December MNORN Member Meeting/Annual Meeting

Date: December 14th
Time: 6:30 PM - 8:00 PM
Location: virtual

Join us at 6:30pm for a time to catch up with each other. At 6:50pm, there will be a brief annual meeting, followed by the program at 7pm.

Program Topic: Secondary Trauma

Secondary trauma is when the stress of working with traumatized patients/clients begins to interfere with your own professional or personal life. If you google "secondary trauma in nurses during COVID-19", you will find articles about nurses' experiences with this all over the world. **Click here to learn more**

Objectives for the program:

- Define the scope of the increase in mental health distress in healthcare providers as it relates to the last two years
- Identify secondary trauma
- Illustrate the concept of "burnout" and "moral injury"
- Consider reframing the language used when describing consequences of secondary trauma
- Discuss options to respond to feelings of secondary trauma and moral injury

Rochelle Perry will be our speaker. Rochelle Perry is a board certified Family Mental Health Nurse Practitioner earning her MSN in 2012 from Rush University in Chicago, IL and currently working on her Doctorate of Nursing Practice through Minnesota State University, Mankato with a graduate date of summer 2022. She has experience in multiple mental health settings, including inpatient child/adolescent/adult/geriatric units, outpatient clinics, teenage runaway shelters, correctional facilities, and community health facilities. She enjoys working with a diverse array of mental health issues. Rochelle provides comprehensive mental health treatment including diagnostic assessments and medication management for clients across the lifespan. Areas of special interest include working with adolescents, young adults, and their families in the transition to adulthood, those struggling with substance use and pursuing recovery and/or struggling with a severe and persistent mental illness.

evite link for rsvp: http://evite.me/xyxdEAw2

There is no charge for this program. Attendees will receive 1 contact hour.

St. Thomas 2025 - Grow the Morrison Family College of Health

School of Nursing to Recruit Students for Fall 2022

By Amy Carlson Gustafson

Minnesota's newest nursing school is officially accepting students – and the news comes at a critical time as the nation grapples with a shortage of nurses.

The Morrison Family College of Health School of Nursing has received the green light from the three governing bodies needed to recruit its first class of students for the Bachelor of Science in Nursing and pre-licensure Master of Science in Nursing programs starting in fall 2022. These approvals came from the Higher Learning Commission (November), the Minnesota State Board of Nursing (August) and the Minnesota Office of Higher Education (April).

Dr. Martha Scheckel, founding director of the School of Nursing, recognizes the importance of St. Thomas achieving this program milestone at a time when society is essentially in a health care crisis.

"It's part of our commitment to serving the common good," Scheckel said. "It's especially important that we are addressing the nursing workforce shortage that has grown during the COVID-19 pandemic."

Scheckel said that throughout her many years in the nursing field, she's never seen such a demand for nurses. While there was a growing nursing shortage pre-pandemic, the current situation has made the need for skilled nurses even more dire.

"When you have to call in the National Guard to support health care institutions like we've had to do around the country ... I have never seen that before in my career," she said. "It's perfect timing for the School of Nursing."

The current nursing shortage is so severe that in September 2021, Ernest Grant, president of the American Nurses Association, penned a letter to Health and Human Services Secretary Xavier Becerra, asking that he declare a national nurse staffing crisis. The American Association of Colleges of Nursing (AACN) anticipates demand for nurses to intensify as baby boomers age and their need for health care grows. Meanwhile, a significant number of nurses are nearing retirement age.

The Bureau of Labor Statistics reports employment for registered nurses is projected to grow 9% by 2030, with nearly 200,000 openings for RNs projected each year over the decade. Yet, a study published in the May/June 2018 issue of the American Journal of Medical Quality predicts that there will still be a shortage of more than 500,000 RNs by 2030.

Aspiring nurses wanted

Prospective graduate students seeking an entry into nursing practice degree can apply directly to the Master of Science in Nursing program. Interested undergraduates need to apply and be accepted into the bachelor's degree in nursing program after completing their first semester at St. Thomas. Both programs are for those currently without a degree in nursing, but who want to earn their license and become registered nurses.

"Our School of Nursing has very distinct goals around closing health equity gaps," said St. Thomas President Julie Sullivan. "We are dedicated to increasing access to culturally responsive care with a goal of enrolling at least 30% students of color and students from other underrepresented backgrounds. Our students will help to provide more care, to more people, in more diverse and rural communities."

Dr. MayKao Y. Hang, vice president, strategic initiatives and founding dean of the Morrison Family College of Health, said the approvals to start recruiting ensure the School of Nursing is prepared to provide rigorous and high-quality training to future students.

“The students who are going to receive this wonderful liberal arts foundation to actually address what we're seeing in society today in a holistic way, which feels transformational,” Hang said. “We are planting a seed in this community that will bear fruit for generations to come.”

