**I attended this year’s Constituent Assembly (presidents and executive directors of the states and ANA staff) with Executive Director, Ernest Klein, in St. Louis, Missouri, in early March. As usual, the agenda was full of information from each state nurses association as well as from our national organization. ANA has been busy positioning nurses on key national committees to ensure our voice is heard. With the implementation of the Affordable Care Act, nurses’ contributions are essential to the success of the proposed mandates. President Karen Daley gave a phenomenal speech about ANA and the contributions of nurses to the health of the nation. She announced the first ethics conference sponsored by ANA for which over 400 have registered to date. Her itinerary has included visiting state nurses associations, listening to the concerns and aspirations of RNs, and working with other organizations so that ANA can represent us as clearly as possible.**

Marla Weston, Executive Director of ANA, announced that the Nurses Career Center is available to help new RNs with resume writing and recruiting. The National Database of Nursing Quality Indicators (NDNQI) conference boosted over 1100 attendees with over 100 posters of best practices. She noted ANA has appointed a task force addressing the IOM Report on the Future of Nursing. Their mandate will be to promote three of the recommendations from the report. I will update you on this in future bulletins.

It was obvious, while I listened to Marla, that she is an exceptional executive director. Her energy, ability to organize and build consensus is a testament to the strength and effectiveness of the organization. We are in good hands.

The Coalition for Patients Rights highlighted the work being done to counter the attack by physician groups that hope to discredit the contribution and limit the scope of practice of advanced practice nurses. Thirty-five organizations have organized to develop a plan to protect the patient’s right to choose their health care provider. The IOM report on the Future of Nursing supports the advanced practice role in its full scope to help solve the nation’s health care crisis. Some in the medical community want to continue thinking vertically about health care. This is antiquated and does not promote the kind of quality and efficiency we need in health care today or in the future.

Medical care is one aspect of health care. Health care in its fullness is more than what traditional medicine has to offer. While it is true that we have the best medicine in the world, the depth and breadth of health care requires the contributions of many disciplines, each having primary importance and contribution in any given patient experience. We have to allow the expression of each health care discipline, in particular nursing, to fully serve the individual, family and community health care needs. It is difficult to change our thinking about the paradigm of health care. We have to. Our system can be improved, and it needs to change if we are to meet the demands of the future. More of the same will not do.

Discussion, during the Constituent Assembly, was passionate about impending legislation in ways nursing can contribute to an improved system. The Future of Nursing: Campaign for Action focuses on the critical role played by the largest segment of that workforce—the nation’s 3 million nurses—and the actions that will enhance their ability to contribute as essential partners in the delivery of services. Building from a 2010 Institute of Medicine report on nursing, Campaign for Action has several immediate objectives that will impact nurses’ knowledge, skills and experience. Yet each objective is set within the broader context of creating a health care environment that is truly coordinated, integrated and equitable for everyone.

Campaign for Action initially intends to Advance inter-professional collaboration throughout health care settings; Strengthen nurse education and training to ensure an adequate supply of highly competent and professional nurses; Expand leadership ranks to ensure nurses have a voice in management teams, in boardrooms and during policy debates; Enable all health professionals to practice to the full level of education and training.

**How did this effort get started?**

The Future of Nursing: Campaign for Action marks the implementation phase of a landmark study and report from the Institute of Medicine (IOM) and RWJF. Called the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the IOM, the study occurred over two years and resulted in a robust report and recommendations outlining ways nursing can contribute to an improved American health care delivery system.

Led by former U.S. Secretary of Health and Human Services Donna Shalala, the IOM’s 18-member committee was charged with developing a transformational report on the future of nursing, with solutions to improve the quality of patient care while controlling costs.
The first 13 months of the Initiative involved information gathering, preparation of the consensus report and summaries of the regional forums. Three regional forums as well as two technical or policy-oriented workshops provided input to the study committee.

The Committee recommendations, which were announced in October 2010, dually laid the groundwork for the launch of the National Advisory Committee (NAC) to guide the work of the National Advisory Committee on the long-term aims of the Initiative. NAC met for the first time in June 2011.

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APPLICATION FOR RN MEMBERSHIP in ANA / ISNA

Please print or type

Last Name, First Name, Middle Initial
_____________________________________________________________________________
City, State, Zip+4
Preferred email address
_____________________________________________________________________________

1. SELECT PAY CATEGORY

<table>
<thead>
<tr>
<th>Full Dues—100%</th>
<th>Monthly (EDPP)—$23.25</th>
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</thead>
<tbody>
<tr>
<td>Reduced Dues—50%</td>
<td>Monthly (EDPP)—$11.88</td>
</tr>
<tr>
<td>Not employed; full-time student, or 62 years or older</td>
<td>Annual—$68.25</td>
</tr>
<tr>
<td>Special Dues—25%</td>
<td>Annual—$273</td>
</tr>
</tbody>
</table>

2. SELECT PAYMENT TYPE

FULL PAY—CHECK
FULL PAY—BANKCARD

3. SEND COMPLETED FORM AND SIGNATURE FOR BANKCARD PAYMENT TO:
St. Louis, MO 63150-4345
P.O. Box 504345
American Nurses Association
Customer and Member Billing
F.O. Box 504345
St. Louis, MO 63150-4345

The ISNA is a Constituent Member of the American Nurses Association

CLICK ON “JOIN/RENEW” AND FOLLOW THE LINKS.

Please complete all sections of the application. All information should be accurate.

The ISNA is a not-for-profit organization that promotes the health and safety of nurses, their patients, and the public. Our mission is to advance the economic and professional status of nurses and to influence health policy through advocacy, education, and service.

To join the ISNA, you must be a licensed registered nurse.Membership fees are subject to change without notice. Please check our website for the most current information.

