MNORN Member Meeting

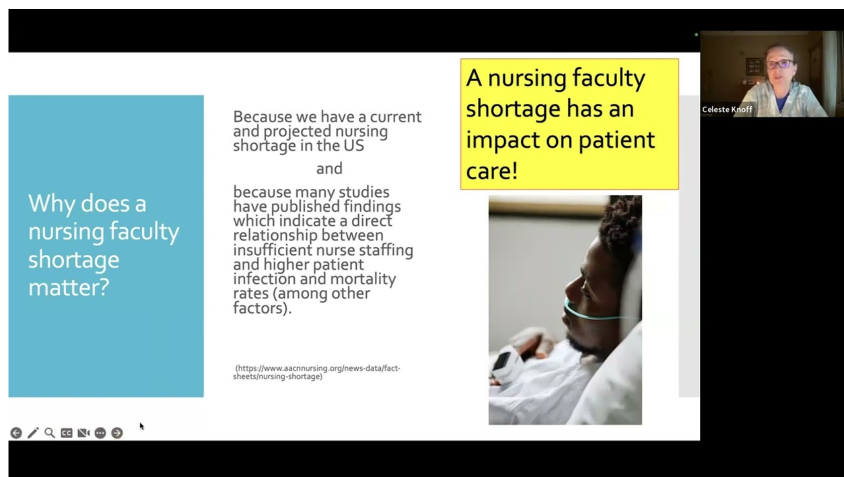
Due to the timing of this year's ANA Membership Assembly, we will not have a June MNORN Member Meeting. Watch for the date of the July meeting, when we will report on outcomes of Membership Assembly.

For those who weren't able to attend the May Member Meeting, "Nursing Education, Spanning Your Career," we hope you will take the time to watch the recording of the meeting and send feedback to kkoehn@mnorn.org

If you would like a certificate of attendance for watching the recording, just let us know. You will be sent a link to the evaluation of the meeting. Once that is completed, you will be sent your certificate.

We are eager to get as much input into this topic as possible. Thanks, in advance, for your comments.

Recording and Report of the May Member Meeting: Nursing Education, Spanning Your Career



Nursing Education, Spanning Your Career Slideshow

PRESENTERS:
- Nicule Abel
- Celeste Knoff
- Sarah Stevens

Background: When MNORN members are surveyed about issues they would like ANA to be discussing at Membership Assembly, year after year issues around nursing education come to the top. The issues range from pre-licensure, faculty, and beyond - demonstrating our professional beliefs that nursing requires continuous learning.

During the May Member Meeting, we explored issues and strategies, using methodology used by ANA during the Dialogue Forums at Membership Assembly. We had three fast-paced discussions. Celeste led the discussion on Faculty; Nikule on Student/Entry into Practice; and Sarah on Professional Development.

The goal of this meeting was to help develop a proposal for MNORN to submit to ANA a dialogue forum topic on education for the 2025 Membership Assembly.

Learning Objectives

- Describe the status of nursing faculty in the US and its implications to nursing & healthcare.
- Identify strategies and systems to affect change in the nursing faculty status.
- Discuss and inform the audience on the issues new graduate nurses are facing with entry to practice.
- Discuss and inform the audience on the issues nurses experience regarding continuing professional development.

Evaluations included:

What factors influenced your decision to attend?

- Convenience, timing. Most of all, the topic - so current and important to all nurses
- The topic is so important right now, so this presentation will encourage us all to deal with nurse faculty issues
- I am a long time nursing faculty member and have been "living" the issues/barriers facing nursing education over many years
- Contact hours, topic, presenters
- Topic
- Loved the last one I attended
- I was available. A virtual option to attend was available
- Topic and community!

- I enjoy attending each MNORN monthly meeting. Among my passions is education, so I particularly enjoyed this topic. Thank you for an informative and thoughtful presentation and discussion!

Other comments:

- Do hope MNORN will be able to make this formal proposal to ANA
- Reported paper data was excellent
- Excellent presenters
- A much needed discussion!
- Thanks!
- So much great information! We could have used more time for dialogue on each of thee three focus areas. I hope that additional conversation will occur on this important topic.
- Great presentation and discussion
- Loved info

2024 ANA Membership Assembly

The ANA Membership Assembly is the governing and official voting body of the American Nurses Association (ANA). It identifies and discusses issues of concern to members and provides direction to the ANA Board of Directors.

One of the key responsibilities of the ANA Membership Assembly is to determine policy and positions for the Association. The meeting of the ANA Membership Assembly provides a forum for discussion of critical nursing practice and policy issues and input from a broad cross section of nursing leaders.