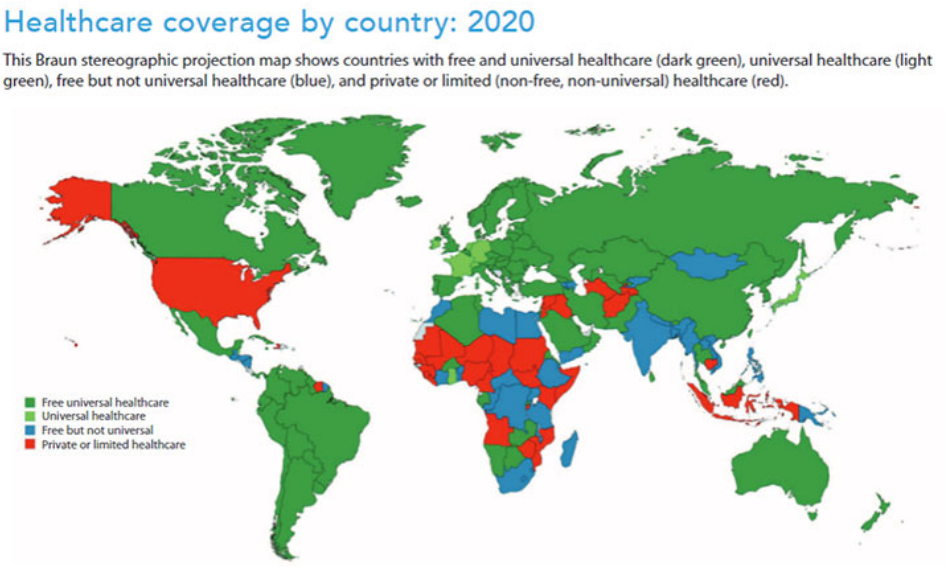
A whole person and whole community focus

The School of Nursing will offer a curriculum aimed at showing students how to address health equity and change the systems that produce them. It is designed to educate students to treat the whole person – mind, body, spirit and community – and promote health and wellness.

“A St. Thomas graduate from the School of Nursing will know how to advocate for systems change,” Hang said. “They’ll be able to work well with others, understand how to use information to make good decisions and be comfortable caring for all.”

An emphasis on health equity, social justice, cultural responsivity and advocacy for the greater good is woven throughout the curriculum of both nursing programs. Through clinical placements, students will be exposed to the many opportunities available to nurses.

"The clinical placements that students who are going into nursing receive are going to look different at St. Thomas," Hang said. "What we're seeking and what we have built are relationships with community organizations that have nursing in historically excluded communities including the Downtown Improvement District in the heart of Minneapolis."



Collaborating across campus

St. Thomas is a comprehensive, Catholic university that provides holistic and personalized education for more than 10,000 students. Its mission is to educate students to be morally responsible leaders who think critically, act wisely and work skillfully to advance the common good.

"I believe being part of a faith-based institution enriches a student nurse's education, which then goes on to enrich and strengthen their practice," Scheckel said.

As part of the Morrison Family College of Health, School of Nursing students will gain a strong background in working as part of a full health care team, with chances to collaborate with students in other College of Health programs (social work, counseling psychology, and health and exercise science) as well as the Interprofessional Center for Counseling and Legal Services.

"The multidisciplinary nature of the Morrison Family College of Health means that we can embed into our programs an interprofessional core that comes from these different disciplines," Hang said. "We can teach students how to not be just bystanders in any health delivery system or community system. We will teach them how to agitate for systems change and to dismantle inequities in health care."

Redesigning healthcare: Global insights for nurses. A look at best practice

American Nurse: October 27, 2021
Author(s): Teddie Potter, PhD, RN, FAAN, FNA.

Editor's note: *This is part of our continuing series designed to tackle issues related to how the profession will move forward as the COVID-19 pandemic evolves. Access a virtual roundtable on the topic here.According to The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity, the COVID-19 pandemic has revealed and amplified significant gaps in the U.S. healthcare system, including race-related health disparities and lack of access to primary healthcare. However, these problems existed before the pandemic. They're the outcome of a system that fails to address social determinants of health (SDOH) and health equity.*

Benton and colleagues summarized the findings of a survey conducted by the American Nurses Association, the American Organization of Nursing Leaders, and Johnson & Johnson. Over 4,000 nurses were surveyed to determine the impact of COVID-19 on nurses. The data show that even during the double crisis of a global pandemic and a collapsing healthcare system, nurses created innovative solutions and designed process changes. The summary makes the following recommendations for transforming the U.S. healthcare system:

- Identify gaps and appoint nurse leaders today.
- Grow the pipeline of new nurses.
- Embrace nurse-led experimentation within health systems.
- Rethink systems and policies that hinder community-level access to care.

Creating opportunities for innovative thinking and new models of care requires nurses to recognize current gaps and acknowledge the need for transformative redesign.