Signature for Bankcard Payment

Welcome to New and Reinstated ISNA Members

Lillian Abdur-Rahman  Indianapolis
Joy Adebowo  Plainfield
Mary Adler  Merrillville
Janie Arington  Evansville
Victoria Barajas  Crown Point
Susan Baty  Hobart
Selea Beard  Evansville
Marianne Benjamin  Indianapolis
Janice BueLOW  Indianapolis
Sheriha Chambliss  Indianapolis
Darla Clark  Lebanon
Leslie Coughlin  Carmel
Katha Corcellus  Trafalgar
Mary Crowder  Hardinsburg
Shawna Curtis  Indianapolis
Claudia David  Indianapolis
Debbie Darby  Evansville
Steven Fields  Ridgeville
Natalie Fitzgerald  Indianapolis
Kathleen Free  Hanover
Sarah Goff  Newburgh
Karen Grooms  Noblesville
James Guy  Warsaw
Barbara Habermann  Indianapolis
Cheronia Hajewski  Newburgh
Tanya Hall  Indianapolis
Sara Herbig  Carmel
Cynthia Herrington  Spencer
Nancy Hostetler  Fishers
Randy Houston  Indianapolis
Jerrilyn Jones  Indianapolis
Theresa Joy  Indianapolis
Margaret Keen  Greenfield
Tonya Kiger  Bainbridge
Samuel Kobba  Avon
Samantha Laker  Ft Wayne
Cathy Lover  Westfield
Trina Marlatt  Attica
Maria McClain  Indianapolis
Lora Meyer  Indianapolis
Tonjameka Miller  Indianapolis
Teressa Moore  Centerpoint
Shannon Navarro  Fort Wayne
Patricia Nikolov  Noblesville
Patricia Nikolov  Noblesville
Margaret O’Drobinak  Crown Point
Michelle Peck  Indianapolis
Melissa Quinby  South Bend
Amy RichmonD  Richmond
Sarah Rutchik  Mishawaka
Amina Santali  Fort Wayne
Kathleen Schaffer  New Haven
Anna Shaynak  Fishers
Debra Sipes-Fears  Plainfield
Stacey Smith  Sullivan
Dorothy Soverly  Griffith
Tamara Strunk  Greenwood
Amara Taylor  Jeffersonville
Judy Ulman  Dyer
Diane Von Ah  Carmel
Phyllis Walker  Indianapolis
FELI TA Wash-White  Noblesville
Brandi White  Indianapolis
Jacob Wiegand  Indianapolis
Certification Corner

By Sue Johnson, PhD, RN, NE-BC

I always enjoy the opportunity to recognize the certification success of nurses in different specialties. In the fall of 2010 twelve Interventional Radiology nurses, the entire unit staff, at a Northeast Indiana hospital expressed an interest in becoming Certified Radiology Nurses (CRNs). The hospital was able to assist them in their preparation by sponsoring a two-day review course on a weekend so everyone could participate. All twelve nurses completed the review course and took their certification exam. Everyone passed!

Here’s what they had to say in their own words:

“Getting certified as a group was great because we could bounce questions off one another to get a perspective about that particular subject. I truly learned a great deal this way!”–David Cocks, RN

“It meant having support, feeling like we were all in it together. It also gave me great resources for study questions. I really felt good to have all my co-workers in the same boat with me. I did not feel alone. It helped to take some of the pressure off.”–Tara McMahon, RN, CRN

“The most exciting part of the certification process was the day results came in the mail. It was a Saturday and the first text message I got was from Steve Pease saying he passed. That was the start of the text messaging frenzy. I was so excited; I was jumping around my house, texting our manager as the results came in. It took most of the day to hear from everyone. It came down to one nurse I hadn’t heard from and I finally made the decision to call her at home. I just couldn’t wait any longer! The final text message went to our manager, “100% passed!!!” It was an excellent day. I was so proud of all of the radiology nurses. They were very brave to take this challenge on together!”–Dianna Stevens, RN, CRN-Lead Diagnostic Imaging Nurse

This achievement translates into excellent patient care and cohesiveness for these professional nurses. They are very special as are all certified nurses. You can do it too! Give yourself permission to reach for excellence by becoming certified yourself and consider a team approach as they did. You’ll be glad you did!

Do you want to share your story with your colleagues? It may encourage them to join you? Please contact me at sue.johnson@parkview.com to share your experiences.

CNE Approved Providers List

The Indiana State Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

The ISNA Committee on Approval approves continuing nursing education providers to award nursing contact hours to the individual activities they develop and present. Any individual, institution, organization, or agency in Indiana responsible for the overall development, implementation, evaluation, and quality assurance of continuing nursing education is eligible to seek approval as a provider. Information must be submitted describing three different educational activities planned, presented, and approved by the Indiana State Nurses Association in the two years preceding the application and should be representative of the types of educational activities usually provided. Applications are reviewed by the Committee on Approval at their meetings in May and November.

For information, contact the ISNA office, e-mail ce@IndianaNurses.org, or visit the ISNA web site www.IndianaNurses.org/education. The following are continuing nursing education providers approved by the ISNA Committee on Approval:

For complete contact information go to: www.indiananurses.org/providers.php

Columbus Regional Hospital, Columbus, IN
Community Health Network, Indianapolis, IN
Deaconess Hospital, Evansville, IN
Franciscan Alliance, St. Margaret Mercy, Hammond, IN.
Franciscan Alliance, St. Francis, Beech Grove, IN.
Good Samaritan Hospital, Vincennes, IN.
Health Care Education & Training, Inc., Carmel, IN.
Health Care Excel, Inc., Terre Haute, IN.
Hendricks Regional Health, Danville, IN.
Indiana University Health, Indianapolis, IN.
Indiana University Health Ball Memorial Hospital, Muncie, IN.
Indiana University Health Bloomington, Bloomington, IN.
Indiana University Health North, Carmel, IN.
Indiana University Health West, Avon, IN.
Indiana Wesleyan University School of Nursing, Marion, IN.
King’s Daughters’ Hospital & Health Services, Madison, IN.
LaPorte Regional Health System, LaPorte, IN.
Lutheran Health Network, Fort Wayne, IN.
Major Hospital, Shelbyville, IN.
Marion General Hospital, Marion, IN.
MCV & Associates Healthcare Inc., Indianapolis, IN.
Memorial Hospital & Health Care Center, Jasper, IN.
Memorial Hospital of South Bend, South Bend, IN.
Methodist Hospitals, Gary, IN.
Parkview Health System, Fort Wayne, IN.
Porter Education and Rehabilitation Center, Valparaiso, IN.
Purdue University Continuing Nursing Education, West Lafayette, IN.
R.L. Roudebush VA Medical Center, Indianapolis, IN.
Reid Hospital & Health Care Services, Richmond, IN.
Schneck Medical Center, Seymour, IN.
Scott Memorial Hospital, Scottsburg, IN.
St. Joseph Regional Medical Center, South Bend, IN.
St. Mary’s Medical Center, Evansville, IN.
St. Vincent Hospital & Health Care Center, Indianapolis, IN.
The Community Hospital, Munster, IN.
Valparaiso University College of Nursing, Valparaiso, IN.
Wishard Health Services, Indianapolis, IN.

