The ISNA Bulletin is the Official Publication of the Indiana State Nurses Association

ISNA®
INDIANA STATE NURSES ASSOCIATION
www.indiananurses.org

ADVOCATING ON BEHALF OF REGISTERED NURSES SINCE 1903.

Quarterly circulation approximately 115,000 to all RNs and LPNs in Indiana.

Volume 37, No. 3 May, June, July 2011

President's Message

Barbara Kelly

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 report 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

President's Message continued on page 12

Gonzalez to Keynote ISNA Annual Meeting

September 30, 2011

Rose Gonzalez

Rose Gonzalez, ANA Director of Government Affairs has worked in the Government Affairs Department for more than 16 years. She has served as director for over 10 years. In this role she oversees the department which lobbies both the Executive Branch and Congress on issues important to nursing, including nursing workforce development programs, staff nurse issues and issues of concern to Advanced Practice Nurses. She coordinates the work of the ANA-PAC which provides funding for candidates running for political office on the federal level and N-STAT which is ANA's grassroots program as well as its State Government Affairs program which serves as a resource and provides strategy to ANA's state nurse associations on state legislation. This allows for an integrated approach to Federal and State legislative activities.

Before coming to ANA she served as the Acting Executive Secretary of the New York State Boards for Optometry and Veterinary Medicine and prior to that worked with the NYS Board of Nursing. She has held various positions in nursing and worked in various health care settings. She has a BSN from Mount Saint Mary College and an MPS with a concentration in health care administration from the State University of NY in New Paltz. She is currently enrolled in a nursing doctoral program at George Mason University and is in her dissertation phase.

Future of Nursing: Campaign for Action

Overview

Campaign for Action is a multi-year initiative by the Robert Wood Johnson Foundation (RWJF) to help transform the system and culture of health care. Its goal is to ensure that all Americans have access to high-quality, patient-centered care and that all health care professionals are better prepared and able to practice to the fullest extent of their education and training. *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 that nurses have a voice on management teams, in boardrooms and during policy debates;

Enable all health professionals to practice to fully 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.

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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, describe a plethora of system improvements, including proven, solution-oriented ways to solve the nursing and nurse faculty shortages in the U.S. and to ensure that the benefits if nurse-led models of care can be realized throughout the health care system. The recommendations also focus on the role of nurses in health care promotion, disease prevention and care at the end of life, including avoiding expensive conditions that are more affordable to treat at the outset.

RWJF is collaborating with AARP on the campaign, working through diverse Regional Action Coalitions (RAC) to initiate local-and state-level implementation measures. Additionally, RWJF and AARP are enlisting campaign support across the health care spectrum and engaging prominent leaders and organizations from the public and private sectors.

RWJF has long invested in the human capital of health care–the individuals who shape health care research, policy and practice as well as those who deliver care. It supports scholars and fellows programs for doctors, dentists, nurses and other professionals; initiatives for front-line workers; studies that build an evidence base; and projects that elevate best practices. The Foundation always seeks collaborative, multi-disciplinary approaches and considers diversity a guiding principle, RWJF has committed to Campaign for Action.

Timeline

The Institute of Medicine released its report in October 2010. RWJF launched *Campaign for Action* the following month during a National Summit on Advancing Health through Nursing held in Washington, D.C. The two-day event brought together more than 500 health leaders from across the country to strategize on the best ways to begin moving forward with substantive action.

Since the summit, *Campaign for Action* has continued to build momentum. Its website, www.thefutureofnursing.org, functions as a virtual campaign headquarters that provides valuable resources to the RACs and nurse and non-nurse health leaders while keeping all groups and the public apprised of important developments.

National Advisory Committee

A distinguished Advisory Committee is guiding *Campaign for Action* at the national level. It is being chaired by Sheila Burke, an adjunct lecturer in public policy at Harvard's Kennedy School of Government, who served as chief of staff to former Senate Majority Leader Robert Dole of Kansas. Its members include leaders in health care, business, education, labor and consumer advocacy.