Identifying gaps

Comparing the U.S. healthcare system to those in other countries can help identify gaps in access, efficiency, and equity and provide insights into how to address them. Knowing the gaps and being knowledgeable about innovative practices will support U.S. nurses as they work to accelerate care transformation.

The *Mirror, Mirror* reports published by the Commonwealth Fund (the Fund) can help nurses compare global health systems. The Fund synthesizes health system data from three sources: surveys it conducts in 11 high-income nations, data from the Organization for Economic Co-operation and Development, and World Health Organization statistics. The intent is to learn which policies and practices lead to high performance that will move all nations toward optimal and affordable healthcare for all.

The Fund's ranking is based on five domains: access to care, care process, administrative efficacy, equity, and healthcare outcomes. The ranking in each of these domains drives the final overall ranking of each nation's healthcare system. In 2021, the overall ranking (from one to 11) is: Norway, Netherlands, Australia, United Kingdom, Germany, New Zealand, Sweden, France, Switzerland, Canada, and the United States.

None of the nations rank high or low in all areas. Even Norway, which ranked first overall, came in 8th in equity and in care process. Despite its shortcomings, the United States ranks 2nd in the care process domain. In general, U.S. health professionals deliver excellent preventive care and safe care. They engage patients and honor their preferences. Compared to the other nations, the United States has higher rates of mammography screening and vaccination for influenza, and more patients talk with their providers about nutrition, smoking, and alcohol use. However, these positive results are experienced only by those with healthcare coverage.

Despite the noteworthy strengths in care process, the United States ranks 11th for access, administrative efficacy, equity, and healthcare outcomes, giving it the overall lowest ranking.

To make matters worse, the United States significantly outspends all the other high-income nations for the worst healthcare outcomes. According to the Fund, in 2021 the United States spent nearly 17% of its gross domestic product on healthcare, which is about twice as much as the average high-income nation. Despite this, the United States has the highest infant mortality rate and the lowest life expectancy. In addition, the U.S. rate of preventable

mortality (causes of death that can be prevented by effective public health and primary prevention) is twice as high as the best-performing nation in that category.

It can be shocking to learn that the U.S. healthcare system has so many flaws, but failure to admit system shortcomings contributes to an ineffective and inequitable system. These gaps can be opportunities for redesigning a better post-pandemic syste

Examples of global best practices

Based on the Fund's findings, high-performing nations share these characteristics, which improve healthcare outcomes and equity.

- Universal healthcare coverage and removal of cost barriers. The United States is one of the few countries not to offer free, universal, or free and universal healthcare.
- Primary care available locally in all communities and for all people
- Reduced administrative burdens for providers and patients
- Investment in services to address SDOH.

A closer examination of global models that exemplify these features can provide insights for redesigning U.S. healthcare. The first two examples are from high-income nations profiled by the Fund, and the third demonstrates that excellent health outcomes depend on a well-designed—not a well-financed—system.

Norway: Universal coverage, cost barrier removal

According to United Nations' Sustainable Development Goals (SDGs), one of the targets for the third goal (health) is to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." Norway exemplifies excellence in this domain, and the Fund ranks Norway second in access to care and first overall.

Comparing healthcare systems: Norway and the United States

The data in this table compare healthcare costs and outcomes for Norway and the United States.

	Norway	United States
Percentage of gross domestic product spent on healthcare	10.2%	16.9%
Healthcare spending per capita	$6,187	$10,207
Out-of-pocket health spending per capita	$877	$1,122
Out-of-pocket spending on pharmaceuticals prescribed and over-the-counter	$456	$1,220
Life expectancy (years)	82.7	78.6
Obesity prevalence	12%	40%
Adults age 18 years or older diagnosed with two or more chronic conditions	16%	28%

Source: Tikkanen and Abrams 2020

According to the Fund, Norway's National Insurance Scheme covers 85% of health expenditures. Covered services include primary care, hospital care, mental health treatment, rehabilitation, prescription drugs, preventive care, home and palliative care, medical equipment, and dental care for children and people with chronic diseases and in long-term care. *(See Comparing healthcare systems: Norway and the United States.)*

Buurtzorg Nederland: Reduced administrative burdens

The Fund ranks the Netherlands second overall. Even though it scored high in access to care, administrative efficiency ranked 8th. One nurse decided to address this issue by redesigning home care. Jos de Blok, a practicing home care nurse became frustrated with excessive layers of bureaucracy, countless administrative tasks, and emphasis on productivity rather than relationships.

Instead of leaving nursing, de Blok returned to the original district model of home nursing and created Buurtzorg (Neighborhood Care). His solution was to create small neighborhood-based teams of nurses who determine the needs of clients and families without additional management layers. He believes that management is the greatest contributing factor to fragmented care and wasted time and resources. According to the Center for Public Impact, Buurtzorg spends only 8% of its budget on administration compared to the 25% Dutch average. This nurse-led model exemplifies the best practice of reduced provider and patient administrative burdens.

