Volume 7
Number 3

ANA - NEW YORK NURSE

WE MAKE A DIFFERENCE FOR NURSES IN NEW YORK STATE

January 2023

The Official Publication of the American Nurses Association - New York
ANA - New York Nurse will reach over 72,600 New York nurses and schools of nursing.

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PRESIDENT'S MESSAGE

Sowing the Seeds of Nursing's Future

Dr. Marilyn L. Dollinger, President ANA-NY

It was wonderful to see so many of you at the 10th Anniversary Annual Meeting in Niagara Falls at the end of October. For those of you who could not attend, I am sharing my president remarks with you in this column.

I have included a summary of the 2022 Board actions and my activities as President in the Book of Reports. I am proud of the initiative that the Board and committees have shown in expanding the program options for members—and we are just getting started!

I want to focus these remarks on the future. As reflected in the theme for this conference: *Sowing the Seeds of Nursing's Future*, now is the time to take a critical look at where we want to go and how to get there. The pandemic changed…everything.

As we discussed during our workforce panel after the opening keynote session with Dr. Ernest Grant, American Nurses Association President, and Dr. Sylvain Brousseau, Canadian Nurses Association President—we are facing a global healthcare workforce crisis. Going forward--we all –from the bedside to the boardroom need a "global lens". Global health care needs are front and center because a disease outbreak halfway around the world can be our problem-- in days.

Natural disasters fueled by climate change and the migration of refugees and victims of war are straining borders and resources around the world. We need global surveillance systems, disaster planning and crisis management competencies in our tool kits so we can do our part to prevent and alleviate the unimaginable human suffering that affects so many.

Amid calls for social justice, racism and disparities in care will not be tolerated. We need care that is trauma-informed, culturally appropriate, and equitable, that supports the social determinants of health.

In 2020, people pivoted to virtual work and school in a few weeks and now, they want to work and study differently. We must look at nursing education, care delivery models, roles and interprofessional teamwork. Competition and hierarchies must give way to innovation, collaboration, and efficiency. We must allow health care providers of all types to be recognized, fully engage, and use all their skills and expertise. There is so much work to do and not enough of us to do it.

This is our call to action.

But--we cannot and will not-- be overwhelmed.

Hope is the seed that we must sow first.

That seed of hope must be nurtured with self-care that fosters resilience; adequate staffing that puts safe, high-quality care first; and a safe and collegial work environment that unleashes energy and innovation.

There are thoughtful, smart people all over the world doing excellent work. As a profession, we need to add our voice to other healthcare providers and leaders to determine what is needed to leverage and sustain the innovation that is already making a difference.

As a professional association, we must use our influence to advocate that the laws and regulations are in place to support the systems, policies, and funding to make these goals a reality. To have this voice and influence---we need you—our members. We are over 8000 strong **and growing**.

To harness this energy, we are sowing seeds to make sure there are new opportunities for meaningful member engagement. The Board has approved my proposal to implement Special Interest Groups (SIG) to give members a way to engage outside of the more limited committee

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FROM THE DESK OF THE EXECUTIVE DIRECTOR

Seize The Opportunity!

Jeanine Santelli, PhD, RN, AGPCNP-BC, FAAN

As COVID-19, RSV, and the flu add to the pre-existing challenges to health care delivery, nursing has finally started to be seen, albeit occasionally, in the media. The public, and our health care colleagues, are beginning to get a glimpse of what we have been doing on a day in, day out basis for centuries. I challenge us, as a profession, to seize this opportunity. I know, you all are saying, "Are you kidding? We can't possibly do ONE MORE THING!"

I issue the challenge because, quite frankly, if we don't advocate for ourselves and take the reins on nurses' role in health care, someone else will. In the mid-1800's the LPN/LVN program was created to meet the shortage of RNs. In the late 1900's we saw the emergence of UAPs. Now community paramedicine is being proposed. All of these roles have been needed to fill the care gaps that RNs can't, and, bottom line, our patients and communities need care. Those of us who are a bit more mature remember the days when we learned how and performed tasks such as: starting IVs and drawing blood – now done by IV teams/phlebotomy (billable), testing urine and measuring specific gravity – now done in the lab (billable), performing ROJM exercises – now PT (billable), performing respiratory toilet and administering breathing treatments (billable), mixing IV meds – now left to Pharmacy which is probably the best way, and wound care – now done by PT (billable). Does anyone see a theme here?

Why is nursing still billed under room and board? Because, as a profession, we don't advocate for ourselves and articulate what we do. We also spend the bulk of our time doing clerical tasks that do not require an RN. Alright, none of this is news – so what do we do about it?

Strategies and solutions to leverage the opportunity that is before us:

- Studies have shown that if nurses were allowed to practice at the top of our license (the stuff we were educated and legally permitted to do) and we got rid of the clerical red tape (do you love your EHR?) there would not be a nursing shortage!
- Reporting of heath system capacity should be in terms of number of nursing hours available, not number of beds. Beds can, and are, stacked up in every nook, cranny, closet, and hallway, but to quote Dr. Sylvain Brousseau, President of the Canadian Nurses Association, "No nurses, no healthcare!"
- Registered professional nurses can get a National Provider Identifier (NPI). They're free and they are the first steps toward being counted and are used by other health professionals for billing purposes. Isn't it time that we create the pathway to bill for what we do? What if nurses were contracted staff like our physician colleagues? Would systems still want us to take the time to document everything in twelve different places in the dang EHR rather than actually doing things for and with our patients?
- To take things a step further, shouldn't nursing care be a revenue line, not an expense line in system budgets? Who is responsible for reducing length of stay, community-acquired infections, falls, errors/ adverse reactions, readmissions…the list goes on and on. Nursing saves the healthcare system way more money than we cost!

We need to reframe our own perceptions of our value before we can convince anyone else!

Article Submission

- Subject to editing by the ANA-NY Executive Director & Editorial Committee
- Electronic submissions ONLY as an attachment (word document preferred)
- Email: membership@anany.org
- Subject Line: *ANA-New York Nurse* Submission: Name of the article
- Must include the name of the author and a title.
- ANA-NY reserves the right to pull or edit any article / news submission for space and availability and/or deadlines
- If requested, notification will be given to authors once the final draft of the *ANA - New York Nurse* has been submitted.
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structure. Special Interest Groups are for members who want to share ideas and learn from others with the same interests or learn about a new specialty. This might include nurses who care for individuals with intellectual and developmental disabilities in a special interest group so they can inform policy makers and advocate more effectively for their patients and families and eliminate barriers to care. This might include nurses who want to study and implement the recommendations across New York State that President Grant talked about yesterday from the work by the Commission to Address Racism in Nursing. This might include…any group that has an idea that will engage them and their colleagues in learning and making a difference in nursing and health care. We want your energy, creativity, and vision! We are adding member engagement staff to make sure the Special Interest Groups have the organizational support to be successful. Watch for emails from ANA-NY about these new opportunities for engagement.

We are so glad you are here. What do you want and need from your professional organization? Let's keep talking. We can only be as strong as our members and in 10 years—we have come a long way!

In closing, as we celebrate this 10th anniversary, I want to acknowledge and thank the leaders who have served as president of ANA-NY before me: Winnie Kennedy, Betty Mahoney, and Lee Mancuso. I also want to acknowledge and thank the past and current executive directors: Karen Ballard and Jeanine Santelli.

2022 ANA Leadership Summit Report

Working Together to Create a Culture of Safety

Dr. Marilyn L. Dollinger, President ANA-NY

The 2022 ANA Leadership Summit was held in Washington D.C. December 6-8. The overall theme "Working Together to Create a Culture of Safety" gave the presidents and executive directors from Constituent and State Nursing Associations (C/SNA), representing 46 states and 3 territories, an opportunity to meet and discuss how the innovative work of the multi-stakeholder groups convened by ANA can move forward at the state level. These task forces include the National Commission to Address Racism in Nursing, the Nurse Staffing Task Force and the Workplace Violence and Incivility Panel. The reports are available on the ANA website. State leaders gave updates on progress in their states, and everyone was energized by the work that is taking place. But—there is still much to do.

We heard from members of the ANA Board, CEO Loressa Cole reviewed the ANA Enterprise Strategic Plan and Treasurer Joan Widmer reviewed the budget. The attendees participated in media training and discussed the update on membership fees research. We welcomed the newly elected Leadership Council VP Vicky Byrd (MT) and member-at-large Andrew Nydegger (UT). (The Leadership Council has elected C/SNA leaders and serves as an advisory council to the ANA Board.)

The Summit attendees gave an enthusiastic standing ovation during the tribute to ANA President Ernest Grant as he completes his term. The Summit was a success and we returned home with work to do.

We must now strategize how we are going to educate nurses across New York State about the issues mentioned above and begin the difficult work on racial reckoning, staffing and workplace environment challenges.

The ANA-NY Board will start the work on how we approach these challenges early in 2023. We need to hear from all ANA-NY members. How can your experiences inform this work? How can you be involved? How do nurses in New York state address the barriers to safe working conditions, improve retention of nurses in all settings and achieve a "Culture of Safety"? Watch for messages about these opportunities.

This cannot be done quickly, and it will not be easy. But if nurses are going to be a part of creating the new systems and models of care that are needed to achieve these goals—we must get to work.

LEGISLATIVE UPDATE

By Amy Kellogg and Caiti Anderson

Much has occurred in Albany since our last newsletter. Most significantly, the state held its general election on November 8, 2022. As it is an even-numbered year, all statewide offices, seats in the New York State Senate and Assembly, U.S. House of Representatives, Senator Schumer's senate seat, and a variety of local races were on the ballot. There was also one ballot initiative for voters to consider.