Northeast Indiana hospital district embraces the development of quality patient care at the highest level. Having our whole department get certified shows the commitment to excellence we strive for. It is a good feeling to know that the nurses you work alongside share in that commitment.”–Stephen Pease, RN, CRN

“Getting certified as a group was great because we could bounce questions off one another to get perspective about that particular subject. I truly learned a great deal this way!”–David Cocks, RN, CRN

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May, June, July 2011

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**Open Enrollment**

**October 18, 2011**

- **Event/Location**: Indiana University School of Nursing
- **Contact Information**: Phone 317-274-7779, Web: [Indiana University School of Nursing](http://nursing.iupui.edu/continuing/)

**April 21, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**April 26-27, 2011**

- **Event/Location**: Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference
- **Contact Information**: Phone 317-274-7779, Email: cens@iupui.edu, Web: [www.nursing.iupui.edu/continuing/nurse_aide/index.shtml](http://www.nursing.iupui.edu/continuing/nurse_aide/index.shtml)

**May 11, 2011**

- **Event/Location**: Indiana University School of Nursing–Qualified Medical Aide (QMA) Instructor Education
- **Contact Information**: Phone 317-274-7779, Email: cens@iupui.edu, Web: [www.nursing.iupui.edu/continuing/nurse_aide/index.shtml](http://www.nursing.iupui.edu/continuing/nurse_aide/index.shtml)

**May 13, 2011**

- **Date/time**: 10:00 A.M.
- **Event/Location**: Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN, 46168
- **Contact Information**: IONE, Phone 317/423-7771, Web: [www.indiananurse.org/id3.html](http://www.indiananurse.org/id3.html), Email: mbisesi@johnsonmemorial.org

**May 19, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**June 3, 2011**

- **Date/time**: 9:30 A.M.
- **Event/Location**: Indiana State Nurses Association Board of Directors Meeting
- **Contact Information**: Indiana State Nurses Association, Phone: 317/299-4575, Web: [www.indiananurses.org](http://www.indiananurses.org), Email: info@indiananurses.org

**June 16, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**July 21, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**August 9-10, 2011**

- **Event/Location**: Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference
- **Contact Information**: Phone 317-274-7779, Email: cens@iupui.edu, Web: [www.nursing.iupui.edu/continuing/nurse_aide/index.shtml](http://www.nursing.iupui.edu/continuing/nurse_aide/index.shtml)

**August 12, 2011**

- **Date/time**: 10:00 A.M.
- **Event/Location**: Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN, 46168 2nd floor conference room
- **Contact Information**: IONE, Phone 317/423-7771, Web: [www.indiananurse.org/id3.html](http://www.indiananurse.org/id3.html), Email: mbisesi@johnsonmemorial.org

**August 18, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**September 9, 2011**

- **Date/time**: 9:30 A.M.
- **Event/Location**: Indiana State Nurses Association Board of Directors Meeting
- **Contact Information**: Indiana State Nurses Association, Phone: 317/299-4575, Web: [www.indiananurses.org](http://www.indiananurses.org), Email: info@indiananurses.org

**September 9, 2011**

- **Event/Location**: Deadline Pre-Registration ISNA Annual Meeting of the Members
- **Contact Information**: Indiana State Nurses Association, Phone: 317/299-4575, Web: [www.indiananurses.org](http://www.indiananurses.org), Email: info@indiananurses.org

**September 15, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**September 30, 2011**

- **Event/Location**: ISNA Annual Meeting of the Members Primo Banquet Center South, 2615 E. National Ave., Indianapolis, IN, 46222
- **Contact Information**: Indiana State Nurses Association, Phone: 317/299-4575, Web: [www.indiananurses.org](http://www.indiananurses.org), Email: info@indiananurses.org

**October 8, 2011**

- **Date/time**: 1:00 P.M.
- **Event/Location**: Indiana Organization of Nursing Executives (IONE) Board Meeting/Brown County Inn
- **Contact Information**: IONE, Phone 317/423-7771, Web: [www.indiananurse.org/id3.html](http://www.indiananurse.org/id3.html), Email: mbisesi@johnsonmemorial.org

**October 18-19, 2011**

- **Event/Location**: Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference
- **Contact Information**: Phone 317-274-7779, Email: cens@iupui.edu, Web: [www.nursing.iupui.edu/continuing/nurse_aide/index.shtml](http://www.nursing.iupui.edu/continuing/nurse_aide/index.shtml)

**October 19-21, 2011**

- **Event/Location**: Indiana Organization of Nursing Executives (IONE) Fall Conference/Brown County Inn
- **Contact Information**: IONE, Phone 317/423-7771, Web: [www.indiananurse.org/id3.html](http://www.indiananurse.org/id3.html), Email: mbisesi@johnsonmemorial.org

**October 20, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**November 11, 2011**

- **Date/time**: 10:00 A.M. (Transition Meeting)
- **Event/Location**: Indiana Organization of Nursing Executives (IONE) Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN, 46168
- **Contact Information**: IONE, Phone 317/423-7771, Web: [www.indiananurse.org/id3.html](http://www.indiananurse.org/id3.html), Email: mbisesi@johnsonmemorial.org, 2nd floor conference room

**November 11-12, 2011**

- **Event/Location**: Indiana Spinal Group: Back Talk: A Comprehensive Review and Practical Approach to Spinal Diagnosis and Treatment, Carmel, IN

**November 17, 2011**

- **Event/Location**: Indiana State Board of Nursing
- **Contact Information**: Phone 317/243-2043, Email: plaz@pla.IN.gov, Web: [www.pla.IN.gov](http://www.pla.IN.gov)

**December 15, 2011**

- **Event/Location**: Indiana State Board of Nursing
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Few of us would deliberately do something unethical. And, most of us have some familiarity with the American Nurses Association’s Code for Ethics for nurses. Yet, in complex situations, with a number of professionals and perspectives involved, sometimes doing the right thing—what’s ethical—is difficult to determine. Thus, nurses need to know about current ethical thinking and to acknowledge the value of an interdisciplinary process that includes the patient and/or family in solving ethical dilemmas.