In the Buurtzorg model, the home care nurse provides all the care, including intake and assessments, personal care, and complex care. The nurse manages the schedule and maintains records. The nurse also draws upon and coordinates formal and informal networks of support in the neighborhood. This approach solves fragmentation of care, and

relationships with the same team of nurses over time yields increased satisfaction for both clients and nurses.

This approach has brought impressive results. According to the Center for Public Impact, client satisfaction rates for Buurtzorg were 30% higher than the national average for other healthcare organizations. Buurtzorg consistently earns the title of best Dutch employer, and the model has financially saved the Dutch healthcare system; Buurtzorg clients use only 40% of the care that they can receive compared to non-Buurtzorg clients who use 70% of services. The Buurtzorg model addresses chronic illness and administration efficiency issues that frequently stymy other healthcare systems.

According to the Fund, bureaucratic tasks in the current U.S. healthcare system have yielded decreased provider and client satisfaction and have needlessly increased costs. The Buurtzorg model doesn't solve acute care issues, but it may offer a cost-effective solution for preventing many people from advancing to acute care. (Click here to learn more about Buurtzorg.)

Cuba: Free primary care, investment to address SDOH

Comparing healthcare systems: Cuba and the United States

The data in this table compare healthcare costs and outcomes for Cuba and the United States.

	Cuba	United States
Life expectancy at birth (2019) (years)	78.8	78.8
Neonatal mortality rate (per 1,000 live births)	2.18	3.7
Infant mortality rate (probability of dying between birth and age 1 per 1,000 live births)	3.81	5.56
Under 5 mortality rate (probability of dying by age 5 per 1,000 live births)	5.12	6.47
Antenatal care coverage for at least 4 visits	97.8%	92%
Physicians per 1,000 people (most recent year 2017)	8.3	2.6
Out-of-pocket expenditures for healthcare per capita in $US (2018)	$108.6	$1,143
Suicide mortality rate (per 100,000) in 2019	14.5	16.1

Sources: World Bank, World Health Organization

To dispel the myth that excellent healthcare is delivered only by high-income, global north nations, consider the Cuban healthcare model. Cuba's system exemplifies primary care that's available locally in all communities and investment in services that prioritize SDOH.

According to Pineo, a Latin American public health scholar, before the 1959 Cuban revolution, Cuba had only one rural hospital and rural infant mortality rates of 32 per 1,000 live births. Half of adults were illiterate, and two-thirds of the population lived in mud-floor houses without drinking water or electricity.

After the revolution, a new model was

developed to deliver primary care throughout the nation. The model draws heavily on primary prevention and consideration of social and environmental determinants of health. Pineo writes: "In Cuba, healthcare, along with education, housing, transportation, and basic necessities, is either free or available at a nominal charge… Cuba practices social medicine, dealing more with the conditions that lead to poor health—nutrition, potable water, sanitation, vaccination, mosquito control—giving less focus to expensive curative treatments… In Cuba, health is regarded as a basic human right, not as a purchasable commodity."

The Cuban model begins with comprehensive family care at the neighborhood level, where citizens receive free primary family medical care at a doctor–nurse clinic. In these clinics, the focus is prevention and individual and population health outcome improvement. The physician and nurse live in the community, frequently in apartments above the clinic. The team also includes a public health expert responsible for mosquito control, drinking water quality management, and sewer system adequacy. Pineo reports that the physician and nurse teams see patients in the clinic in the morning and make home visits in the afternoon, ensuring everyone in the community is seen at least twice a month whether they're ill or not. *(See Comparing healthcare systems: Cuba and the United States.)*

Cuba has universal health insurance coverage and offers accessible neighborhood-based primary care for all citizens, but the key to the country's remarkable outcomes may be that their entire system focuses on health promotion and prevention. It truly is a healthcare model rather than the illness care models seen in the United States and other high-income nations.

Call to action: Accelerate the change

The Fund's observations about high-performing global healthcare systems and insights from global best practices provide some obvious next steps for nurses eager to accelerate transformation of the U.S. healthcare system.

Nurses must advocate for policy changes that support a national health insurance program to ensure comprehensive healthcare for all. The United States is an outlier. Nations that prioritize healthcare as a right for all citizens enjoy better health outcomes. Evidence from Norway, the Netherlands, and Cuba show that removing cost barriers and investing in prevention and primary care can significantly improve a nation's health.

Nurses must insist on health equity. The Fund's ranking of the United States as second in care processes shows that we know how to deliver care. The problem is that optimal care and best practices aren't available to everyone. Nurses must work for policies that ensure cost-free primary healthcare and preventive care for everyone.

All nurse practitioners (NPs) must be granted authority to practice to the full extent of their education, advanced clinical training, and national certification. *The Future of Nursing 2020–2030* report emphasizes that this action will markedly improve access to care, especially in remote and impoverished counties. Full NP practice authority will likely advance health equity.