New York Governor's Race

In what became a high-profile race, Governor Kathy Hochul, and her Lieutenant Governor Antonio Delgado, were elected to their first full term as Governor and Lieutenant Governor, defeating their Republican challengers Representative Lee Zeldin and his running mate Alison Esposito. This race garnered national attention as the polls showed this race being closer than what is typically seen in New York for a Democratic candidate. However, in the end, Governor Hochul won the election, and Lee Zeldin officially conceded. With the win, Governor Hochul makes history as the first woman to be elected as the Governor of New York.

New York Attorney General and Comptroller Races

Attorney General Letitia James beat Republican challenger Michael Henry, securing her second term as Attorney General. Likewise, Comptroller Thomas DiNapoli won his fifth term of office, beating Republican challenger Paul Rodriguez.

State Senate

All 63 seats in the New York State Senate were up for election this year. Although all polls, and very early election night returns, seemed to point towards the Democrats losing their supermajority, Democrats may hold on to their supermajority. As of this writing, the Democrats have 41 seats, and the Republicans have 21. Democrats need 42 seats to maintain their supermajority.

The remaining seat to be decided is District 50, with Senator John Mannion (D) leading Rebecca Shiroff (R) by 51 votes. This race has gone to an automatic hand recount. Hand recounts are required in any New York race that is decided by less than .5% of the vote.

While the overall number of Senate seats may remain the same for both the Democrats and the Republicans, the breakdown of where those seats are located will look different because several incumbents lost their races. Additionally, there were several open seats that changed party hands. On the Democratic side, in the 5th District, Senator John Brooks lost to Steven Rhoads (R); in the 7th District, Senator Anna Kaplan lost to Jack Martins (R); and in the 38th District, Senator Elijah Reichlin-Melnick (D) lost to Bill Weber (R).

In districts where incumbents were redistricted into the same district, the Democratic candidates prevailed. Senator Michelle Hinchey (D) beat Senator Susan Serino (R) in the 41st District, and Senator Sean Ryan (D) beat Senator Ed Rath (R) in the 61st District. In the 52nd District, which was an open seat, Lea Webb (D) defeated Richard David (R). Finally, in another open seat in the 17th District, Iwen Chu (D) defeated Vito Labella (R). Chu will be the first Asian-American woman to serve in the State Senate.

State Assembly

All 150 seats in the New York State Assembly were up for election this year. Heading into Election Day, there was an assumption that the veto-proof majority for the Assembly Democrats would not be in question. This remained true, but the margin of this veto-proof majority has been decreased. Currently, Democrats hold 107 seats in the Assembly, and it appears Democrats will have 102 seats going into 2023 once all recounts are completed.

There were three major upsets in the Assembly. Longtime chair of the Environmental Conservation Committee, Assemblymember Steve Englebright (D), lost to Edward Flood (R). Additionally, Assemblymember Peter Abbate (D), a 36-year incumbent and the chair of the Governmental Employees Committee, lost to Lester Chang (R). Another longtime incumbent and chair of the Housing Committee, Assemblymember Steven Cymbrowitz, lost to Michal Novakhov (R).

It is important to note that all the Senate and Assembly election results will impact the committee chairs in both the Senate and Assembly next year. In the Senate, the defeat of Senators Brooks, Kaplan, and Reichlin-Melnick means we will have new chairs for the Veterans, Homeland Security & Military Affairs Committee, the Commerce, Economic Development and Small Business Committee, and the Procurement and Contracts Committee. Additionally, the current chairs of the Environmental and Local Governments Committees did not seek reelection. As Senators are elevated to take over as committee chairs, other committee chair positions will likely change as well.

In the Assembly, we will see new committee chairs for the Environmental Conservation Committee, Housing Committee, and the Governmental Employees Committee. This is in addition to new chairs for the Energy Committee, Health Committee, and the Real Property Taxation Committee, where the current chairs did not seek reelection. Further, the Insurance Committee and People with Disabilities Committee will also need new chairs because the current chairs were defeated in the Primary.

Federal Races

Senator Charles Schumer successfully secured his fifth term in the Senate, beating Republican challenger Joe Pinion. New York Republicans picked up a few seats in the House of Representatives, which has national implications. Perhaps the most shocking result is the defeat of incumbent Democratic Congressman Sean Patrick Maloney. Congressman Maloney is the head of the Democratic Congressional Campaign Committee, which is charged with electing Democrats across the country. It was assumed he would be in a safe seat and an easy win for the Congressional Democrats. The Republicans also picked up two seats on Long Island, and in the Hudson Valley and one in Syracuse.

Looking Ahead

Of the 1009 bills passed by the Legislature this year, 297 have yet to be sent to the Governor. This is not unusual because the Governor's staff needs time to review the legislation before making recommendations for the Governor. The Governor has until December 31, 2022, to act on the bills awaiting her signature. One of the bills awaiting the Governor's signature is the surgical smoke bill, A9974/S8869, sponsored by Assemblymember Richard Gottfried and Senator Gustavo Rivera. This bill would require general hospitals and ambulatory surgery facilities to adopt and implement policies to prevent exposure to surgical smoke. We are continuing to advocate that the Governor sign this important piece of legislation.

Further, as we wrap up our legislative work from the 2022 session, we are preparing for the imminent beginning of the 2023 session, which began on Monday, January 9, 2023. The Legislative Committee presented the legislative priority list to membership at the October annual meeting. There are five pillars of the legislative priority list: safe staffing, public health and health equity prioritization, education, ensuring future pandemic readiness, and health care reform. These guiding principals will shape the work we do during the upcoming legislative session.

If you have any questions about the legislative process or the priorities of ANA-NY, please contact a member of the Legislative Committee. As always, we welcome your questions, thoughts, ideas or comments on legislation or the bill track.

“We don’t count the days. We make the days count. We’re Calvary Nurses.”

Latisha Russell, RN
Bronx Campus Nurse

Shawn Boyd, RN
Bronx Campus Nurse

Kevin Nyack, RN
Hospice Nurse

Kelly Saulnier, RN
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10TH Annual Conference Recap

Thank you to everyone who joined us in Niagara Falls this October for ANA-NY's 10th Annual Conference! It was a weekend filled with education, connection, and celebration, and we are so appreciative of everyone who traveled from near and far to join us.








ALZHEIMER'S ASSOCIATION

Managing Dementia-Related Behaviors: Hallucinations, Delusions and Paranoia

As a nurse, you are likely to encounter individuals living with Alzheimer's disease or dementia who are experiencing dementia-related behaviors. In fact, up to 97% of those living with dementia will exhibit at least one behavioral symptom in addition to memory loss and other cognitive challenges over the course of their illness. Although the behaviors experienced are varied, the most common are hallucinations, delusions and paranoia. Understanding the differences and how to respond can be helpful.

A hallucination is a false perception of objects or events and is sensory in nature. When individuals with Alzheimer's or dementia have a hallucination, they see, hear, smell, taste or even feel something that isn't really there. For example, they may see a dog standing behind them or feel insects crawling on their hand. In contrast, a delusion is defined as a false idea or belief, sometimes originating in a misinterpretation of a situation. They may think that someone is stealing from them or that the police are following them. Although not grounded in reality, these situations are very real to the person with dementia. This kind of suspicious delusion is sometimes referred to as paranoia.

"Some hallucinations/delusions may be terrifying or threatening and can cause the person – and those caring for them – intense distress," said Beth Smith-Boivin, executive director of the Alzheimer's Association Northeastern New York chapter. "However, these behaviors are not always upsetting. A person living with dementia may actually take comfort in hearing the voice of an old friend and engage in a conversation with the imagined person."

Non-pharmacological interventions are often the best ways to help someone experiencing hallucinations or delusions. Here are some steps to take when you encounter these challenging behaviors:

- **Assess the situation.** How is the person responding to the hallucination or delusion? Is it upsetting to them or leading them to do something dangerous? If not, it's typically best to ignore them and re-direct the person's attention to something else. It's also important to avoid arguing with the person about what he or she sees, hears, or believes.
- **Offer reassurance.** Reassure the person with kind words and a gentle touch. Gentle patting may turn the person's attention toward you and reduce the symptom. Assure them that you are there to help.
- **Look for reasons behind the hallucination or delusion.** You can attempt to decode reasons for behaviors by first acknowledging the person's feelings. For example, "I know this must be frightening for you." or "It sounds like you are really worried."
- **Use distraction.** Suggest that the person come with you for a walk or sit next to you in another room. Frightening hallucinations and delusions often subside in well-lit areas where other people are present. You might also try turning the person's attention to an activity like listening to music, drawing, or looking at a photo album.
- **Modify the environment.** If you can identify a trigger in the environment, you may be able to remove it. For example, if a person is frightened by their reflection in the window, you can try closing the curtains. Turn on more lights to reduce shadows that could look frightening. If the person has delusions about people stealing from him or her, have duplicates of those items on hand if possible so you can provide the person with a replacement if it becomes lost.

While non-pharmacological interventions are often effective, medications may be helpful in cases when the person is persistently upset by the symptoms and non-pharmacological interventions have been exhausted. Notify the physician of any behavioral challenges to help determine the underlying cause and an appropriate course of action.

The Alzheimer's Association is committed to helping professionals meet the challenges of Alzheimer's disease. For more information on dementia-related behaviors, visit alz.org/professionals or call 800-272-3900.

ORGANIZATIONAL AFFILIATE SPOTLIGHT

New York State Association of School Nurses (NYSASN)

The New York State Education Department (NYSED) defines school nurses as registered professional nurses. We promote student health by bridging healthcare and education. School nurses are the only healthcare providers in the school setting that provide daily triage, from acute to chronic disease management. We are advocates who educate and coordinate care between the community and school to optimize students' health and reduce absenteeism enhancing the academic success of students. Our role is to provide care to the whole child: body, mind, and social well-being. We care for New York's future.