For more information, please visit: www.thefutureofnursing.org.

INDIANA NAMED AS A REGIONAL ACTION COALITION

Goal is Long-Term Change in Health and Health Care

PRINCETON—The Future of Nursing: Campaign for Action, a Robert Wood Johnson Foundation initiative to ensure that the health care workforce can deliver high quality, patient-centered care to every American, announced the selection of 10 Regional Action Coalitions (RACs). These long-term partnerships have been convened to move key health care workforce-related issues forward at the local, state and national levels.

Indiana joins the following states join the New Jersey, New York, Michigan, Mississippi and California RACs, which initiated their activities last fall: Washington, Idaho, Utah, Colorado, New Mexico, Illinois, Louisiana, Virginia. Florida. The lead agencies for Indiana are the Indiana Center for Nursing (formally Nursing 2000 and the Indiana Nursing Workforce Development Coalition) and Indiana Area Health Education Center (AHEC). ISNA participated in the development of the application and will participate on the project steering committee.

The Campaign for Action (CFA) is focused on preparing health professionals to lead the change that will improve the health care system. Its aim is to maximize their contributions to collaborative, interdisciplinary teams across the spectrum. In collaboration with AARP, CFA is enlisting support across the health care spectrum and engaging prominent leaders and organizations from government, business, academia and philanthropy.

"The Campaign for Action must work at every level if we are to initiate and sustain the changes necessary to improve health care for all Americans," said Susan B. Hassmiller, Ph.D., RN, F.AN. senior advisor for nursing at the Robert Wood Johnson Foundation. "Our new RACs will help shoulder this effort. They are essential to fulfilling the campaign's mission."

RACs function as a component of the campaign's field operations. Comprised of diverse groups of stakeholders from a variety of sectors, their mission is focused on fostering interprofessional collaboration, the ability of all health care professionals to practice to the full extent of their education and training, strengthened nurse education and training and the increased participation of nurses as leaders. RACs will further CFA by capturing best practices, determining research needs, tracking lessons learned and identifying replicable models.

"The uniqueness of each applicant's coalition and their proven capacity were key factors in our selection of these 10 geographically diverse groups from across the country," said Susan Reinhard, Ph.D., RN, FAAN, senior vice president of the AARP Public Policy Institute and chief strategist, Center to Champion Nursing in America. "They have already made great strides in their states, and their RAC applications reflected capable coalition leadership and clear goals and objectives coupled with strong action plans."

Twenty applications were received in February for this round of RAC selections. CFA aims to ultimately engage groups in all 50 states. To help build and sustain momentum across the country, states that have not yet become RACs have access to campaign materials and communications for use in the change efforts they have initiated in their states.

According to Hassmiller, "we are glad to see such enthusiastic interest from the states in becoming RACs, and look forward to reviewing additional applications and again expanding the RAC community this summer."

ISNA BULLETIN

An official publication of the Indiana State Nurses Association Inc., 2915 North High School Road, Indianapolis, IN 46224-2969. Tel: 317/299-4575. Fax: 317/297-3525.E-mail: info@indiananurses.org.
Web site: www.indiananurses.org

ISNA MISSION STATEMENT

ISNA works through its members to promote and influence quality nursing and health care.

ISNA accomplishes its mission through advocacy, education, information, and leadership.

ISNA is a multi-purpose professional association serving registered nurses since 1903.

ISNA is a constituent member of the American Nurses Association.

BULLETIN COPY DEADLINE DATES

All ISNA members are encouraged to submit material for publication that is of interest to nurses. The material will be reviewed and may be edited for publication. To submit an article mail to ISNA Bulletin, 2915 North High School Road, Indianapolis, IN. 46224-2969 or E-mail to klein@indiananurses.org.

The **ISNA Bulletin** is published quarterly every February, May, August and November. Copy deadline is December 15 for publication in the February/March/April *ISNA Bulletin*; March 15 for May/June/July publication; June 15 for August/September/October, and September 15 for November/December/January.

If you wish additional information or have questions, please contact ISNA headquarters.