Nurse-led community care models need further investment and support. Primary care clinics at the neighborhood and community level enhance relationship-based care and advance prevention efforts. The Buurtzorg model demonstrates the positive effects of managing processes locally, and the Cuban model illustrates the benefit of healthcare delivered in the community by providers who live there.

Nursing curriculum must be redesigned to give attention to primary prevention and SDOH. As seen in the Cuban model, health professionals can be educated to advance a healthcare system that focuses on SDOH and emphasizes chronic illness prevention. In *The Essentials: Core Competencies for Professional Nursing Education,* the American Association of Colleges of Nursing considers SDOH a core nursing concept. The authors dedicated one competency (7.2b) specifically to recognizing the impact of SDOH and health disparities. This competency is an important step forward, but it's not sufficient for redesigning the healthcare system. All nursing faculty are called to consistently encourage students to address SDOH and primary prevention throughout their nursing education so that it becomes a nursing practice standard.

Every nurse's responsibility

It is up to every American nurse to ensure that all people have access to, and coverage for, comprehensive healthcare. Nurses have the knowledge and skills to accelerate the transformation of the U.S. healthcare system.

Teddie Potter is a clinical professor, director of planetary health, co-director of the Katharine J. Densford International Center for Nursing Leadership, and coordinator of DNP in Health Innovation and Leadership at the School of Nursing, University of Minnesota in Minneapolis.

References

American Association of Colleges of Nursing. *The Essentials: Core Competencies for Professional Nursing Education*. April 6, 2021. aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

Benton L, Begley R, Hatmaker D. Look to nurses to help accelerate the transformation of health care. Stat. August 20, 2021. statnews.com/2021/08/20/look-to-nurses-to-help-accelerate-the-transformation-of-health-care

Center for Public Impact. Buurtzorg: Revolutionising home care in the Netherlands. November 15, 2018. centreforpublicimpact.org/case-study/buurtzorg-revolutionising-home-care-netherlands

National Academies of Sciences, Engineering, and Medicine. *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. Washington, DC: National Academies Press; 2021.

Pineo R. Cuban public healthcare: A model of success for developing nations. *J Dev Soc*. 2019;35(1):16-61. doi: 10.1177/0169796X19826731

Schneider EC, Shah A, Doty MM, Tikkanen R, Fields K, Williams II RD. Mirror, mirror 2021: Reflecting poorly: Health care in the U.S. compared to other high-income countries. Commonwealth Fund. August 4, 2021. commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly

Tikkanen R, Abrams MK. U.S. health care from a global perspective, 2019. Higher spending worse outcomes? The Commonwealth Fund. January 30, 2020. commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. International health care system profiles: Norway. The Commonwealth Fund. June 5, 2020. commonwealthfund.org/international-health-policy-center/countries/norway

Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton GA. International health care system profiles: United States. The Commonwealth Fund. June 5, 2020. commonwealthfund.org/international-health-policy-center/countries/united-states

United Nations. Goal 3: Ensure healthy lives and promote well-being for all at all ages. un.org/sustainabledevelopment/health

World Bank. DataBank: Health nutrition and population statistics. databank.worldbank.org/source/health-nutrition-and-population-statistics

World Health Organization. The global health observatory. who.int/data/gho/data/countries

Retrieved from https://www.myamericannurse.com/redesigning-healthcare-global-insights-for-nurses/ November 17, 2021

Included in the list of vacancies in State Boards, councils and Committees are the following openings for Registered Nurses:

- Medical Services Review Board - 1 seat, alternate
- MN Board of Nursing - 1 seat

How to apply:
Visit the Open Positions page.
Scroll down to find the correct Agency/Board/Council.
Choose the correct seat type, and click button that says APPLY
The system will walk you through creating an application profile.

Page 2 of the application will now allow you to attach the following documents:

- Letter of Interest
- Resume or Biography

Applicants are encouraged to use the online application as the Appointing Authority will have access to your information as soon as it is submitted.
Applications submitted via downloadable application may experience some delay in reaching the Appointing Authority.

Paper applications may be submitted by email to: Open Appointments or by mail or in person to:
Office of the Minnesota Secretary of State
180 State Office Building
100 Rev. Dr. Martin Luther King, Jr. Blvd.
St Paul, MN 55155-1299

Dissemination of Non-scientific and Misleading COVID-19 Information by Nurses

On November 16th the following policy statement was issued, endorsed by nine national nursing organizations including the National Council of State Boards of Nursing and the American Nurses Association.

At the December Minnesota Board of Nursing meeting, executive director Kimberly Miller stated that the Board of Nursing is in the process of developing criteria for how to respond to complaints. The criteria should be in place within the next couple of weeks.

Policy Statement: Dissemination of Non-scientific and Misleading COVID-19 Information by Nurses

Purpose
To address the misinformation being disseminated about COVID-19 by nurses.