In 1986, a grassroots group of school nurses founded the New York State Association of School Nurses (NYSASN). These individuals were united by their vision and mission to *advance the practice of school nursing and enhance the educational success of students by promoting quality health services.* As a professional organization, we monitor and respond to legislation that has a direct impact on school nurses and the health concerns of students. NYSASN is the voice for school nurses across the state as we strive to educate stakeholders about the vital role school nurses play in the educational outcomes for our students. NYSASN collaborates with NYSED to improve school health services and, since 1989, we have been providing an annual School Nurse Orientation program each summer for new school nurses. NYSASN annually honors school nurses across the state, recognizing those who demonstrate best practices and exemplify going above and beyond via our *Excellence in School Nursing* award and *Everyday Hero* recognition. In addition, NYSASN offers its members scholarships for those seeking to continue their studies at the undergraduate and graduate levels. We provide educational opportunities and continuing education credits to school nurses at our annual conference. The conference creates a great opportunity for networking and sharing ideas. This year, we will be holding our Annual Conference, *Emergency Care in Schools*, at the Doubletree by Hilton, in Syracuse on April 22, 2023. Further information about the conference and our organization can be found on our website at nysasn.org.

EVIDENCE YOU CAN USE

Relational Quality between the RN and Nursing Assistant: Essential for Teamwork and Communication

Carol Anne Kozik, DNS, FNP-BC

In 2007, The Institute of Medicine (IOM) conducted and published a comprehensive review of the future of healthcare. The IOM emphasized the need for interdisciplinary teams in providing care for the aging population. This focus on interdisciplinary teams has primarily studied the roles and importance of collaboration among nurses, providers, and other healthcare professionals. Little research has been conducted on direct care providers, unlicensed personnel who the IOM refers to as "the linchpin of the formal health care delivery system for older adults" (p.199). Yet the Registered Nurse and nursing assistant (NA) team is common in acute care and is an essential part of long-term care and home health care. What do we know about the RN/NA partnership and how can this relationship function in a way that enhances healthcare outcomes for patients, reduces RN stress, and increases the satisfaction of nursing assistants? Researchers Campbell, Kennerly, and Swanson (2021) explored the quality of the relationship between RNs and NAs to further understand how to develop team effectiveness. Their study yielded some surprising results.

Teamwork, Communication, and Relational Quality

To appreciate this study, it is useful to develop a working knowledge of the concepts of teamwork, communication, and relational quality. In an ideal team, each team member contributes unique knowledge to the team. These individual components of knowledge are pooled in the team, leading to a broader understanding of patient care and workload. The key to this collaboration is the integration of knowledge gained through all aspects of care. This integration is dependent on effective communication, based on both sharing and listening, with respect for each other's contribution. It is essential that communication is two-way and clearly understood by both parties. Together, teamwork and communication define relational quality (RQ), a combination of communication effectiveness and trust, between a leader and follower.

This study examined relational quality between RNs and NAs and explored the associations between relational quality and beliefs of teamwork and communication openness and relational quality. This study was conducted using a convenience sample of full time RN and NA employees across eight healthcare institutions across the Southeastern United States using the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety and Culture (AHRQ HSOPSC). The data reviewed for this study was a secondary analysis of an original study by the AHRQ on patient safety and culture. Researchers selected specific questions about teamwork and communication. Selected questions included four questions on teamwork, and three questions on communication openness. Researchers also added seven questions from a survey specifically on relational quality (Leadership Member Exchange Theory or LMX7). All responses were documented on a 5-point Likert type scale. The LMX 7 RQ questions compare leader/follower responses. For the purposes of this study, "leader" referred to the RN and "follower" referred to the nursing assistant.

Results

A total of 889 RNs and 263 NAs completed the survey with an internal consistency of $\alpha = 0.86$ (RN) and $\alpha = .089$ (NA). Internal consistency measures how well the survey measures what it is intended to measure, in this case the survey's goal and the survey are well aligned. Results were reported as composite scores for teamwork and communication openness questions. Linear relationships between RQ and teamwork, and between RQ and communication openness were measured by Pearson correlation. The strength of association between RQ and teamwork was strongest among NAs ($r=0.61$) than among RNs ($r=0.36$, $p\leq0.001$) This finding was also clear in the relationship between RQ and communication openness (NA $r=0.44$, RN $r=0.32$, $p\leq0.001$) although to lesser degree. Overall, for both RNs and NAs, there was a weaker association between RQ and communication openness.

A two-sample t-test was performed to compare differences between RN and NA positive responses on individual RQ questions and on overall mean positive response. Two separate item analyses are of particular interest to this review; there was a significant difference between RN and NA responses related to the question, "How well do RNs understand the demands and stressors of NAs on your unit?" with RNs responding "Quite a bit" or "A great deal" 68% of the time (M=68, SD= 46.8) and NAs responding positively 27% of the time (M=27, SD=44.7); t=12.37, p≤0.001. A second item, "" how well do RNs on your unit recognize potential in NAs?" also showed a significant difference between RN positive responses (M=66, SD=47.2) and NAs (M=35. SD=47.7); t=9.59, p p≤0.001. There was also a significant difference between overall positive responses from RNs (M=59, SD=33.4) and NAs (M=36, SD=35.2); t=35.2, p≤0.001.

Discussion

These results supply some thought-provoking information on RN/NA teams. The strong NA association between relational quality and teamwork seems confounding, however, the authors note that definitions and models of teamwork may vary. The authors suggest that when answering teamwork questions, both RNs and NAs consider their peers as the teams, rather than each other as the team, and RNs may not even consider NAs as full team members. This notion is supported by earlier studies (Gabrielsson et al., 2016; Rubin et al., 2009). This conclusion become more meaningful when paired with the discrepancy between RN and NA reports of understanding the potential of the NA. As an outsider to the team, NA contributions to the whole picture of the patient may not be acknowledged, or even heard. Yet it is the NA who has the most interaction in bathing, feeding, transferring, and ambulating the patient.

Both RN and NA responses showed a weaker correlation between relational quality and communication openness. Although the correlation between RQ and communication was stronger for NAs, there was less discrepancy between RN and NA responses. This could be interpreted in several diverse ways, lack of appreciation for communication within the team, absence of experience with open communication, or a symptom of a hierarchical relationship between team members.

Although RNs reported positive relationships with NAs, there was no reciprocal response from NAs, suggesting a discrepancy in perceptions and RN unawareness of the NA experience. It is interesting that a significant difference is clear in the NA perception of RN awareness of stressors and demands of NA work. The RN, as team leader may not have an awareness of the physical and emotional challenges in the NA role.

Conclusions

This study suggests changes that can be made to optimize the RN/NA team. RQ may be enhanced by routinely scheduling an RN and NA as a team to build trust and communication. RN/NA teams can be encouraged to work together when caring for patients with high physical or emotional needs. Unit rounding can help the team leader support awareness of the challenges of the day and intervene to decrease stressors. Communication is enhanced when RNs include NAs in a shift report and concerns of the day. Including the NA's ideas and information in team rounds builds teamwork and increases the patient's whole picture. Communication and delegation need to be intentional in ensuring that messages are clear, and that nonverbal communication does not convey a hierarchical message. Lastly, RN/NA teams should be acknowledged as an essential partnership with unique roles and responsibilities. This partnership can improve patient care, alleviating stress, and building skills for both members.

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CONTINUING EDUCATION

DNP Capstone Project Literature Review: A Protocol to Improve Identification and Management of Vertebral Compression Fractures

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Tao Fen Cheng, Hunter-Bellevue School of Nursing, City University of New York

Literature Review

The following review of the literature search of the PubMed and CINHAL databases was limited to the period between January 2016 to December 2021. Searches were performed using combinations of medical subject headings (MeSH), including ″vertebral compression fracture,″ ″delayed diagnosis,″ ″underrecognized,″ ″protocol,″ ″guideline,″ ″pain management,″ ″older adult,″ ″disability,″ ″physical functionality,″ and ″physical mobilization.″ The searches yielded seventytwo publications relevant to the project. Primary sources included research studies, systematic reviews, and meta-analyses. The systematic analysis of population health data was acquired from the Centers for Medicare & Medicaid Services (CMS), the World Health Organization (WHO), and the International Osteoporosis Foundation (IOF).

The inclusion criteria consisted of English articles from the last five years, primary research studies, and target population of older adults aged 65 or above with a diagnosis of vertebral compression fracture (VCF). The exclusion criterion included review articles, and diagnoses of pathological fracture caused by malignancy, infection, and ankylosing spondylitis. Additionally, studies that included cervical compression fractures were excluded because this project focuses on lumbar spine compression fractures. A DNP project conducted by Carey (2017), who developed an EBP protocol for VCF management and osteoporosis preventive care in a hospital-based setting, was included in the review since it was critical for this project. Outcomes were aimed to assess providers' knowledge and timely VCF management using an EBP VCF clinical protocol. This literature review examined factors that cause extended intervals ranging between diagnosis and treatment, health issues resulting in VCF unrecognition and delayed treatment, outdated knowledge, and financial burden.

Effects of Time Interval between Diagnosis and Treatment

The extended time intervals between the date of the patient's trauma and the diagnosis of VCF often hinder the management and quality of care. The recent studies stressed that VCFs were considered the silent epidemic of the 21st century due to multiple incidents characterized by delayed diagnosis, misdiagnosis or underdiagnosis. Both Capdevila-Reniu et al. (2021) and Aso-Escario et al. (2019) believed that VCFs are commonly diagnosed late, leaving patients exposed to inappropriate treatment and making them vulnerable to multiple complications. Capdevila-Reniu et al. (2021) suggested that health care providers are responsible for undiagnosed VCFs.