An example of a change in ethical thinking involves the Golden Rule: “Do unto others as you would like to have them do unto you.” However, out of respect for the multiple cultures in our society, this rule has become the Platinum Rule. “Do unto others as they would like to have done unto them.”

Thus, in trying to determine what is right in a situation that involves a patient with a cultural background different from ours, it is important to obtain some background on the person’s cultural values and to be sensitive to the individual’s approach to problem-solving. At the same time, nurses should treat each patient as an individual and NOT stereotype patients according to their culture of origin. Therefore, it is important to ask each patient their values and desired approach to solving a clinical situation.

Principle-based Ethics vs. the Ethic of Care

For centuries, ethicists have ascribed to the principles of beneficence, non-maleficence, and justice. Within the last few centuries, the concept of autonomy has become prominent in some societies, especially in America, where individualism has become sacrosanct. These concepts form the basis of principle-based ethics. However, traditional approaches to health care were not a way we treat and relate to each other began to expand in the 1960s in America with the various movements, including:

- Women’s rights
- Patients’ rights
- Autonomy
- Self-determination
- The right of privacy
- Professionalism
- The concept of a patient (Varecka and Jassak 1989)
- The concept of the patient’s surrogate decision-maker

With all the changes in the 60s came an increasing respect for the feminine perspective. This perspective emphasized more consideration of knowing the details of what is happening.

Informed consent, another important aspect of respecting autonomy, has strong legal requirements, including:

- The purpose of the treatment
- How long the treatment will last
- What the consequences of a patient’s decision to stop treatment will be
- What the risks and discomforts will be
- What benefits to the patient or others are hoped for
- What alternative options are available
- How the patient’s records will be kept confidential and who might review them (for example, in a research study).
- What medical treatments or compensation are available if injury occurs
- A statement that the patient’s participation is voluntary and that, if he or she decides not to participate, care will still be provided without penalty
- A statement that the patient’s surrogate decision-maker may be harm involved if the patient stops part way in a treatment process.

Additional elements may be required in some circumstances:

- A statement that some risks may be foreseeable
- The researcher may have to stop the treatment without the patient’s consent
- There may be additional costs to the patient
- The consequences of a patient’s decision to stop treatment will be. (There may be harm involved if the patient stops part way in a treatment process)
- A statement of the very latest information about the treatment will be provided to the patient while he is undergoing the treatment
- The number of patients receiving the treatment. (Varecki and Jassak 1989)

Justice derives from the general rule of human conduct to treat other people fairly; like cases are treated alike; there is equitable distribution of risks and benefits. This principle imposes unclear responsibilities on health care professionals because society has NOT sorted this out.

With managed care, millions uninsured and the availability of expensive, high-tech interventions,
health care professionals are often pressured to make difficult access and allocation decisions without clear-cut guidelines. Dr. Leah Curtin offers one of the most rational statements on justice: “People have the right to justice in the distribution of health resources as opposed to a right to any and all specific care or treatments, whether or not they need them and/or are likely to benefit from them.” Citizens must acknowledge their responsibility to themselves to their health and to their community. The ethic of care, the ANA Code of Ethics for Nurses (Refer to Table 3), and one’s own personal moral background which is often based in a religious tradition. Sometimes this awareness stems from taking the time to think about and reflect upon a situation. At other times, there is just a gut feeling that something is not right.

An Ethical Decision Making Process for the Registered Nurse

The first step in ethical decision-making is being aware that an ethical problem exists. Awareness may originate from a variety of sources, including the principles described above, the ethic of care, the ANA Code of Ethics for Nurses (Refer to Table 3), and one’s own personal moral background which is often based in a religious tradition. Sometimes this awareness stems from taking the time to think about and reflect upon a situation. At other times, there is just a gut feeling that something is not right.

Table 3: The American Nurses Association Code of Ethics for Nurses

1. The nurse, in all professional relationships, practice with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social worth, personal attributes, or the nature of health problems.
2. The nurse’s primary commitment is to the patient, whether an individual, family, group or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration and knowledge development.
8. The nurse collaborates with other health professionals and the public as promoting community, national and international efforts to meet health needs.
9. The professional of nursing, as represented by association and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice and for shaping social policy.

The next step in an ethical process involves thinking critically about a situation to determine if it is an ethical dilemma. Some circumstances that may involve some ethical issues, but may be better solved by another process include the following:
- Medical or health care errors—these should be addressed through the Clinical Quality Improvement Process within the system.

Table 2: Comparison of Ethical Approaches

<table>
<thead>
<tr>
<th>Principle-based Ethics</th>
<th>Ethic of Care</th>
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<tbody>
<tr>
<td>Responsibilities defined by rights and duties</td>
<td>Responsibilities derived from health care professional-patient relationships</td>
</tr>
<tr>
<td>Reason and objectivity</td>
<td>Emotions enhance reason</td>
</tr>
<tr>
<td>Detachment enhances fairness</td>
<td>Engagement enhances understanding and fairness</td>
</tr>
<tr>
<td>Focused on the individual</td>
<td>Focused on the family (the context)</td>
</tr>
</tbody>
</table>

Table 1: The Meaning of Caring in Health Care Professional-Patient Relationships

<table>
<thead>
<tr>
<th>Relationships</th>
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<tr>
<td>Doing for another</td>
</tr>
<tr>
<td>Being responsive to another</td>
</tr>
<tr>
<td>Valuing another—regardless of culture, social status, etc.</td>
</tr>
<tr>
<td>Extending compassion, mercy and kindness</td>
</tr>
<tr>
<td>Enhancing human dignity</td>
</tr>
<tr>
<td>Connecting with another</td>
</tr>
<tr>
<td>Being touched by another’s situation</td>
</tr>
<tr>
<td>Empowering another to act for him or herself</td>
</tr>
<tr>
<td>Helping another find meaning in his or her situation</td>
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</table>

Over the past 40 years, the ethic of care has gained more acceptance. Incorporating it in ethical deliberations is valued as an adjunct to principle-based ethics. The ethic of care helps decision-makers better understand the situation’s context and recognizes the importance of the health care professional-patient relationship in considering which principles are given priority in guiding moral action. Although the ethic of care can compliment principle-based ethical thinking, it does offer a different perspective that may also cause conflicts with those who prefer to rely mostly on the principle-based approach. Table 2 outlines the differences between principle-based ethics and the ethic of care.