For the purposes of this statement, misinformation is defined as distorted facts, inaccurate or misleading information not grounded in the peer-reviewed scientific literature and counter to information being disseminated by the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA).

Statement
Nurses are expected to be "prepared to practice from an evidence base; promote safe, quality patient care; use clinical/critical reasoning to address simple to complex situations; assume accountability for one's own and delegated nursing care" (AACN, 2021).

SARS-CoV-2 is a potentially deadly virus. Providing misinformation to the public regarding masking, vaccines, medications and/or COVID-19 threatens public health. Misinformation, which is not grounded in science and is not supported by the CDC and FDA, can lead to illness, possibly death, and may prolong the pandemic. It is an expectation of the U.S. boards of nursing, the profession, and the public that nurses uphold the truth, the principles of the Code of Ethics for Nurses (ANA, 2015) and highest scientific standards when disseminating information about COVID-19 or any other health-related condition or situation.

When identifying themselves by their profession, nurses are professionally accountable for the information they provide to the public. Any nurse who violates their state nurse practice act or threatens the health and safety of the public through the dissemination of misleading or incorrect information pertaining to COVID-19, vaccines and associated treatment through verbal or written methods including social media may be disciplined by their board of nursing. Nurses are urged to recognize that dissemination of misinformation not only

jeopardizes the health and well-being of the public, but may place their license and career in jeopardy as well.

References

American Association of Colleges of Nursing (AACN). (2021). The Essentials: core competencies for professional nursing education. Retrieved from https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/ Essentials-2021.pdf

American Nurses Association. (2015). Code of Ethics for Nurses. Retrieved from https://www.nursingworld.org/ practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

Endorsements

National Council of State Boards of Nursing (NCSBN)
Accreditation Commission for Education in Nursing (ACEN)
American Association of Colleges of Nursing (AACN)
American Nurses Association (ANA)
American Organization for Nursing Leadership (AONL)
National League for Nursing (NLN)
NLN Commission for Nursing Education Accreditation (CNEA)
National Student Nurses' Association (NSNA)
Organization for Associate Degree Nursing (OADN)

The policy endorsed by nurses associations follows the Federation of State Medical Boards' statement issued this summer, warning that doctors who spread coronavirus vaccine misinformation risk disciplinary action, including the revocation of their license. Physicians, the statement said, have an "ethical and professional responsibility to practice medicine in the best interests of their patients," which is violated when they spread inaccurate information about the vaccines. They were soon followed by other certifying boards focused on specific specialities, including the American board of Family Medicine, American Board of Internal Medicine and American Board of Pediatrics.
According to a Washington Post article (12-6-21) a handful of doctors have already lost their licenses:

- The Oregon Medical Board revoked the license of a doctor who refused to follow public health guidelines in his clinic, spread misinformation about masks and overprescribed opioids.

- A San Francisco doctor who promoted a false conspiracy linking covid-19 with 5G networks surrendered his license to California's medical board.

- Rhode Island's Board of Medical Licensure suspended the license of a doctor who discouraged patients from getting the coronavirus vaccines.

https://www.washingtonpost.com/politics/2021/12/06/some-doctors-spreading-coronavirus-misinformation-are-being-punished/

Think like an expert witness to avoid falls liability

An 88-year-old patient slips on the floor, falling and breaking his hip. Your immediate concern is getting him the help he needs, but you also wonder if you could be legally liable for what happened. By thinking like an expert witness, you can help determine if this concern is valid and whether you could have taken steps to avoid the situation in the first place. But first, you need to understand some background information.

Falls facts

From 2007 to 2016, the fall death rate for older adults in the United States increased by 30%, according to data from the CDC. Each year, 3 million older adults are treated in emergency departments (EDs) for fall injuries, and more than 800,000 people are hospitalized each year because of injuries related to a fall. These falls extract a high price—more than $50 billion for medical costs in a single year.

Nurse professional liability claims involving falls are identified in the *Nurse Professional Liability Exposure Claim Report: 4th Edition*. The report notes that many of the closed claims analyzed in the report dataset which involved falls occurred because the nurse failed to follow fall-prevention policies and procedures. Further, the report states that falls most frequently occurred in inpatient hospital, surgical services, and aging services settings, as well as in patients' homes.

Given the statistics and the many places falls can occur, a fall is not an uncommon occurrence in a nurse's career. A fall does not automatically mean the nurse is liable; for that to happen, key elements of malpractice need to be present.

Elements of malpractice

To be successful in a malpractice lawsuit, plaintiffs must prove four elements:

1. A duty existed between the patient and the nurse: The nurse had a responsibility to care for the patient.
2. The duty to care was breached; in other words, the nurse may have been negligent. To determine if negligence occurred, the expert witness would consider whether the nurse met the standard of care, which refers to what a reasonable clinician with similar training and experience would do in a particular situation.
3. The patient suffered an injury. Even if a duty existed and it was breached, if no injury occurred, it's unlikely the lawsuit would be successful. Keep in mind, however, that injury can be defined as not only physical injury, but also psychological injury or economic loss.
4. The breach of duty caused the injury—the injury must be linked to what the nurse did or failed to do. This can be summed up in one question: Did the act or omission cause the negative outcome?