On the other hand, Aso-Escario et al. (2019) claimed that undetected VCF diagnosis was directly related to the insensitivity and lower specificity of the radiological procedures. The study led by Aso-Escario et al. (2019) was done in developing countries and underserved populations. It has been argued that a lack of medical resources such as medical diagnostic equipment was responsible for the delayed VCF diagnosis. In contrast, Capdevila-Reniu et al. (2021) claimed that providers were responsible for the diagnosis delay in underserved populations and developing communities. Both Capdevila-Reniu et al. (2021) and Aso-Escario et al. (2019) determined that one of the causes of the delays in diagnosis can be related to the providers' unfamiliarity with available diagnostic protocols. Additionally, they believed that patients with VCFs failed to seek immediate medical assistance and lacked awareness of the available treatments, other than staying at home on bed rest. Both studies pointed out that accurate diagnostic protocols and increased providers' knowledge of VCF occurrence would prevent delays in the diagnosis of VCF. They suggested promoting public health education programs to raise awareness about VCF and avoid diagnostic delays in seeking medical assistance. Both studies implied that the duration of trauma events play a key role in the diagnosis of VCF in a timely manner as part of the clinical assessment process. Furthermore, the interval time between initial visit and treatment was a vital element to be considered and directly correlated to the patients' outcomes.

Underdiagnosed VCF as a Trigger for Health Issues

Underdiagnosed VCF leads to multiple health concerns and complications. VCF adds to significant pain that leads to reduced mobility, resulting in patient's suffering from the psychological fear of isolation and loss of independence. Unrecognized VCF constitutes a significant health problem caused by acute and chronic pain. Drew et al. (2020) and Al-Sari et al. (2016) emphasized that acute pain caused functional decline as an immediate medical complication. Older patients pursue more bed rest due to back pain, and immobility that predispose them to life-threatening complications. Studies showed that as few as two days of bed rest leads to bone mass loss, muscle atrophy and lower extremity strength loss (Drew et al., 2020, Chandra et al., 2018; Al-Sari et al., 2016). Conclusively, the loss of bone density and muscle strength contribute to increased accidental falls.

Furthermore, uncontrolled pain resulting from physical immobilization causes pressure injuries, venous embolism, respiratory and urinary tract infections (Drew et al., 2020). Moreover, adding narcotic anesthesia for pain control creates adverse effects of sedation, nausea, and constipation that further accelerated physical deconditioning, increased fall risk, and prolonged recovery (Al-Sari et al., 2016). The long-term consequences of health-related issues associated with pain include depression and social isolation that can significantly impact patients' quality of life (Drew et al., 2020; Al-Sari et al., 2016). Inappropriate management of VCFs resulted in vertebral deformity, height loss, kyphosis, impaired pulmonary function, reduced mobility, and balance impairment (Drew et al., 2020; Al-Sari et al., 2016). Furthermore, progressive kyphosis leads to decreased ventilatory capacity and reduced abdominal space, early satiety, and poor nutrition (Drew et al., 2020; Al-Sari et al., 2016). Both Drew et al. (2020) and Al-Sari et al. (2016) concluded that patients living with VCF had reduced physical health status compared with patients without VCF, which significantly impacted their health-related quality of life.

Unrecognition and Misdiagnosis caused by Nonspecific Clinical Manifestations

The unrecognition and delayed diagnosis of VCFs are primarily due to their nonspecific presentation. The first presenting symptom among patients with VCFs is localized and diffuse pain. An estimated one third of patients with symptomatic VCFs had severe pain, which often leads to seeking medical attention, and two thirds of VCF cases are clinically silent (CMS, 2020; Hoyt et al., 2020; Johansson et al., 2018). Johansson et al. (2018) concluded that there is an inconsistent associative pain pattern with the level of vertebral body collapse, which also contributes to unrecognition of VCFs.

The pain in older adults is typically described as aggravated by standing, ambulating, and improved in positions of lying down or sitting. The clinical manifestations contribute to misdiagnosis because they can be considered as a degenerative spinal joint disease. Common complaints such as, a sudden onset of severe chest and back pain radiating anteriorly contribute to misdiagnosis of either cardiac or pulmonary diseases (Johansson et al., 2018). Although Hoyt et al. (2020) and Johansson et al. (2018) identified pain as the dominant symptom of VCFs, Hoyt et al. (2020) recognized that VCFs could cause physical limitations even in the absence of pain. Both studies concluded that it is important to diagnose individuals with VCFs, because those patients with asymptomatic and mild symptoms of VCFs are associated with reduced physical function, impaired quality of life, morbidity, and mortality. They further stressed that early detection of VCFs will provide appropriate treatments to decrease the risk of subsequent osteoporotic fractures.

Outdated Knowledge and Inconsistent VCF Guidelines

Conservative VCFs management continues to rely on inconsistent guidelines as a firstline treatment plan (Parreira et al., 2017; Rzewuska et al., 2015). VCFs Treatment plan consists of analgesics, back braces, physiotherapy, bed rest, and osteoporotic medications. Patients with VCFs often become unable to tolerate activities related to normal daily living, culminating in bed rest to avoid movement-induced pain (Parreira et al., 2017). Parreira et al. (2017) and Rzewuska et al. (2015) determined that traditional immobilization techniques, such as bed rest and bracing may create a vicious cycle where decreased activity leads to worsened bone density and muscle density hypertrophy with resultant fracture formation and increased pain. Parreira et al. (2017) pointed out that inconsistency in the recommendations of VCFs clinical guidelines contributed to delayed treatment and deteriorated health-related outcomes.

A lack of consensus of diagnostic imaging testing and clinical pathways is responsible for not recognizing potential VCFs patients. The diagnosis of VCFs relies on a combination of elements, such as medical history, physical examination, and radiographic imaging studies.

The misconception about whether the episodes of back pain are related to the history of preceding trauma contribute to the unrecognition of VCF. Furthermore, using analgesic medications, such as NSAIDs, has resulted in adverse events, including gastrointestinal disorders, kidney failure, and congestive heart failure. The side effects of morphine-based analgesics include constipation, urinary retention, sedation, confusion, and opioid-induced hyperalgesia (Parreira et al., 2017; Rzewuska et al., 2015). Patients using pain medications through the primary care provider may not seek specialized management and often delay proper diagnosis and care.

Surgical procedures for VCFs have led to optimal patients' outcomes if diagnosed appropriately and managed early. Percutaneous vertebral augmentation (PVA), such as Kyphoplasty, is a minimally invasive image-guided treatment procedure to achieve pain relief by percutaneously injecting radiopaque bone cement to stabilize the fractured vertebral body internally (Liu et al., 2013; CMS 2020). The studies showed that VCF patients with pain would benefit from early Kyphoplasty referral. Several meta-analyses and systematic reviews compared pain reduction following Kyphoplasty versus conservative treatment (Liu et al., 2013; Rzewuska et al., 2015; Stefano et al., 2018), and they indicated that early Kyphoplasty referral is superior to conservative management. Conclusively, Liu et al. (2013) demonstrated that Kyphoplasty increases life quality by reducing pain and promoting early mobilization. The American College of Radiology (ACR), the National Institute for Health and Care Excellent Guidelines (NICE) and the American Academy of Orthopaedic Surgeons (AAOS) endorse and supports the use of Kyphoplasty (Parreira et al., 2017).

Preauthorization Process' Burden

Providers must understand the complexification of the insurance preauthorization process, such as the approval required for MRI imaging and treatment procedures, which has caused further continuum care delays. Delay in authorization was defined as any waiting period greater than 7 days (Menger et al., 2017). Menger et al. (2017) stated that preauthorization is often delayed 9 days on average with commercial insurance across all neurosurgery procedures, 8.5 days with Medicare, and 11.5 days with Medicaid. Although preauthorization requirements vary by insurance payers and government regulation changes, the lack of consistency is one of the challenges providers face in shortening the time interval between diagnosis and treatment.

According to the American Medical Association (AMA), an annual survey of 1,000 physicians in 2019 found that 86% described the administrative burden associated with preauthorization as a very high burden. Contrastingly, Turner et al. (2019) pointed out that preauthorization policies are used by both public and private payers to manage the use of costly or potentially avoidable care. However, Turner et al. (2019) suggested that applying preauthorization policies does not always translate into lower overall health care spending. Seventy-four percent of providers reported that a prolonged preauthorization process could lead to treatment abandonment (Turner et al., 2019). An estimated $80,000 annually preauthorization cost burden is placed on the clinics, and it is equivalent to the cost of between $2,200 and $3,400 annually per provider (Turner et al., 2019). Both Turner et al. (2019) and Menger et al. (2017) determined that standardizing the care, streamlining the process, and targeting the VCF requirements are consensus approaches that are aimed at decreasing the financial and patientprovider relationship burden (Turner et al., 2019).