Table 3: The American Nurses Association Code of Ethics for Nurses

- Health care professional impairment—these problems should be handled discreetly and with the focus of assisting the individual. Check your agency’s policies on what colleagues are supposed to do in these unfortunate situations. ONA’s Peer Assistance Program provides support and resources for nurses with these problems (614-448-102).
- Billing fraud, business conflicts of interest, etc., should be forwarded to the agency’s Compliance Program which is required by organizations receiving Medicare/Medicaid funds.

For situations that are clearly ethical dilemmas, the ONA has developed a pocket card that contains an ethical decision-making tree. Refer to Table 4, which describes an easy, six-step ethical decision making process. Identifying an ethical dilemma is the first step in this process. Before the dilemma becomes apparent, the persons involved may just have a gut feeling that something is not right. Once they begin to discuss their feelings, the ethical dilemma becomes clearer and can more easily be defined.

Ethics continued on page 8

Over the past 40 years, the ethic of care has gained more acceptance. Incorporating it in ethical deliberations is valued as an adjunct to principle-based ethics. The ethic of care helps decision-makers better understand the situation’s context and recognizes the importance of the health care professional-patient relationship in considering which principles are given priority in guiding moral action. Although the ethic of care can compliment principle-based ethical thinking, it does offer a different perspective that may also cause conflicts with those who prefer to rely mostly on the principle-based approach. Table 2 outlines the differences between principle-based ethics and the ethic of care.
Table 4: ONA’s Ethical Decision Making Process for the Registered Nurse

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1.</td>
<td>Identify the existence of an ethical dilemma or situation. Ethical dilemmas exist “when two or more courses of action are possible, but neither has a compelling rationale for choice” (Catalano, 1991, p.21). Ethical dilemmas arise from fundamental conflicts among ethical beliefs, duties, principles, and theories.</td>
</tr>
<tr>
<td>2.</td>
<td>Gather and analyze relevant information. Consider the clinical and other situational facts. Consider the patient, patient’s family and significant other(s), and members of interdisciplinary health care team; identify decision-makers and each one’s frame of reference for decisions.</td>
</tr>
<tr>
<td>3.</td>
<td>Clarify personal values and moral position. Identify value conflicts of decision-makers. As needed, consult internal ethics committees and/or experts in related fields, i.e., ethics, religion, law, and medicine.</td>
</tr>
<tr>
<td>4.</td>
<td>Based on steps 2 and 3 determine options. Options in ethical decision making are not easily prioritized—one usually arrives at a decision based on the theory (ies), principles, or combination that best fits with one’s personal and professional values. Consider anticipated outcomes of any action.</td>
</tr>
<tr>
<td>5.</td>
<td>Make a responsible collaborative decision and take action.</td>
</tr>
<tr>
<td>6.</td>
<td>Evaluate the impact of the action taken. Review the process, assess level of satisfaction with the process and results with the understanding that universal agreement and equal levels of satisfaction among the participants may be difficult to accomplish. Explore alternative options as needed.</td>
</tr>
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</table>

Ethics Committees and/or Consultants

Sometimes in situations that are very complex or intense, it is difficult for the health care professionals involved in the patient’s care to reach agreement on the best thing to do. This usually becomes apparent in Step 3 of the ethical decision-making process where caregivers, the patient, and/or the family are clarifying their personal values and moral positions—and they are in conflict. Conflicts can easily arise in today’s pluralistic society. Conflicts should not be considered “bad.” It is important to acknowledge differences and work with everyone involved to achieve the best outcomes for the patient and family. A meeting to dialogue about these issues, facilitated by a multidisciplinary ethics consult team or an ethics consultant, can be invaluable.

Ethics committees and consultants are generally advisory within health care systems. They provide a new set of eyes and ears that can offer fresh, unbiased perspectives and insights. A multidisciplinary ethics consult team may consist of a physician, nurse, social worker and chaplain. An ethics team has the advantage of providing a variety of expertise and of protecting against idiosyncratic perspectives. For what can be expected from ethics consultations by a team or an individual, refer to Core Competencies for Health Care Ethics Consultation published by the American Society of Bioethics & Humanities in 1998.

The Joint Commission for the Accreditation of Healthcare Organizations requires that agencies have an ethical problem-solving process available and accessible to its entire staff and clients. In any ethical deliberations, the key to successful resolution is communication. All members of the health care team must be willing to listen to others, express knowledge and to respect others’ rights to express their opinions.

Case Study

Raquel is a 55 year-old Latino female who is visiting the clinic today. She has become increasingly tired over the past few weeks and has had a severe sore throat for three days. Her son, Marcos, who is 27 and his wife, Jeanna, are with her. After you do your physical assessment, you do a throat culture and draw a complete blood count. You suggest to Raquel and her family that they go to lunch until the test results are back.

Implementation of some ethical principles in this case:

- **Platinum Rule**—At the time you suggest that the Raquel and her family go to lunch is when you should ask Raquel how much information she wants to know. Therefore, when she and her family return from lunch, you will be prepared to tell her what she wants to know. For example, she may tell you that she prefers that you discuss the test results with her son and daughter-in-law so they can make her medical decisions for her. Thus, when the results are known, you would ask Marcos and Jeanne to come into your office while Raquel waited in the lobby.

- **Autonomy**—Most Americans choose to make their own decisions. However, self-determination can also include choosing to have someone else decide for you because you do not want to know the details of your condition. The latter is the case in many cultures. In fact, in the Latino culture, it is considered respectful and the duty of adult children to make the medical decisions for parents to spare them the anguish of bad news.