Expert witnesses will consider these four elements as they review the case, and they'll ask multiple questions (see *Was there liability?*). The questions primarily address prevention and what was done after the fall occurred.

Prevention

The following steps can help prevent falls and, if documented correctly, prove that the nurse took reasonable steps to protect the patient from injury:

Take a team approach. Registered nurses, licensed practical/vocational nurses, and certified nursing assistants are ideal members for a team dedicated to creating a falls reduction plan for each patient.

Assess the risk. Whether in the hospital, rehabilitation facility, clinic, or home, a comprehensive assessment is essential to identify—and then mitigate—falls hazards. This starts with assessing the patient for risk factors such as history of a previous fall; gait instability and lower-limb weakness; incontinence/urinary frequency; agitation, confusion, or impaired judgment; medications; and comorbid conditions such as postural hypotension and visual impairment. It's also important to consider the environment, particularly in the home setting. For example, throw rugs are a known falls hazard.

An excellent resource for assessing community-dwelling adults age 65 and older is the CDC's STEADI (Stopping Elderly Accidents, Deaths & Injuries) initiative, which is an approach to implementing the American and British Geriatrics Societies' clinical practice guideline for fall prevention. The initiative provides multiple resources for clinicians, such as a fall risk factors checklist with the categories of falls history; medical conditions; medications; gait, strength, and balance (including quick tests for assessing); vision; and postural hypotension.

Keep in mind that assessment should be ongoing during the patient's care because conditions may change.

Was there liability?

If a patient falls, an expert witness will likely want to know the answers to the following questions (developed by Patricia Iyers) when deciding if liability may exist:

Before the fall:

- Was the patient identified as being at risk for falls? How was that risk communicated to others?
  - What medications did the patient receive? Do they have side effects that may increase the risk of a fall?
  - Were there specific conditions present that could increase the risk of a fall?
- Were measures implemented to prevent falls?
  - Was the patient capable of using the call light and was it used to call for assistance?
  - Was the bed in the lowest position?
  - Were the lights on in the room or under the bed to help light the area at night?
  - Was the patient given antiskid slippers?

Immediately after the fall:

- How soon was the individual found after he had sustained a fall (it's not always possible to establish an exact time)?
- What was done at the time of the fall?
- Was the patient appropriately monitored after the fall to detect injuries?
- What did the assessment (including vital signs) reveal?
- Did the nurse communicate the findings to the patient's provider?
- Were X-rays ordered and performed?
- Was there an injury? If so, how soon was it treated?
- If the patient hit their head, was the chart reviewed to determine if mediations included an anticoagulant? If on anticoagulant, was this information communicated to the provider so head scans could be performed to check for cranial bleeding?

Following up after a fall:

- Was there a change in mental status after the fall?
- Were additional assessments and monitoring done as follow up?
- Was the patient's risk for falls reassessed after the fall and the plan of care revised to minimize the risk of future falls?

Develop a plan. Once the assessment is complete, the patient care team, including the patient and their family, can develop a falls-reduction plan based on the patient's individual risk factors. The plan should address locations that are at greatest risk, such as bedside, bathrooms, and hallways, and detail action steps. Sample action steps include giving patients nonslip footwear, making sure call lights are within reach, removing throw rugs from the home, and providing exercises to improve balance.

Communicate. It's not enough to create a plan; communication is essential for optimal execution. All care team members, including patients and their families, need to be aware of the patient's fall risk and the falls reduction plan.

Communication also includes education. The STEADI initiative has falls prevention brochures for patients and family caregivers at www.cdc.gov/steadi/patient.html. Families often are underutilized as a resource for helping to prevent falls. They may know the best way to approach patients who are reluctant to follow falls-reduction recommendations and can take the lead to reduce home-related risks. The falls risk reduction plan, communication with others, and education provided should all be documented in the patient's health record.

If a fall occurs

Despite nurses' best efforts, a patient may fall. An expert witness will scrutinize how the nurse responded to the event. The following steps will help to reduce the risk of a lawsuit or the chances that a lawsuit is successful:

Assess the patient. Examine the patient for any obvious physical or mental injuries. For example, check vital signs; look for bleeding, scrapes, or signs of broken bones; ask the patient about pain; and check mental status. Do not move the patient if a spinal injury is suspected until a full evaluation can be made. Be particularly alert for possible bleeding if the patient is taking anticoagulants. When appropriate, ask patients why they think they fell and continue monitoring at regular intervals.