Economic Burden Related to Delayed Diagnosis and Treatment

A few studies evaluated the economic burden of delayed VCF diagnosis and treatment. This posed considerable health and economic burden to public health due to the cost of intensive care units (ICU), prolonged hospital stays, and extensive medication use (Chandra et al., 2018; Ferreira & March, 2019; Hirsch et al., 2018; Hopkins et al., 2020; McCarthy et al. 2016). The average length of stay for hospitalized patients with VCFs is 10 days, hospital mortality ranges from 0.9% to 3.5%, and 1 in 5 patients was readmitted within 30 days. Chandra et al. (2018) indicated that there were approximately 60,000 office visits and 70,000 hospital admissions from VCFs occurring annually in the U.S. One-half of hospitalized patients have been identified as requiring skilled nursing facility care and ongoing care for chronic pain and physical deconditioning, which contributed to significant negative effects. Furthermore, Hirsch et al. (2018) signified that the cost of medical care for VCFs in 2015 was estimated at $1.2 billion. By 2025, there will be over 3 million osteoporotic fractures with $25 billion in related health care costs in the U.S., and VCFs will account for one-quarter of osteoporotic fractures (Hopkins et al., 2020; Chandra et al., 2018; Hirsch et al., 2018).

Conclusion

Attaining healthy, thriving lives and well-being, free of preventable disease, disability, injury, and premature death is one of the overarching goals formed by Healthy People 2030. It aims to improve the health and well-being of older adults by reducing chronic health problems. Undiagnosed and untreated VCFs are associated with chronic pain and disability, leading to a significantly increased risk of mortality and morbidity. The Agency for Healthcare Research and Quality (AHRQ, 2020) demands the establishment of interventional protocols for VCF associated acute and chronic pain. The Future of Nursing Report released by the Institute of Medicine (IOM) indicated that APRNs must develop partnerships with physicians and other professionals to improve quality and safety (ANA, 2010; National Academies of Sciences, Engineering, and Medicine, 2021). Aligning with Healthy People 2030, AHRQ and IOM support the goals of maintaining health, quality of life, and independence in older adults by improving recognition of VCFs and reducing the financial burden on osteoporotic-related fractures.

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COMMITTEE SPOTLIGHT

Audit Committee

The ANA-NY Audit Committee is a standing committee of the Board. The responsibilities of this committee are to: review fiscal operations to ensure that they are consistent with the purposes and functions of ANA-NY, ensure that proper internal fiscal controls are in place, review the accuracy of financial accounting, and recommend an accountant for the financial review. They are also charged with vetting any declared conflicts of interest and are one of the avenues of reporting in the ANA-NY whistleblower policy.

The 2023 members of the Audit Committee are:

Chair – Amy Bivona-Carmignani, BSN, RN, PHN

Amy Bivona-Carmignani, BSN, RN, PHN is Chair of the Audit Committee for ANA-NY. Amy is a Public Health Nurse with the New York City Department of Health and Mental Hygiene, one of the largest public health agencies in the world. Amy has extensive nursing and leadership experience with The Office of Mental Health (OMH), The New York State Office for People with Developmental Disabilities (OPWDD) with specialties in Psychiatry, Adolescent Health, Rehabilitation, School Nursing, and Geriatrics. Amy is currently completing a master's degree in Community Health at CUNY Graduate School of Public Health & Health Policy.

Kathleen Dever, EdD, MS, RN

Kathleen Dever EdD, MS, RN recently retired Professor Emeritus from St. John Fisher University Wegmans School of Nursing after teaching Community Health in both the Undergraduate and RN to BS programs, Nurse Leadership and Healthcare, Policy and Finance at the Graduate level for 16 years. Prior to teaching, Kathie spent 30 yrs. in Community Health Nursing, truly enjoying working with patients, families and staff to support healthy behaviors.

She has been a member of ANA-NY since the ground roots beginning as a member and supporter.

Rose Green, RN (no photo or bio submitted)

Beverly Karas-Irwin, DNP, MS, RN, NP-C, HNB-BC, NEA-BC

Beverly S. Karas-Irwin, DNP, MS, RN, NP-C, HNB-BC, NEA-BC is the Vice President Nursing and Advanced Practice Providers at Summit Health, an organization providing comprehensive and coordinated primary, specialty, and urgent care in over 370 locations in New Jersey, New York, Connecticut, Pennsylvania, and Central Oregon. Dr. Karas-Irwin is a Magnet Appraiser for the American Nurses Credentialing Center. She has authored publications and has presented locally and nationally. Dr. Karas-Irwin is an adjunct professor at Ramapo College of New Jersey. She was previously appointed to the ANA-NY Legislative Committee in 2017, Chair of the committee in 2019 and currently serves on the Audit Committee and ANA-NY Political Action Committee Board.

Dr. Karas-Irwin obtained her Doctor of Nursing Practice in Nursing Administration from University of Pittsburgh, PA; Master of Science in Nursing – Adult Nurse Practitioner from St Peter's College, NJ; Master of Science in Health Service Management from New School for Social Research, NYC; and Bachelor of Science in Nursing from University of Pittsburgh. She is nationally board certified as an adult nurse practitioner, holistic nurse-baccalaureate, nurse executive-advanced and is a fellow in The New York Academy of Medicine.

Ebele Maduekwe, BSN RN

11North night clinician at Stonybrook hospital, Stonybrook NY. Served on Program committee, Audit committee and Awards Committee for ANA New York chapter.

Glennie Millard, BSN, RN

Glennie L. Millard, BSN, RN, retired after 40+ years of Nursing (Civilian and U.S. Military) in several specialties including: Medical-Surgical; Post Anesthesia Recovery; Ambulatory Care; Utilization Review/Discharge Planning Coordination; and The New York State Nurses Association Nurses Representative. Ms. Millard's Professional Memberships include: American Nurses Association (Delegate to HOD and Charter Member of American Nurses Association - New York; New York State Nurses Association (1974-2020); Nurses Association of the Counties of Long Island (NACLI President 2010 to 2014); Sigma Theta Tau International Honor Society of Nursing; Nurse's House past Board Member; Association of Military Surgeons of the United States (AMSUS); Reserve Officers Association (ROA) (President of the Brooklyn Armed Services Chapter 007); CHI ETA PHI Sorority Inc. Theta Chi Chapter, Inc. (President (Basileus) 1999-2001); The American Legion/ The American Legion Auxiliary; and The National Association of Black Military Women. Ms. Millard's Professional Awards include: NACLI Distinguished Nurse Leadership Award 2019; National Council of Negro Women; Marguerite Creth Jackson Sisterhood Award: Theta Chi Chapter; The National Association of Negro Business and Professional Women's Clubs (NANBPW); New York State Nurses Association (NYSNA) Economic and General Welfare Award; Northeast Region (NER) - Soror of The Year Award Chi Eta Phi, Inc.; National Achievement Soror of the Year Award (Chi Eta Phi); The Ruth W. Harper Distinguished Service Award (NACLI). Ms. Millard's United States Army Awards include: The Meritorious Service Medal; The Armed Forces Reserve Medal; The Army Achievement Medal; and The Army Commendation Medal and The Defense Service Ribbon and Inducted into The New York State Senate Veterans' Hall of Fame by New York State Senator Leroy Comrie. Ms. Millard continues to serve on, and participate in, various committees and charitable activities and events.

Patricia Rojas, RN

Before attending nursing school, Patricia Rojas earned a Bachelor of Arts in Environmental Biology from Columbia University. After working in the non-profit sector, Patricia realized her passion was caring for others. She shortly began nursing school thereafter. In 2017, Patricia graduated from the Phillips School of Nursing and was recognized as a Future Nurse Leader by the American Nurses Association (ANA) New York Chapter. By 2018, she earned her BSN from the University of Alabama and is now a Ph.D. nursing student through the Joint Program at the University of Alabama (UA) and the University of Alabama at Huntsville (UAH). She is now a graduate research assistant on a project developing clinical practice guidelines for managing chronic kidney disease at UA. For the past three years, Patricia has worked at New York Presbyterian as an ambulatory care nurse and is now a nurse care manager. Outside of ANA NY, Patricia has served as a committee liaison, board member, and mentor for nursing students for the National Association of Hispanic Nurses (NAHN). In 2019 was awarded NAHN NY Chapter President's Recognition and named one of the 40 under 40 nursing leaders through NAHN National in 2020.

Board Liaison –
Kim Velez, MSN, RN

Kimberly Velez, an RN for 25+ yrs., is currently an Expert Clinical Informatics Nurse and Educator at Northwell Health, Long Island, NY, USA. She earned a Masters in Nurse Executive and two advanced Certificates in Nursing Informatics and Nursing Education. Her nursing career includes management, all areas of Inpatient, Emergency Room, PACU, and as a Float Nurse.

Kimberly belongs to 8 nursing organizations and sits on the board of 6 on National, State, and Local levels, including the Nominating and Elections Committee for ANA, ANA-NY Board of Director, NACLI (local nursing organization as Past-President, three Sigma chapters and spent 14 years on the NYS Board for Nursing (Licensing Department). She also was elected in two national positions as part of the Leadership Succession Committee of Sigma Theta Tau International, and ANIA National. Kimberly is the current ANA-NY board liaison for the Audit Committee.

Kimberly is committed to evidence-based models of research, teaching, community outreach, mentoring and spending time with family.

When the Patient Disagrees

By: Georgia Reiner, MS, CPHRM, Risk Analyst, NSO

Nurses and nurse practitioners take pride in providing detailed information to patients to help them make treatment decisions. But what happens when patients don't make what you think is the "right" choice? Ultimately, you need to respect the patient's autonomy and right to choose (self-determination) even if you feel the patient isn't making the best decision, for example, by refusing an important diagnostic test.

Other examples of patients not following medical advice include those related to vaccination. Some parents may choose not to have their child receive the vaccine for preventing human papillomavirus (HPV) infection. Others may refuse the measles vaccine for their child, which you know puts others at risk for infection. In addition, patients may choose to exclusively use alternative treatment options rather than integrating them into their standard medical care.

Ideally, people will make the best choice for themselves and their loved ones. You can help them in that process (and reduce your own legal risk) by ensuring they have the information they need to make an informed decision and engaging in a shared decision-making process.