- **Beneficence**—Because Raquel’s son and his wife will be making her treatment decisions for her, health care professionals are obligated to give them the same information that they would have given Raquel if she had chosen to make her own decisions.

The Importance of Advance Directives in Ethical Decision Making

The purpose of advance directives are to protect a person’s autonomy and rights to self-determination when the person is unable to tell health care professionals his wishes. People should complete these legal documents before they become critically ill to direct others on how to make health care decisions for them if they are unable to make their own decisions.

There are three types of Advance Directives:

1. **Living Will**: A document directing the health care team regarding withholding or...
withdrawing life sustaining treatment when the person is in a permanently unconscious state and remains unconscious or terminal condition and incapable of making his or her own decisions.

A. Terminal condition is defined as:
1) Irreversible
2) Incurable
3) Unavailable . . . from which there can be no recovery and death is likely to occur within a relatively short time, if life sustaining treatment is not provided. A life sustaining treatment is any medical procedure, treatment, or other measure, whether or not related to a malignancy, that serves to principally prolong the dying process.
4) Confirmed by the 2nd opinion of two medical professionals.

B. The diagnosis of a permanently unconscious state must be:
1) Based on a reasonable degree of medical certainty that:
   a) The patient is irreversibly unaware of himself or herself and the environment.
   b) The patient has a total loss of cerebral functioning so that he or she cannot experience pain or suffering.
2) Confirmed by the 2nd opinion of a physician who specializes in such conditions.

2. Durable Power of Attorney for Health Care: A durable power of attorney gives the individual the ability to make health care decisions for the patient in the event the patient loses the capacity to make health care decisions. A common example of when a durable power of attorney for health care takes effect is when a patient is NOT capable of making his or her own decisions, e.g., from confusion, sedation, chronic condition, etc. The patient’s representative is the person(s) named by the patient in the Durable Power of Attorney to make his decisions when he cannot make his decisions. Health care providers have a duty to communicate health care information about the patient to the patient’s representative so this person can make the necessary health care decisions.

The legal and moral duties of the patient’s representative are to make decisions that are consistent with the patient’s previously stated wishes. If the patient’s wishes are unknown, the representative is allowed to try to decide what to do based on what is best for the patient, knowing the type of person he or she is. A representative is prohibited from changing any restriction established by the patient.

As long as a patient has “capacity,” he makes his own decisions. Capacity to make one’s own decisions is based on an assessment that the patient has the ability to:

a. Understand health-related information.

b. Reason and deliberate about his or her health care choices, AND

c. Apply specific information to his condition.

Note: A judge in a court of law may declare a person “incompetent.” This is a legal designation. Incompetent people are also incapable of making their own decisions. The guardian appointed for them by the court has the authority to make their decisions for them.

Nutrition and Hydration—Special Consideration: On both the Living Will and Durable Power of Attorney forms there is a special box that must be checked if the person does not want artificial nutrition and hydration.

3. Do Not Resuscitate Order/Identification: This newest advance directive in Ohio is a state-approved form or identification used to alert health care professionals that the individual does not want cardiopulmonary resuscitation (CPR) or other processes related to an ethical decision-making process.

Persons NOT having Advance Directives

If a patient does not have capacity and does not have an advance directive, the State of Ohio designates the persons below, in the following order, to be the patient’s legal surrogate:

1. Legal guardian
2. Spouse
3. Adult children (18 years or older)—The majority of adults who are available within a reasonable length of time
4. Parents
5. Siblings—the majority of the adults who are available within a reasonable length of time
6. Aunts, uncles or any other known blood relatives who are located within a reasonable length of time.

When there is disagreement among co-equals (adult children, parents, adult siblings), the health care team should make every attempt to find a harmonious decision among the deciding members of the family. If this cannot be reached, the team should contact other resources, such as the ethics committee or consultant, clergy, social services, etc.

Case Study continued...

Raquel’s complete blood count revealed that she may have acute leukemia and further testing should be recommended. Marcos and Jeanne decide that Raquel should have the additional tests and should be aggressively treated. It’s now two years later. Raquel received chemotherapy and was in complete remission until four months ago when her leukemia relapsed. Two physicians of chemotherapy have not resulted in another remission for Raquel. Marcos and Jeanna decide that Raquel has had enough aggressive treatment. She needs to be taken to a process.

Implementation of some ethical principles in this case:

Ethics of Care—Since you have come to know Raquel and her family so well over the past two years, you know that Raquel would not want to complete a Living Will or Durable Power of Attorney. She has verbally designated her son as her decision-maker, even while she has been capable of making her own decisions. Thus, there is no need to do written advance directives for Raquel as long as the physician has documented Raquel’s specific wishes in the medical record.

DNRC—Since you know the family’s wishes and the reality of Raquel’s prognosis, you suggest to Marcos and Jeanne that they enroll Raquel in hospice care at home. You explain the compassionate comfort care that hospice provides. You also inform them about a DNRC. They restate that they want Raquel to die peacefully at home. You write a DNRC order on the form and give them a copy.

Platinum Rule—You know that hospices usually get permission from the patient for admission to their program. You also know that hospices speak very frankly about dying. So, you call the hospice admission nurse. You explain to him Raquel’s cultural background and her verbal request to have her son make her decisions, which he has been doing throughout the course of his mother’s illness. You fax hospice a copy of the DNRC order and a copy of your clinic notes where you recorded Raquel’s wishes that her medical information be given to her son so he could make her decisions for her.

Summary

Critical ethical thinking is important for nurses in meeting the tough challenges in today’s health care environment. The nurse needs to be familiar with basic ethical principles, the ethic of care, and the latest forms of advance directives. Patients, families and the public trust nurses more than any other profession. (Gallup Health) All nurses must strive to uphold this trust by advocating for patients and using an ethical process to ensure that patients’ needs are appropriately addressed within the health care system.
1. The statement: “Do unto others as they would like to have done unto them,” is known as:
   a. The Golden Rule
   b. The Bronze Rule
   c. The Preamble to the ANA Code of Ethics for Nurses
   d. The Platinum Rule

2. Principle-based ethics include principles that:
   a. Emerged from the rights movements in the 60s
   b. Have been used for centuries, except for the more recent concept of autonomy
   c. Emphasizes health care professionals and patients
   d. Acknowledge the importance of engagement in the health care professional-patient relationship.