Communicate assessment results. Notify the patient's provider of the fall and results of the assessment. The provider may order X-rays for further evaluation. Remember to mention if the patient is taking anticoagulants, particularly in the case of a potential head injury, so the appropriate scans can be ordered.

Revise the plan. As soon as possible after the fall, work with the team to reassess risk factors, revisit the falls reduction plan, and revise the plan as needed. For example, footwear may need to be changed, the amount of sedatives the patient is receiving may need to be reduced, or more lighting may need to be added to a hallway. It's important that actions are taken to prevent future falls.

Document. Each step should be documented in the patient's health record, especially all assessment results and provider notifications. The expert witness can then see that the nurse followed a logical progression, with thorough evaluation and follow-up. Never alter a patient's health record entry for any reason, or add anything to a record that could be seen as self-serving, after a fall or other patient incident. If the entry is necessary for the patient's care, be sure to accurately label the late entry according to your employer's policies and procedures.

Reducing risk

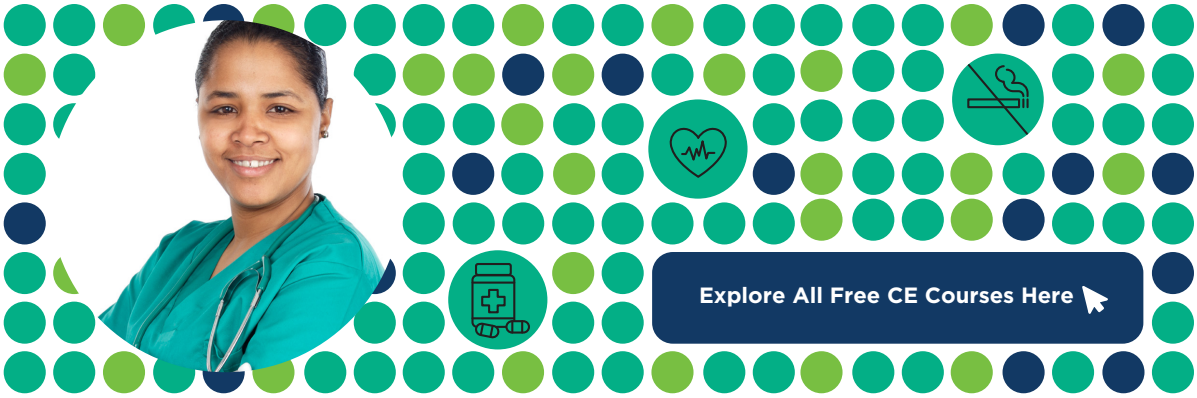
Unfortunately, patient falls are not completely avoidable. However, developing a well-conceived prevention plan can help reduce the risk, and taking appropriate actions after a

fall can help mitigate further injury. Both prevention and post-fall follow up not only benefits patients, but also reduces the risk that the nurse will be on the losing side of a lawsuit.

Article by: Georgia Reiner, MS, CPHRM, Senior Risk Specialist, Nurses Service Organization (NSO)

RESOURCES

Bono MJ, Wermuth HR, Hipskind JE. Medical malpractice. StatPearls. 2020. www.ncbi.nlm.nih.gov/books/NBK470573.
Centers for Disease Control and Prevention. Important facts about falls. www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html.
Centers for Disease Control and Prevention. STEADI: Materials for healthcare providers. 2020. www.cdc.gov/steadi/materials.html.
CNA, NSO. Nurse Professional Liability Exposure Claim Report: 4th Edition. 2020. www.nso.com/nurseclaimreport.
Dykes PC, Adelman J, Adkison L, et al. Preventing falls in hospitalized patients. Am Nurs Today. 2018;13(9):8-13. https://www.myamericannurse.com/preventing-falls-hospitalized-patients.
Iyer P. Legal aspects of documentation. In: KG Ferrell, ed. Nurse's Legal Handbook. 6th ed. Wolters Kluwer; 2015.
Van Voast Moncada L, Mire GL. Preventing falls in older persons. Am Fam Physician. 2017;96(4):240-247. https://www.aafp.org/afp/2017/0815/p240.html.



Discover CE Courses That Just Click

RELEVANT
Commercial tobacco topics and trends

QUICK
Free and easy online courses

ENGAGING
Interactive and pausable modules

Expand your knowledge about topics such as how commercial tobacco use causes and worsens certain diseases and how quitting can help reduce risks and improve outcomes. These quick, free and easy board-accredited CE courses offer timely information and best practices to help your patients stop using commercial tobacco products.

Created by the Minnesota Department of Health and designed to fit the schedules of busy RNs like you, these courses cover a wide range of tobacco-related topics, including:

- Connect the harms of commercial tobacco use to chronic health conditions
- How cessation can reduce risks
- Benefits of cessation after diagnosis

Explore All Free CE Courses Here

DEPARTMENT OF HEALTH | quit partner™

Accreditation information found at CoursesThatClickMN.com