Information, please

Consider this scenario: A patient decides to abruptly stop taking her prescribed beta-blocker because she "doesn't like taking pills." After developing rebound hypertension and tachycardia, she claims she wasn't told of the possible adverse effects of not taking the medication. Unless you can point to documentation that shows the patient received education about the adverse effects of sudden stoppage, you could find yourself named in legal action.

To help avoid situations such as this and the others noted at the start of this article, provide education, which should be delivered in the patient's preferred language. It's also helpful to explain the concept of evidence-based care and to note research studies that support, for example, vaccination for HPV. The consumer summaries offered by the Agency for Healthcare Research and Quality (AHRQ) through its Effective Health Care Program (https://effectivehealthcare.ahrq.gov/consumers) are a resource for patient-friendly information about health conditions. Another resource is the patient section of the Choosing Wisely website (www.choosingwisely.org), where you can download patient information based on recommendations from leading specialty organizations.

Document all education that you provided in the patient's healthcare record, as well as any use of translation services, and include that the patient or parent affirmed their understanding of the material. Follow your organization's policies and procedures related to informed refusal or patients acting against medical advice to ensure you are fulfilling your duties.

Shared decision-making

Information is an integral part of shared decision-making (SDM). The National Learning Consortium defines SDM as "a process in which clinicians and patients work together to make decisions and select tests, treatments, and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values." SDM helps patients understand their options and make decisions that are right for them. Using the model may make it less likely a patient chooses not to follow medical advice. And if the choice is not one you agree with, at least you know the patient made a thoughtful decision.

The five-step SHARE approach from the AHRQ is a useful model for the SDM process. The approach is based on extensive research and clinician input:

1. **S**eek your patient's permission. Explain to the patient that there are choices related to treatment and ask them to participate in the decision-making process. Some patients may not know they should take part in making treatment decisions. If appropriate, ask the patient if others, such as family members or loved ones, should be included in the discussion. An example of how to start the conversation is, "There's good information about how these treatments differ that I'd like to discuss with you before we decide on an approach that is best for you."
2. **H**elp your patient explore and compare treatment options. Assess how much the patient already knows about the options and provide information in plain language. Explain the benefits and risks of each option.
3. **A**ssess your patient's values and preferences. Determine what is important to the patient in relation to the options, using open-ended questions such as "As you think about your options, what's important to you?"
4. **R**each a decision with your patient. Ask if there are any additional questions the patient has before they can decide. Keep in mind that patients may need time to consider their options and consult with others before making the decision.
5. **E**valuate your patient's decision. Evaluation refers to follow-up. In patients with chronic diseases, for example, the decision may need to be revisited at a future date as the patient's condition changes. You should also work with the patient to identify and remove barriers to implementing the decision.

You can access more information about this model, including tools and a workshop curriculum, at https://www.ahrq.gov/health-literacy/curriculum-tools/shareddecisionmaking/index.html.

When a patient refuses

Patients have a legal right to refuse care or to leave the hospital against medical advice. When the patient refuses, listen to the reasons and address them if possible. For instance, a patient who doesn't fully understand a procedure may agree to it once they have additional information. It's also essential to provide information about the consequences of the decision so you meet the criteria for "informed refusal" or leaving against medical advice, according to your employer's policies and procedures. Otherwise, patients could later claim they were not told or did not understand the consequences of their decision. (See Against advice on the next page, as well as page 54 of CNA and NSO's Nurse Practitioner Claim Report: 4th Edition for more information on informed refusal).

Basic rights

Patients have a right to refuse care, but they also have a right to know the implications of their refusal. They also have the right to receive sufficient information before making decisions. You can facilitate optimal outcomes, and reduce your legal risk, by collaborating with patients in decision-making.

Against advice

Patients may choose to refuse treatments or diagnostic tests, to leave the hospital against the advice of their care providers. To reduce the risk of patient harm and the risk of possible legal action, follow these recommendations:

- ***Assess the patient's ability to make decisions.*** If you are unsure, you may want to ask the patient to describe the reason for the visit, repeat back information given about treatment needs, and list basic personal information such as age, birthdate, and current address. If decision-making is impaired, assess if the impairment is temporary (for example, due to medication effects) or long-term. Determine if the patient has designated a surrogate decision-maker.
- ***Listen to the patient's reasons for wanting to leave or refusing treatment*** and address them as you can. For example, a patient may simply be frustrated by prolonged wait time in the ED. Avoid minimizing any of the patient's concerns, criticizing them if they may be misinformed, or telling them they are wrong.
- ***Consider asking the patient's significant others for their assistance*** in convincing the patient to stay or to agree to treatment. However, you do not want others to apply undue duress. Asking open-ended questions that invite people to find their own reasons for change tend to be more effective than strong-arming or shaming.
- ***Document details of the patient's decision in the healthcare record.*** Note those present during the discussion, the patient's stated reasons for the decision, and information provided, including education material and the specific risks of not following the recommended treatment or leaving the facility. Also, document questions from the patient and/or family and the answers you provided.
- ***Continue to provide care not related to the treatment refused.*** In addition, provide care until the patient leaves the premises; this includes discharge instructions, and if you are a prescriber, prescriptions for needed medications. Failure to do so could leave you open to charges of abandonment.
- ***Have the patient sign any form for leaving against medical advice*** that your organization requires and include it in the healthcare record. If the patient refuses to sign, note that on the form. Sometimes the act of asking to sign a form will change a patient's mind, although some organizations have chosen to eliminate such forms because they can create an adversarial relationship with the patient.
- ***If possible, reach out to the patient the next day*** to see how they are doing. Document the call.
- ***Remain calm and professional.*** Be kind and empathetic and use non-judgmental language. People are generally more likely to take the advice of someone they perceive to be likeable and trustworthy.

Discussing vaccines

Parents refusing to have their children vaccinated against measles has led to several outbreaks in the United States, and some jurisdictions have made vaccination a requirement before the child can attend school. The CDC offers a resource for clinicians to use when discussing vaccination with parents. The resource recommends clinicians assume that parents will vaccinate their child, as is usually case. Therefore, it's better to say, for example, "Your child needs three shots today," rather than "What do you want to do about shots?"

For parents who are unsure, give a strong recommendation, such as, "I strongly recommend your child get these vaccines today." You may choose to follow up with a supporting statement that you think will best resonate with the parent such as, "These shots are very important to protect your child from serious diseases." If parents express concerns, listen and provide information. (The CDC has a handout of responses to common questions at www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.pdf.)

If the parent refuses to allow vaccination, explain possible consequences and review their responsibilities such as informing the child's school of the vaccination status and isolating the child during an outbreak. Document the encounter in the healthcare record. In addition, continue to follow up with parents during subsequent visits because they may change their minds.

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A Systematic Approach to Ethical Decision-Making for Nurses

By: Georgia Reiner, MS, CPHRM, Risk Analyst, NSO

Throughout their careers, nurses, nurse practitioners, and other nursing professionals will encounter challenging situations at work that present ethical dilemmas. Deciding what to do in these situations can cause significant stress, as the appropriate course of action can vary depending on each unique set of circumstances. This article reviews a model that nursing professionals can use as a guide to help them gain a better understanding of conflicting issues and navigate ethical dilemmas.

Key ethics principles

Below are key ethical principles nurses should know:

- **Autonomy**. This addresses self-determination, allowing the person the freedom of choice and action. It is important to help patients understand the implications of their decisions and to ensure that family members not pressure patients to make a choice. In addition, if you feel a person is not capable of making a decision, follow organizational policy to determine an appropriate surrogate decision-maker.
- **Beneficence**. This refers to "doing good." Although this principle seems simple, it is not always easy to determine what is "good" in an ethical dilemma. Beauchamp and Childress state that beneficence includes protecting and defending the rights of others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping people with disabilities, and rescuing persons in danger.
- **Nonmaleficence**. This principle refers to not causing harm to others, including not inflicting intentional harm and not engaging in actions that risk harming others. One way to address this principle is to weigh potential harm against potential benefits. The goal is to select interventions that create the least amount of harm to obtain the most beneficial outcome.
- **Fidelity**. Honoring commitments is the focus of fidelity. Fidelity incudes acting with caring and being honest; patients need to feel they can trust you. For example, if a patient does not want to share her advanced cancer diagnosis with family members, you should honor that wish.
- **Justice**. Justice does not mean treating everyone the same. Rather, it means treating a person in a way that meets his or her individual needs. Examples include providing education materials in patients' preferred language and offering free flu shots to those in need.

Nurses are well aware of patients' rights, such as the right of patients for self-determination (the right to make decisions about their own care). This right has even been codified in law as a result of the Patient Self-Determination Act (PSDA) of 1991, which requires healthcare agencies receiving Medicare and Medicaid reimbursement to provide information about advance directives. Patients' rights, like self-determination, also play a role in ethics. For example, Provision 1.4 of the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* (the *Code*) states that the patient has a right to self-determination.

In the clinical setting, ethical conflicts related to self-determination and other ethical principles are not unusual. Consider these possible scenarios: A family member disagrees with an advance directive that a patient completed now that the patient is unable to speak for themself. A patient declined to receive a potentially life-saving treatment even after receiving information about the process. A nurse wonders if a patient has received enough information from the physician to truly give informed consent. How can these types of ethical dilemmas be resolved? Taking a systematic approach can help you navigate toward a decision, but first it is useful to understand how legal issues relate to ethical principles.

Legal responsibilities

Even though the *Code* relates to ethics and not the law, attorneys could turn to it for evidence that a nurse's behavior did not meet the standard of care. For example, the *Code* states, "Nurses preserve, protect, and support those rights by assessing the patient's understanding of the information presented and explaining the implications of all potential decisions." If you fail to act when you think a patient did not receive enough information about a treatment decision, you could be held liable.