3. Fidelity and advocacy are two responsibilities of health care professionals related to the principle of:
   a. Nonmaleficence
   b. Justice
   c. Beneficence
   d. Autonomy

4. Value conflicts may involve the use of high tech interventions (e.g., intensive care units) when their use may cause the patient a great deal of suffering with minimal chance of a positive outcome. Explaining the benefits and burdens of the possible short and long-term outcomes in language the patient and/or family can understand is an example of the ethical principle of:
   a. Nonmaleficence
   b. Justice
   c. Beneficence
   d. Autonomy

5. Mr. Carlos is a 65-year-old Mexican-American who comes to the clinic with a chronic cough. His chest x-ray shows a large mass in his right upper lobe. The physician and nurse are approaching the exam room where Mr. Carlos is waiting. Mr. Carlos’ son, Juan, steps out of the room. He asks you not to tell his dad the medical information found on the chest x-ray. What should the physician and nurse do?
   a. Honor Juan’s request, believing that he is being beneficent toward his dad.
   b. Out of respect for Mr. Carlos’ autonomy, proceed into his room to give him the results of his chest x-ray.
   c. Explain to Juan that you will honor his request as long as his dad states that he prefers that Juan be told the medical information found on the chest x-ray. and let him tell his dad to avoid nonmaleficence.

6. Which of the following are required for informed consent?
   1) The purpose of the treatment.
   2) What the risks and discomforts will be.
   3) What benefits to the patient or others are hoped for.
   4) What alternative options are available.
      a. 1) and 2
      b. 3) and 4
      c. 1), 2) and 4)
      d. 1), 2), 3), and 4)

7. Futility is often debated along with which ethical principle?
   a. Nonmaleficence
   b. Justice
   c. Beneficence
   d. Autonomy

8. The ethic of care has gained more acceptance over the past 40 years.
   a. True
   b. False

9-12. Indicate beside the statements below whether they describe:
   a. Principle-based ethics
   OR
   b. Ethic of care

   9. Emotions enhance reason.
   10. Focused on rights and duties
   11. Focused on the family as the context
   12. Reason and objectivity are important

13. Which of the following statements are parts of ANA’s Code of Ethics for Nurses?
   1) Acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person;
   2) Participates in the profession’s efforts to establish and maintain conditions of employment conducive to high quality nursing;
   3) Participates in the profession’s efforts to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing;
   4) Collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public. 
      a. 1) and 2
      b. 3) and 4
      c. 1), 2) and 4)
      d. 1), 2), 3), and 4)

14. An ethical process is the best mechanism for handling medical errors.
   a. True
   b. False

15. Clarifying personal values is part of an ethical process.
   a. True
   b. False

16. Sometimes a gut feeling that something is not right or feeling uncomfortable about a patient’s situation is the first step to solving an ethical dilemma.
   a. True
   b. False

17. Advance directives for the state of Ohio include:
   1) No Code Blue Order
   2) Durable Power of Attorney for Health Care
   3) Living Will
   4) Do Not Resuscitate Comfort Care (DNRCC) Order
      a. 1) and 2
      b. 3) and 4
      c. 2), 3) and 4)
      d. 1), 2), 3), and 4)

18. A living will takes effect if the person:
   a. 1) Acts to safeguard the client and the public 
   b. 2) Durable Power of Attorney for Health Care
   c. 3) Living Will
   d. 4) Do Not Resuscitate Comfort Care (DNRCC) Order
      a. 1) and 2
      b. 3) and 4
      c. 2), 3) and 4)
      d. 1), 2) and 3)

19. A living will takes effect if the person:
   a. Is confused.
   b. Has cancer.
   c. Is in coma.
   d. Is confused.
   e. Is in a coma.

20. Mrs. Jones, a 47-year-old executive with breast cancer, did not write an advance directive because she did not want to think about the possibility of dying. She is now in the Emergency Department with severe shortness of breath from metastatic disease and is not capable of making her own decisions. Who in her family has the legal right to make the decision whether to put her on a respirator?
   a. Ex-husband
   b. Eldest son who is 25
   c. Two adult sons and an adult daughter
   d. Mother who is 65

Evaluations:

1. Were the following objectives met? Yes No
   a. Describe the health care professional’s responsibilities related to the principles of beneficence, nonmaleficence, autonomy and justice.
   b. Compare principle-based ethics with the ethic of care.
   c. Recognize the tenets of ANA’s Code of Ethics for nurses.
   d. Identify situations that are solved through other processes rather than an ethical process.
   e. List steps of an ethical decision-making process.
   f. Differentiate among the three Advanced Directives.
   g. List the persons, in order of priority, whom Ohio law designates as legal surrogates of persons without Advanced Directives.
   h. Was this independent study an effective method of learning?

2. Was this independent study an effective method of learning? If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?

4. What other topics would you like to see addressed in an independent study
Wisconsin, Indiana and Ohio concerning the restrictions on collective bargaining for state employees. Many nurses are part of health care institutions affected by these pieces of legislation. ANA reaches out to these nurses because ANA is similar to a family, with each state being a family member, each with different needs and strategies to solve their problems. We have states with collective bargaining units represented by their state nurses associations, states with nurses who are represented by other non-nurse groups, and states with no collective bargaining units. ANA is diverse in many ways and I see this as one area which causes more conversation, emotionalism and polarization than any other. Just like families, the unit must serve all members individually and collectively. And just like families, it is not easy to keep the unit together and on track. We (the state organizations) are the same yet we are different... autonomous and dependent. This is a difficult task for ANA and each state, and requires respect and sensitivity.

When nurses run out of options to ensure the safety of the patients they serve and to secure fair and safe work environments, collective bargaining is a tool to help them achieve these goals. If nursing administrators and managers are engaged, understand, and act upon what it takes to provide a safe patient and fair work environment then collective bargaining units are not necessary. (I recognize that this is easier said than done, but still the truth!) We need to ensure that our administrators and managers are equipped with knowledge of the best practices for their work environment. Nurses need to be involved at all levels, from bedside care, to writing policies, to developing solutions to our health care crisis. Hospitals securing Magnet status is one way to keep nurses involved at all levels of care. As each state deals with its work environment issues, we must respect their decisions to use collective bargaining or not use it. ANA supports nurses who decide to use collective bargaining as one tool and those who do not choose to use this method to ensure a safe patient and work environments. Whether you believe in union activity or not, it is part of the family conversation and will not and should not deter from our work.

