Health

Holy Rosary Healthcare
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Whether you are liable or *NOT*.
Your defense costs could top $100,000.

But don't just take our word for it …

Here's a true story!

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.

The Professional Liability Insurance offered through Mercer Consumer to members of ANA can save you from the devastating costs related to defending yourself in a lawsuit. Learn more and get a free quote. Call 800-375-2764 or visit www.proliability.com/69545.

*Please contact the program administrator for more information or visit proliability.com for a free quote.

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