Welcome to New and Reinstated ISNA Members

Lillian Abdur-Rahman	Indianapolis
Joy Adewopo	Plainfield
Matyt Adler	Merrillville
Janie Arington	Evansville
Victoria Barajas	Crown Point
Susan Batey	Hobart
Seleta Beard	Evansville
Marianne Benjamin	Indianapolis
Janice Buelow	Indianapolis
Sheritha Chambliss	Indianapolis
Darla Clark	Lebanon
Leslie Coughlin	Carmel
Kathy Crecelius	Trafalgar
Mary Crowder	Hardinsburg
Shawna Curtis	Indianapolis
Claudina David	Indianapolis
Dana Dubuque	Evansville
Steven Fields	Ridgeville
Natalie Fitzgerald	Indianapolis
Kathleen Free	Hanover
Sarah Goff	Newburgh
Karen Grooms	Noblesville
James Guy	Warsaw
Barbara Habermann	Indianapolis
Cherona Hajewski	Newburgh
Tanya Hall	Indianapolis
Sara Herbig	Carmel
Cynthia Herrington	Spencer
Nancy Hostetler	Fishers
Randy Houston	Indianapolis
Jerrlyn Jones	Indianapolis
Theresa Joy	Indianapolis
Margaret Keen	Greenfield
Tonya Kiger	Bainbridge
Samuel Kobba	Avon
Samantha Laker	Ft Wayne
Cathy Lowe	Westfield
Trina Marlatt	Attica
Maria McLin	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
Mechelle Peck	Indianapolis
Melissa Quimby	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	Greenfield
Amara Taylor	Jeffersonville
Judy Ulman	Dyer
Diane Von Ah	Carmel
Phyllis Walker	Indianapolis
Felita Wash-White	Noblesville
Brandi White	Indianapolis
Jacob Wiegand	Indianapolis

State-only membership is now available for $180.00/year or $15.50/month online at www.IndianaNurses.org. Click on "Join/Renew" and follow the links.

ISNA
INDIANA STATE NURSES ASSOCIATION

The ISNA is a Constituent Member of the American Nurses Association

APPLICATION FOR RN MEMBERSHIP in ANA / ISNA

Or complete online at www.NursingWorld.org

PLEASE PRINT OR TYPE

Last Name, First Name, Middle Initial

Name of Basic School of Nursing

Street or P.O. Box

Home phone number & area code

Graduation Month & Year

County of Residence

Work phone number & area code

RN License Number State

City, State, Zip+4

Preferred email address

Name of membership sponsor

1. SELECT PAY CATEGORY

_____ **Full Dues–100%**
Employed full or part time.
Annual-$273
Monthly (EDPP)-$23.25

_____ **Reduced Dues–50%**
Not employed; full-time student, or 62 years or older.
Annual-$136.50
Monthly (EDPP)-$11.88

_____ **Special Dues–25%**
62 years or older and not employed or permanently disabled. Annual $68.25

2. SELECT PAYMENT TYPE

_____ **FULL PAY–*CHECK***
_____ **FULL PAY–*BANKCARD***

Card Number

VISA/Master card Exp. Date

Signature for Bankcard Payment

_____ **ELECTRONIC DUES PAYMENT PLAN, MONTHLY**

The Electronic Dues Payment Plan (EDPP) provides for convenient monthly payment of dues through automatic monthly electronic transfer from your checking account.

To authorize this method of monthly payment of dues, please read, sign the authorization below, and enclose a check for the first month (full $23.25, reduced $11.88).

This authorizes ANA to withdraw 1/12 of my annual dues and the specified service fee of $0.50 each month from my checking account. It is to be withdrawn on/after the 15th day of each month. The checking account designated and maintained is as shown on the enclosed check.

The amount to be withdrawn is $ _____ each month. ANA is authorized to change the amount by giving me (the under-signed) thirty (30) days written notice.

To cancel the authorization, I will provide ANA written notification thirty (30) days prior to the deduction date.