These are just a few highlights from our time together at the Constituent Assembly. It is a good time to be a nurse. We have lots of work to do to make the changes needed to transform health care. The Constituent Assembly was a great place to have the family conversation.
In the current U.S. economy where employers can be so selective in their hiring, some ask the Indiana State Nurses Assistance Program for Nurses (ISNAP) why they should bother to retain or hire the nurse who is participating in ISNAP when they can hire another nurse without known risk?

ISNAP’s answer...
1. Substance abuse and dependency, as well as psychiatric disorders, are prevalent in our society and individuals working in the health care industry are not immune. Nurses with substance abuse and dependency have identified the lack of education and ignorance about substance abuse and dependency along with the negativity towards those with these disorders as hindering their being identified and entering treatment.

2. The cost of turnover in nursing, when accounting for both direct and indirect costs, may cost employers anywhere from 60–100 percent of the former nurse’s salary, plus the salary of the new nurse. By retaining nurses participating in the Texas Program, Baylor University Medical Center Dallas, realized an over $4 million savings in turnover cost avoidance during a nine-year period.

3. As reported by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, when individuals receive treatment for substance abuse, significant savings are realized by employers, including greater productivity, decreased turnover, decreased medical care and sick leave costs, and fewer on-the-job injuries. These factors represent only a few of the variables involved in the total cost of drug abuse and addiction that is estimated at costing the U.S. over one-half trillion dollars annually.

4. When employers retain or hire an ISNAP nurse, they have a nurse with an identified risk who is closely monitored, including random drug testing and a work-site monitor. The nurse applicant who is less known, i.e., not in ISNAP, may seem more desirable but may actually prove to have more liabilities. Research has shown that nurses in alternative programs (vs. nurses under licensure discipline) not only return to practice sooner but also if relapse occurs, they are identified sooner—providing less risk of harm. The caveat for employers: Be careful! Being too punitive to an ISNAP nurse may cause you to go from the frying pan to the fire!

5. Though the Recovery Monitoring Agreement (RMA) imposes firm boundaries or restrictions on the ISNAP participants’ nursing practice, they need not dissuade employers from hiring nurses in ISNAP. When co-workers are informed of the restrictions and why they are needed, as required under the RMA, co-workers are less likely to enable participants towards relapse while at work.

6. The participation and monitoring requirements under ISNAP are extensive and serve to protect patients, the participating nurse, and co-workers. ISNAP participants are required to inform both their employer and their professional peers who have a legitimate need to know of their participation. Nurses in ISNAP must also document their support system, e.g., attendance at self-help meetings such as Alcoholics Anonymous and Narcotics Anonymous, or therapy.

7. Nurses participating in ISNAP are often very motivated to make the sacrifices necessary to improve their lifestyles through their recovery, thereby benefiting their patients and their employers as nurse managers of ISNAP nurses have attested to time and time again. Thus, ISNAP provides the framework for nurses to live a healthier lifestyle and with employers’ assistance, the checks and balances that allow them to have greater accountability of their nursing practice.

8. Nurses in ISNAP are required to maintain and demonstrate safe nursing practice and are monitored for the duration of their participation (usually one to three years). Translation: Employers are likely to gain a long-term employee.

9. Nurses in ISNAP have high success rate given the chronicity of their diseases. At least 65 percent of ISNAP nurses who sign RMA’s successfully complete ISNAP’s rigorous requirements.

10. If health care employers often, directly or indirectly, care for or help in the rehabilitation of patients who may have a substance abuse or psychiatric disorder as well as other chronic diseases, why would they not allow similar care and re-entry to practice for their nurse employees, especially those who have demonstrated good practice and loyalty? Caveat: Don’t throw the baby out with the bath water!

The Indiana State Nurses Assistance Program is both a voluntary, alternative program and an Indiana State Board of Nursing mandated program for RNs and LPNs of Indiana whose substance use disorders may have impaired their practice. ISNAP is administered by the Indiana State Nurses Association under contract with the Indiana Professional Licensing Agency.

To find out more at www.IndianaNurses.org, Nurses can contact ISNAP for consultation and possible referral or obtain information about continuing education for one’s facility at 800/838-6623.

References

Thanks to Mike Van Doren, MSN, RN, CARN, Program Director, Texas Peer Assistance Program for Nurses. Reprinted and modified for Indiana with permission from Texas Nurses Association. Copyright © 2011 TEXAS NURSING VOICE
ISNA Board of Directors Meeting Summary

March 4, 2011

Present: Barbara Kelly, President/ANA Delegate; Paula McAfee, Vice President; Michael Fights, Treasurer/ANA Delegate; Directors Mary Cisco, Angela Heckman, Judy Morgan and Cynthia Stone; Mary Davidson, Administrative Assistant; Ernest Klein, Executive Director.

Absent with notice: Diana K. Sullivan, Secretary; Vicki Johnson, Director.

Others: Kathy Weaver, Public Health Nurse Chapter.

ISSUE DISCUSSION

A. Summary report was given by Ernest Klein related to IOM/RWJF Regional Action Coalition.

B. Announcement of the upcoming IN Nursing Center Summit–April 1

C. Legislative issues

APPROVED:

Financial Statement Dec 31, 2010 presented by Michael Wolf, CPA.

Move Growth and Development funds to Assets/Gen fund.

November 19, 2010 minutes.

Speaker for the Annual Meeting of the Members.

REPORTS

President’s Report. Barbara Kelly gave a verbal report.

Safety Task Force—Cynthia Stone made presentation to BOD on ergonomic issues related to improving patient lift technology in the clinical setting and its impact on reduced injury and associated medical costs.

Psych/Mental Health Chapter. Exploring their options as a chapter.

Public Health Chapter. Kathy Weaver reporting.

Staff Report: Report given by the Executive Director.

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