In addition, keep in mind that principles such as self-determination and patient autonomy applies not only to end-of-life care but to all treatment decisions. Therefore, going against a patient's wishes could put you in legal jeopardy. For example, drawing blood from a patient who states he does not want lab work done could be considered battery.

To help avoid legal peril, use a systematic approach to making ethical decisions, based on ethical principles (*see Key ethics principles*). One such approach is a framework for ethical decision making from the American Counseling Association (ACA). While written for counselors, the framework outlines seven steps any healthcare professional can use to approach ethically ambiguous situations:

#1. Identify the problem.

To identify the problem, you first need to gather information related to the situation. Focus on facts, not assumptions. Consider whether the issue is related to yourself and what you are doing (or not doing) or is related to the patient or the patient's loved one and what they are doing or not doing. For example, in the case of a young teenager who has not been informed he has brain cancer at the request of his parents, an ethical issue relates to the dynamics of the parents not wanting the diagnosis to be shared and the healthcare professionals who must consider the impact on the patient.

Be sure you are truly facing an ethical problem and not a clinical, legal, or professional one or a combination. Other considerations include whether the issue is related to technology (e.g., mechanical ventilation) or organizational policy. For example, legal statutes and organizational policy related to removing a patient from life support could conflict with what you see as the right ethical path. If there is any element of a legal issue involved, be sure to consult your organization's risk management or legal department, or an attorney.

#2. Apply the code of ethics.

Once you have identified the problem, turn to the Code. In some cases, the answer may be there. For example, a patient gives you a computer tablet as a thank-you gift. You had wanted to purchase a new tablet to replace your old one, but you are unsure if you should accept the gift. Provision 2.4 of the *Code* states, "Accepting gifts from patients is generally not appropriate." The provision goes on to state that one factor to consider is the value of the gift. The cost of a tablet means you should decline the gift. (In addition, your organization likely has a policy that prohibits gifts from patients.)

You should also consider other relevant codes that might apply. For example, the American Association of Nurse Anesthetists has their own Code of Ethics for the Certified Registered Nurse Anesthetist.

If the issue is not resolved by codes of ethics, you will need to move on to the next step.

#3. Determine the nature and dimensions of the dilemma.

To accomplish this task, analyze the dilemma in terms of ethical principles. Determine which principles apply and which have priority in this case. For instance, a patient with a history of chronic pain is asking for an early refill of his narcotic prescription. Granting the prescription might meet the principle of beneficence in the short term by providing pain relief but could violate the principle of nonmaleficence by putting the patient at risk of substance misuse.

As part of your analysis, consider consulting the literature to ensure current, evidence-based practice. Thinking and consulting with colleagues or managers can also help you see other points of view. Another excellent resource is your organization's ethics committee. In certain situations, you may even want to consult with your state or national professional association for input.

#4. Generate potential courses of action.

This is the time for brainstorming ideas for actions to take. Write the ideas down without taking time to consider whether they are viable. Having another colleague help you with this step is a good idea.

#5. Consider the potential consequences of all options and determine a course of action.

Now you should evaluate the potential courses of action you identified. Consider each option in the context of the information you have and evaluate the positive and negative effects of the option in relation to ethical principles you have identified. You will also want to evaluate each action for the potential effects on you, the patient, and any others who will be affected, for example, the patient's family or the organization. It may be helpful to write a list of pros and cons for each option.

Toss out options that are problematic and take a closer look at the remaining ones, ultimately picking the one that best fits the situation.

#6. Evaluate the selected course of action.

Once you have chosen a course of action, test it to determine if it truly is the best option. The three "tests" are justice, publicity, and universality:

- To apply the test of *justice*, consider your own sense of fairness and whether you would treat others the same in the situation.
- To apply the test for *publicity*, ask if you would want your behavior reported in the media.
- And to apply the test for *universality*, consider whether you would recommend the same course of action to another nurse.

If your option does not fulfill all three tests, return to the start of the process. You may find that you did not properly identify the problem. If your choice met the tests, you are ready to move forward.

#7. Implement the course of action.

Know that just because you feel the action is the right one does not mean it will be easy to carry out. You may need to engage in stress reduction techniques before and after the action.

Guide to ethical decision-making

Here is a summary of the seven steps to ethical decision-making:

#1. Identify the problem.
#2. Apply the code of ethics.
#3. Determine the nature and dimensions of the dilemma.
#4. Generate potential courses of action.
#5. Consider the potential consequences of all options and determine a course of action.
#6. Evaluate the selected course of action.
#7. Implement the course of action.

Download an infographic outlining the process at www.counseling.org/docs/default-source/ethics/ethical-dilemma-poster_fa.pdf?sfvrsn=2. While the process was written for counselors, the same principles can apply to nursing if you simply substitute the American Nurses Association Code of Ethics with Interpretive Statements for the American Counseling Association Code of Ethics.

Once the action is completed, determine if the result was what you anticipated. This is a good opportunity to learn how be more effective in making ethical decisions in the future.

A proactive approach

Ethical dilemmas can cause significant distress, even when managed appropriately. To reduce distress, follow a step-by-step approach to making decisions. Consult your manager or your organization's risk management or legal department for assistance. And if there are significant legal concerns involved, it may be useful to consult an attorney before proceeding.

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NO KIDDING!

What is a Tick's Favorite Margarita Flavor? Lyme

Connie J. Perkins, PhD, RN, CNE

This edition of the *No Kidding!* column is personal. This past summer, my fellow-nurse husband and I went on a medical journey to get his Lyme disease diagnosis. Four days of fatigue, fevers, and rigors led us to the ED for a diagnosis of "some random virus", later leading to a mono diagnosis. Despite the antibiotics, he kept getting worse- malaise, joint pain, trunk rash, and finally left sided facial paralysis that we triaged together as not a stroke while out for his birthday. We felt confident it was Lyme disease given the symptoms, where we live, and that he was an avid hunter who already started scouting for the fall season. We never pulled a tick off him or found a bull's eye rash, but we knew in our nursing guts that it had to be Lyme disease. We requested blood tests and rounds of Doxycycline until finally he felt better and the fourth blood draw came back positive after 10 weeks of being sick. His facial paralysis eventually resolved, but he is still building back up endurance that he lost over the summer. He is not part of a small group. In fact Borrelia burgdorferi (the bacterium responsible) inflicts 476,000 people each year in the United States alone (Global Lyme Alliance, 2022). To put that figure into perspective, "…there are 618% more new cases of Lyme disease in the U.S. than Hepatitis B, Hepatitis C, and West Nile Virus combined" (Global Lyme Alliance, 2022, para. 9). The two-step blood test that is available may be accurate only 65% of the time because it takes several weeks for our bodies to make the antibodies that these tests are looking for (Centers for Disease Control and Prevention [CDC], 2022a). Our four-legged companions have had an annual Lyme disease vaccine available since 1992, so when is it going to be our turn (Barnette, 2020)? In 2002 there was a vaccine available called LYMERix®, but it was removed from the market because it there wasn't sufficient demand for the product and its efficacy decreased over time (CDC, 2022b). However, phase 3 human trials are underway from Valneva and Pfizer for a more effective annual vaccine and the University of Massachusetts Medical School has developed a PrEP for the disease (CDC, 2022b). Although the phase 3 vaccine trials started in August 2022, they don't expect being able to apply for FDA approval until 2025 likely in Europe first (Pfizer, 2022). The PrEP vaccine, which would "… kill the bacteria in the tick's gut while the tick drinks its victim's blood before the bacteria can get into the human host" completed phase I of the clinical trials in August and anticipates starting phases II and III in the Spring of 2023 (Precision Vaccinations, 2022). For my history and APA loving friends, Lyme is a disease that is capitalized because it is actually named after a town in Connecticut where it was first diagnosed in a group of children previously thought to have rheumatoid arthritis (which is not capitalized) (American Psychology Association, 2022). In conclusion, I'm happy to raise my margarita glass to a future with prevention options- cheers!