Signature for Electronic Dues Payment Plan

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

NURSES TRUSTED to CARE

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

Certification Corner

By Sue Johnson, PhD, RN, NE-BC

Sue Johnson

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 is their story in their own words:

"Working towards certification has helped me to grow personally and professionally with other radiology colleagues. The time spent together studying and preparing for the certification exam helped foster pride and confidence in our department that we were contributing to 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

"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

"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

"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!"-Diana 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.

Indiana Nurses Calendar

Date/Time	Event/Location	Contact Information
Open Enrollment	**Developing Your Skills as a Clinical Nurse Specialist Preceptor**	Indiana University School of Nursing Phone 317-274-7779. Web: http://nursing.iupui.edu/continuing/
April 21, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
April 26-27, 2011	**Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference**/IUPUI Greenwood Learning Center, 555 East County Line Road, Suite 104, Greenwood, IN.	Phone 317-274-7779. Email: censg@iupui.edu Web: http://nursing.iupui.edu/continuing/nurse_aide/index.shtml
May 11, 2011	**Indiana University School of Nursing–Qualified Medical Aide (QMA) Instructor Education**/IUPUI Greenwood Learning Center, 555 East County Line Road, Suite 104, Greenwood, IN.	Phone 317-274-7779. Email: censg@iupui.edu Web: http://nursing.iupui.edu/continuing/nurse_aide/index.shtml
May 13, 2011 10:00 A.M.	**Indiana Organization of Nursing Executives (IONE)** Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN. 46168	IONE, Phone 317/423-7731. Web: www.indianaone.org/id3/html Email: mbisesi@johnsonmemorial.org
May 19, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
June 3, 2011 9:30 A.M.	**Indiana State Nurses Association Board of Directors Meeting** 2915 N. High School Road, Indianapolis, IN.	Indiana State Nurses Association, Phone: 317/299-4575 www.IndianaNurses.org Email: info@indiananurses.org
June 16, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
July 21, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
August 9-10, 2011	**Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference**/IUPUI Greenwood Learning Center, 555 East County Line Road, Suite 104, Greenwood, IN.	Phone 317-274-7779. Email: censg@iupui.edu Web: http://nursing.iupui.edu/continuing/nurse_aide/index.shtml
August 12, 2011 10:00 A.M.	**Indiana Organization of Nursing Executives (IONE)** Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN. 46168 2nd floor conference room. Phone 317/839-7200	IONE, Phone 317/423-7731. Web: www.indianaone.org/id3/html Email: mbisesi@johnsonmemorial.org
August 18, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
September 9, 2011 9:30 A.M.	**Indiana State Nurses Association Board of Directors Meeting** 2915 N. High School Road, Indianapolis, IN.	Indiana State Nurses Association, Phone: 317/299-4575 www.IndianaNurses.org. Email: info@indiananurses.org
September 9, 2011 DEADLINE!	**Deadline Pre-Registration ISNA Annual Meeting of the Members September 30, 2011**	Indiana State Nurses Association, Phone: 317/299-4575 www.IndianaNurses.org. Email: info@indiananurses.org
September 15, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
September 30, 2011	**ISNA Annual Meeting of the Members** Primo Banquet Center South, 2615 E. National Ave., Indianapolis, IN.	Indiana State Nurses Association, Phone: 317/299-4575 www.IndianaNurses.org. Email: info@indiananurses.org
October 18, 2011 1:00 P.M.	**Indiana Organization of Nursing Executives (IONE)** Board Meeting/Brown County Inn	IONE, Phone 317/423-7731. Web: www.indianaone.org/id3/html Email: mbisesi@johnsonmemorial.org
October 18-19, 2011	**Indiana University School of Nursing–Nurse Aide Program Director & Instructor Training Conference**/IUPUI Greenwood Learning Center, 555 East County Line Road, Suite 104, Greenwood, IN.	Phone 317-274-7779. Email: censg@iupui.edu Web: http://nursing.iupui.edu/continuing/nurse_aide/index.shtml
October 19-21, 2011	**Indiana Organization of Nursing Executives (IONE)** Fall Conference/Brown County Inn	IONE, Phone 317/423-7731. Web: www.indianaone.org/id3/html Email: mbisesi@johnsonmemorial.org
October 20, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
November 11, 2011 10:00 A.M. (Transition Meeting)	**Indiana Organization of Nursing Executives (IONE)** Board Meeting/Hendricks Regional Health Bldg., 1100 Southfield, Plainfield, IN. 46168	IONE, Phone 317/423-7731. Web: www.indianaone.org/id3/html Email: mbisesi@johnsonmemorial.org 2nd floor conference room. Phone 317/839-7200
November 11-12, 2011	**Indiana Spinal Group: Back Talk:** A Comprehensive Review and Practical Approach to Spinal Diagnosis and Treatment, Carmel, IN.	The Spinal Group, Phone 317-228-7000 Web: http://www.indianaspinegroup.com/backtalk/2011/backtalk.html
November 17, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm
December 15, 2011	**Indiana State Board of Nursing** Indiana Government Center South, 402 W. Washington Street, Indianapolis, IN.	Phone 317/243-2043. Email: pla2@pla.IN.gov Web: www.in.gov/pla/nursing.htm

Independent Study

ETHICS

ONF-09-31-I

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 ethical thinking about the way we treat and relate to each other began to expand in the 1960s in America with the various movements, including:

- Civil rights
- Women's rights
- Patients' rights

With all the changes in the 60s came an increasing respect for the feminine perspective. This perspective emphasized more consideration for the health care professional's relationship with the patient and the context of the situation. This line of ethical thinking began to be labeled the ethic of care or care-based ethics. Today, many ethicists incorporate both the traditional principle-based ethics approach and the ethic of care in solving ethical dilemmas.

Principle-based Ethics

Four principles provide the basic framework for this ethic: beneficence, nonmaleficence, autonomy and justice.

Beneficence derives from the health care professional's fiduciary (professional) relationship to do good and to act to help the patient. This principle imposes responsibility on health care professionals for fidelity (remaining loyal to the patient) and advocating for the patient. Value conflicts related to beneficence may involve prolonging a person's life versus respecting the person's definition of his or her quality of life and/or desire to continue life. Another common conflict is using beneficence as a rationale for paternalism–where the health care professional believes his judgment should prevail because of the patient's inability to fully understand or grasp the situation.

Nonmaleficence derives from the general rule of human conduct that applies to everyone to not harm others and to act to prevent harm to others. This principle imposes responsibility on health care professionals to maintain patients' confidentiality and to analyze the benefits and burdens of the treatments given to patients. Explanations of benefits and burdens must include truthful explanations of the possible short and long-term outcomes in language the patient and/or family can understand. 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. Thus, the use of technology must be considered with respect to the patient's and family's overall treatment goals and acceptable quality of life.

Autonomy derives from the patient's right to self-determination and the right of privacy. This principle imposes responsibility on the health care professional to tell the truth and provide informed consent. Although telling the truth may seem to be an easy thing to do, in reality it is one of the most difficult skills for health care professionals to develop. First, health care professionals assess how much of the truth the patient wants to know. Persons from other cultures often do not want detailed information–and sometimes they do not even want to know the diagnosis. For this individual, respecting his autonomy would mean asking the person who should receive the information. This person would then become the patient's surrogate decision-maker. Although surrogate decision-makers usually only function when patients are incapable of making their own decisions, a capable person can request that another person make his decisions if he prefers not to know the "bad news." For example, in traditional Spanish families, out of honor for one's elders, it is the duty of adult children to hear the medical information and to make difficult health care decisions to protect the parent from the stress 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 treatment will be like.
- If any part of the treatment is experimental.
- 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 be reviewing 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 my stop treatment at any time with the assurance that care will still be provided without penalty.

Additional elements may be required in some circumstances:

- A statement that some risks may not be foreseeable.
- The researcher may have to stop the treatment without the patient's consent.
- There may be additional costs to the patient.
- What 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 that 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. (Varricchio and Jassak 1989).