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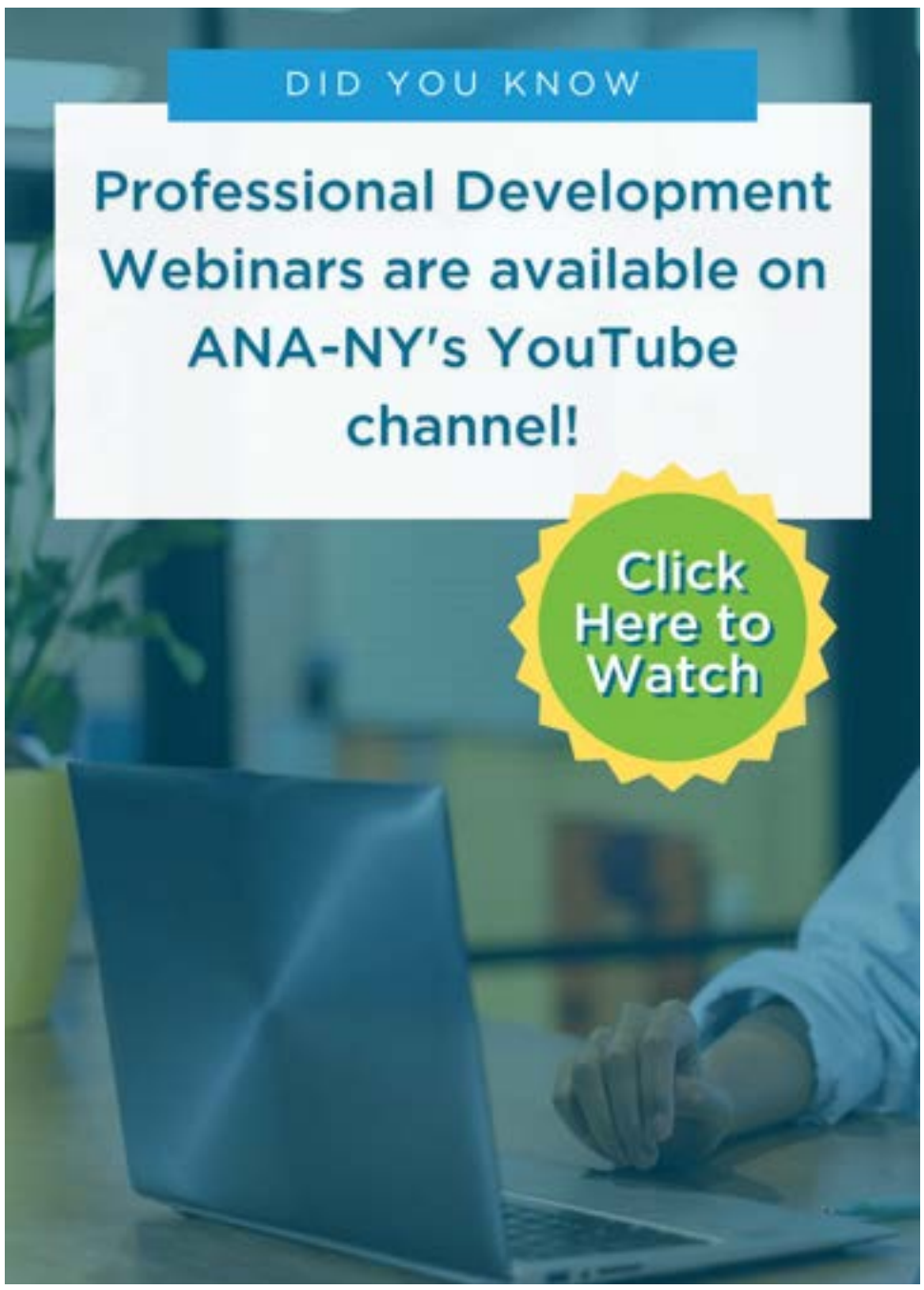
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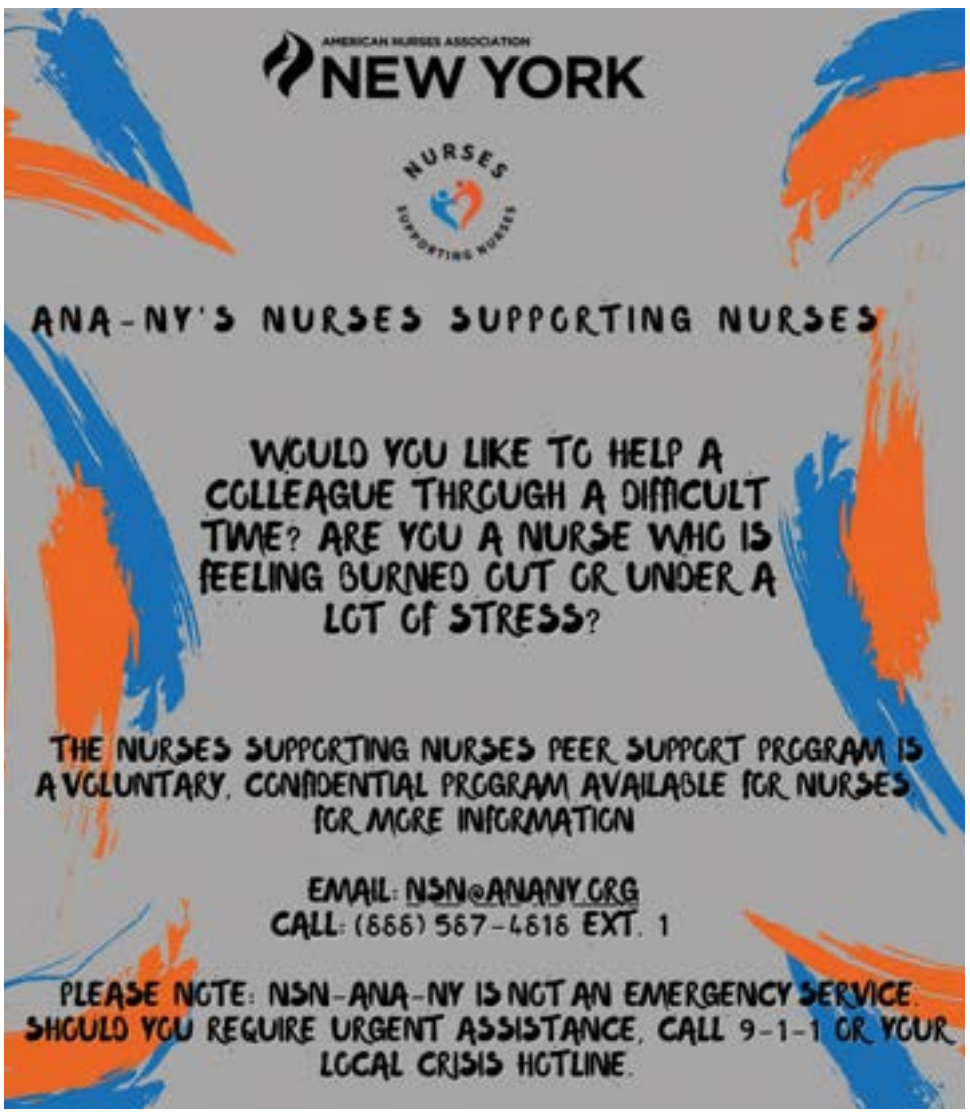
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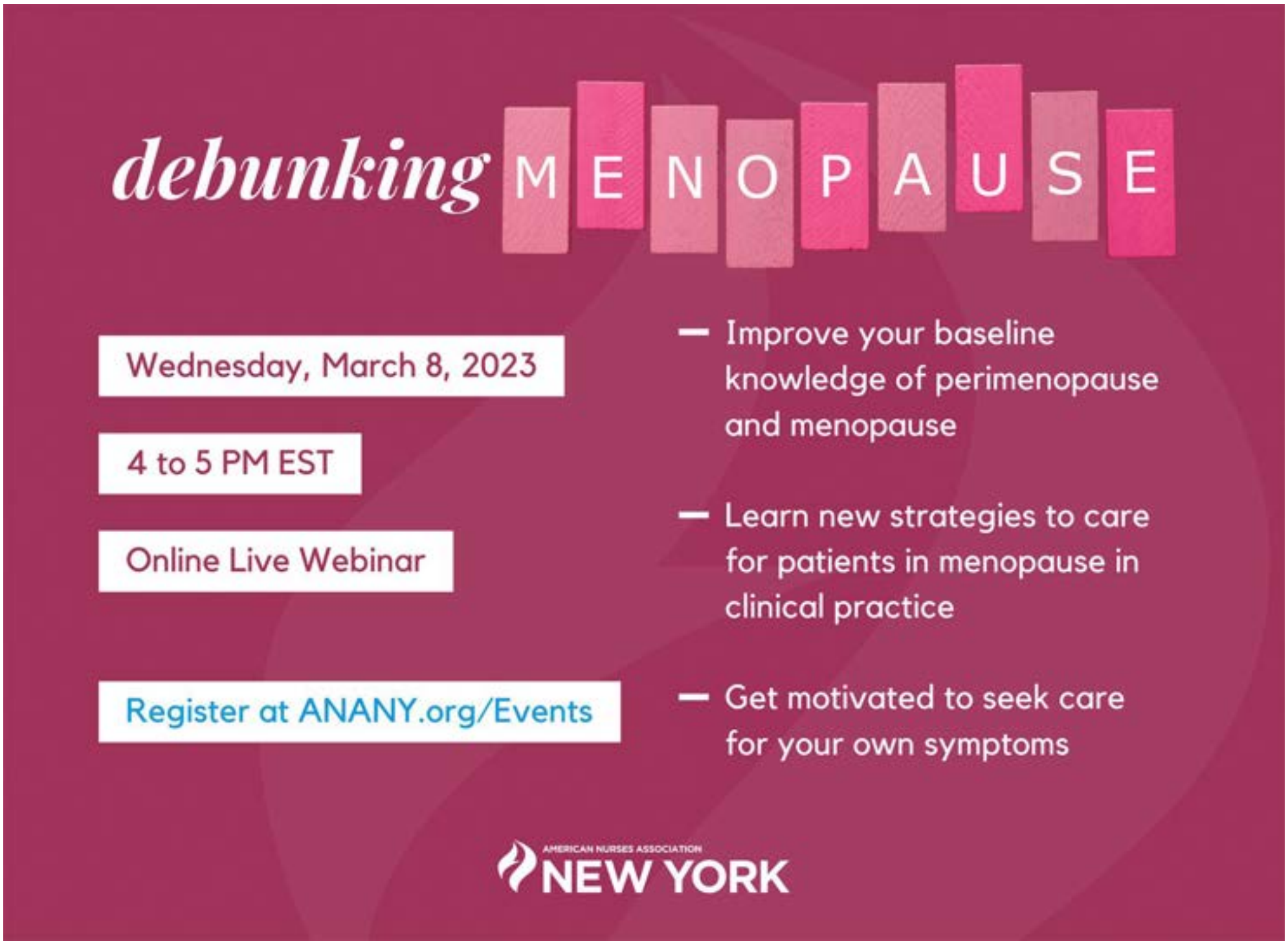
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