* Italicized words added by this author.

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,

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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 maintain their health to the best to their abilities."

Note that Dr. Curtin refers to whether patients are likely to benefit from treatments. This then brings in the concept of futility, which is another poorly defined issue in health care. Futility in terms of what? In terms of what the patient says would result in an acceptable quality of life? In terms of what the specialist says in terms of the return of function in an organ system? In terms of the overall chance of the patient's survival–is it futile if it is < 1%, < 5%, or <10 %? And, is it just to spend thousands on futile treatment for a few when so many are not even getting basic health care?

In summary, the principle-based approach to ethics analyzes dilemmas by identifying important values. Unfortunately, these values may conflict with each other. In these circumstances, the decision-makers have to decide which principle has priority in that particular situation. Thus, many ethicists find it useful to combine principle-based ethics with the ethic of care.

The Ethic of Care

As mentioned earlier, this ethical approach emerged in the 60s in America with the feminist movement. Women in ethics found that the traditional, male reliance on principle-based ethics was somewhat lacking. They advocated that consideration be given to health care professionals' relationships with patients and the context of the situation. Some of the essential elements included in a caring relationship are defined in Table 1.

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

- Doing for another
- Being responsive to another
- Valuing another–regardless of culture, social status, etc.
- Extending compassion, mercy and kindness
- Enhancing human dignity
- Connecting with another
- Being touched by another's situation
- Empowering another to act for him or herself
- Helping another find meaning in his or her situation

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.

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 or economic status, 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.
- 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). And, the Ohio Board of Nursing's Alternative Program offers help regarding these issues. They can be reached at 614-466-0376.
- 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.**

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Table 2: Comparison of Ethical Approaches

Principle-based Ethics	Ethic of Care
▪ Responsibilities defined by rights and duties	▪ Responsibilities derived from health care professional-patient relationships
▪ Reason and objectivity	▪ Emotions enhance reason
▪ Detachment enhances fairness	▪ Engagement enhances understanding and fairness
▪ Focused on the individual	▪ Focused on the family (the context)

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Table 4: ONA's Ethical Decision Making Process for the Registered Nurse

1. **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.
2. **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.
3. **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.
4. **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.
5. **Make a responsible collaborative decision and take action.**
6. **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.

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' viewpoints 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

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withdrawing life sustaining treatment when the person is in a permanently unconscious state permanently unconscious state or terminal condition **and** incapable of making his or her own decisions.

A. A terminal condition is defined as:
   1) Irreversible
   2) Incurable
   3) Untreatable
      . . . from which there can be no recovery and death is likely to occur within a relatively short time, if life sustaining treatments are not given. A life sustaining treatment is any medical procedure, treatment, or other measure, when administered to a patient that serves to principally prolong the dying process.
   4) Confirmed by the 2nd opinion of another physician.

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 document that designates another person 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 person is NOT capable of making his or her own decisions, e.g., from confusion, coma hallucinations, chronic sedation, etc. The patient's representative is the person(s) named by the patient in the Durable Power of Attorney form to make his decisions when he cannot make 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 supposed 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 and initialed** if the patient **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 desires to have comfort care instead of resuscitation, following the state-approved protocols.

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 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 can be 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 no consensus can 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 done. Marcos and Jeanna 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 more courses 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 at home with her family.
Implementation of some ethical principles in this case:

- Ethic 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.
- DNRCC–Since you know the family's wishes and the reality of Raquel's prognosis at this point, you suggest to Marcos and Jeanne that they enroll Raquel in hospice care at home. You explain the comprehensive comfort care that hospice provides. You also inform them about a DNRCC. They restate that they want Raquel to die peacefully at home. You write a DNRCC 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 DNRCC 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 legal stipulations of advance directives. Patients, families and the public trust nurses more than any other profession. (Gallup 2000). All nurses must strive to uphold that trust by advocating for patients and using an ethical process to ensure that patients' needs are appropriately addressed within the health care system.

INDEPENDENT STUDY

This independent study has been developed to enable nurses to recognize and deal with ethics. 1.06 contact hours will be awarded for successful completion of this independent study. Ohio Nurses Foundation, Copyright © 2010, Ohio Nurses Foundation.

The Ohio Nurses Foundation (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

DIRECTIONS

1. Please read carefully the enclosed article "Ethics."
2. Complete the post-test, evaluation form and the registration form.
3. When you have completed all of the information, return the following to the **Indiana State Nurses Association, 2915 North High School Rd, Indianapolis, IN 46224:**
   A. The post-test;
   B. The completed registration form;
   C. The evaluation form; and
   D. The fee: ISNA Member/LPN ($15) – NON ISNA Member ($25)

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 70 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Zandra Ohri, MA, MS, RN, Director, Nursing Education, zohri@ohnurses.org, 614-448-1027, or Sandy Swearingen, sswearingen@ohnurses.org. 614-448-1030, Ohio Nurses Foundation at (614) 237-5414.

OBJECTIVES

Upon completion of this independent study, the learner will be able to:

1. Describe the health care professional's responsibilities related to the principles of beneficence, nonmaleficence, autonomy and justice.
2. Compare principle-based ethics with the ethics of care.
3. Recognize the tenets of ANA's Code for Ethics for nurses.
4. Identify situations that are solved through other processes rather than an ethical process.
5. List steps of an ethical decision-making process.
6. Differentiate among the three Advance Directives in Ohio.
7. List the persons, in order of priority, whom Ohio law designates as legal surrogates of persons without Advanced Directives.

This independent study was developed by: Elaine Glass, MS, RN AOCN, Health Planning Administrator, Ohio Department of Health. Bureau of Long Term Care Quality, Columbus, OH. The author has no vested interest.

The author and planning committee members have declared no conflict of interest.

There is no commercial support or sponsorship for this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or

Introduction

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Ethics: Post Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name: _____

Final Score: _____

Please circle one correct answer for each question.

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 information.
   d. Give Juan the information about 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 effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing; and
   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) and 3)

18. A living will takes effect if the person:
   a. Has a terminal condition or is in a permanently unconscious state.
   b. Has cancer.
   c. Is in a coma.
   d. Is confused.

19. Capacity is determined by a judge in a court of law.
   a. True
   b. False

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

Ethics
ONF-09-31-I
Registration Form

Name:_____
(Please print clearly)

Address: _____
Street

_____
City/State/Zip

Daytime phone number:_____

_____ RN _____ LPN

Fee: _____ ISNA Member/LPN ($15)
_____ Non-ISNA Member ($25)

Please email my certificate to:

_____
Email Address (please print clearly)

MAKE CHECK PAYABLE TO THE INDIANA STATE NURSES ASSOCIATION.

Enclose this form with the post-test, your check, and the evaluation and send to:
ISNA, 2915 North High School Road, Indianapolis, IN 46224.

ISNA OFFICE USE ONLY

Date Received:_____ Amount:_____

Check No _____

Evaluation:

	Yes	No
1. Were the following objectives met?		
a. Describe the health care professional's responsibilities related to the principles of beneficience, nonmaleficence, autonomy and just.	☐	☐
b. Compare principle-based ethics with the ethic of care.	☐	☐
c. Recognize the tenets of ANA's Code of Ethics for nurses.	☐	☐
d. Identify stiuations 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 Directors.	☐	☐
g. List the persons, in order of priority, whom Ohio law designates are legal surrogates of persons without Advanced Directives.	☐	☐
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

The Ohio Nurses Association (OBN-001-91) is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

President's Message continued from page 1

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.

10 Good Reasons To Hire/Retain ISNAP Nurses:
A Commentary
Indiana State Nurses Assistance Program For Nurses

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.
   When employers have pro-active policies and procedures in place that acknowledge the existence of these disorders in the nursing work force, identification and referral is enhanced, leading to safer work conditions and improved employee morale.
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 more punitive and restrictive 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 800/638-6623.

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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.

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.