MNORN's representatives to Membership Assembly this year are:

- Heidi Orstad
- Cami Peterson-DeVries
- Sunita Eres

Alternates, who will also be attending:

- Berg Ellenberger
- Mary Tanner

- Christy Waltz

Other MNORN members attending:

- Nikule Abel (ANA Board member)
- Sara McCumber
- Stephanie Witwer (President, American Academy of Ambulatory Care Nursing)
- Jennifer Tucker (ANA Nominations and Elections Committee)
- Kathi Koehn

Among the activities during Membership Assembly include Hill Day, when members will meet with our Minnesota members of Congress; Election of new officers for ANA; and discussion of relevant topics through the process of Dialogue Forums - which provide a platform for state associations to inform and guide ANA in their work on nursing policies and practice issues.

Dialogue Forums Topics for 2024

Dialogue Forum #1 - Breaking Barriers to Nurse Workforce Well-Being: A Call for Licensure and Employment Policy Reform to Combat Stigma

Description: Nurses have struggled with mental and emotional well-being due to the inherent obligations and stressors of their profession. Nurses encounter higher rates of mental health issues, substance abuse, and even suicide compared to the general population (Choflet et al., 2023). Tragically, the stigma surrounding seeking support perpetuates a culture of silence, where nurses suffer in solitude, fearing repercussions such as losing their license or enduring professional setbacks (Murthy, 2022). Because these realities have not been adequately addressed, they have resulted in a nursing workforce mental health crisis, which has been compounded by the COVID-19 pandemic. A fundamental shift in culture and a united organizational response are imperative to dismantle the systemic barriers obstructing personal and professional well-being.

Dialogue Forum #2: Improving Care for the Veterans Population

Description: The conflicts in Iraq and Afghanistan have resulted in a significant increase in the veteran population, creating unique healthcare challenges and needs. The Veterans Health Administration (VHA) has faced strain in providing timely care, prompting Congress to pass the MISSION Act in 2018, allowing veterans to access healthcare services outside the

VHA through the VA Community Care (VACC) program. While well- intentioned, the expansion of care into the community overlooks the specific healthcare needs of veterans, particularly in the context of the unique challenges arising from military service. ANA has historically supported increased access to care for veterans and, in response to the MISSION Act expansion, should reinvest efforts to ensure that United States veterans receive appropriate healthcare services. Veterans, with their distinct determinants of health and increased rates of mental health disorders and exposure-related illnesses, require healthcare providers, including Registered Nurses, to undergo specialized training and education for the detection and treatment of these challenges to improve healthcare outcomes. This policy proposal outlines recommendations for action to ensure that all healthcare providers are adequately prepared to provide the highest level of care to this specific patient population.

Dialogue Forum #3: Enhancing Ethical Practice Through the Voice of Nursing: 2025 Code of Ethics Revision

Description: The ANA's commitment to maintaining a Code of Ethics for Nurses is enshrined in its Certificate of Incorporation, which mandates the establishment and upkeep of ethical standards within the nursing profession. The Code of Ethics for Nurses with Interpretive Statements (the Code or Code) is subject to periodic updates, with revisions occurring approximately every ten years in accordance with ANA policy. The purpose of revising the Code is to uphold the longstanding tradition of nursing ethics rooted in relational values while addressing contemporary challenges. This Dialogue Forum provides an opportunity to learn about the evolution of the Code, the approach used to revise the document, and provide feedback on the proposed changes for the 2025 version.

AJN Off the Charts
blog of the American Journal of Nursing

At Red Cross National Headquarters, a Vision of Past and Present Priorities

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By Susan B. Hassmiller, PhD, RN, FAAN, principal, SuLu Coaching & Consulting

“Because of the climate crisis, the Red Cross launches nearly twice as many relief operations for major disasters than it did a decade ago.”

Today a group of us tracing the career and legacy of Clara Barton arrived at the ornate national Red Cross headquarters in Washington, D.C., a building I have been at countless times over my last 48 years of volunteering. Every time I enter, it reminds me of the people who have worked so hard to help millions of people have better lives—whether through disaster or war recovery, aid for military families, or donating the gift of blood.

Built as a memorial to the women of the Civil War with U.S. and private funds, the headquarters features exquisite architecture. The building's showpiece—the Tiffany stained glass windows—are designed to "symbolize reconciliation following the Civil War and are reputed to be the largest suite of Tiffany windows created for a secular environment."

A BRIEF HISTORY

We learned how the Red Cross initially focused on domestic and overseas disaster relief efforts, assisted the U.S. military during the Spanish-American War, and conducted peacetime relief work as part of the global Red Cross network. It introduced first aid, water safety, and public health nursing programs before World War I. During the two world wars, the Red Cross staffed hospitals and ambulance companies and recruited nurses to serve in the military.

Today, as a member of the International Red Cross and Red Crescent Societies, the American Red Cross provides lifesaving aid—under the principles of neutrality and impartiality—to millions displaced worldwide. It is active in Ukraine, Israel, and Gaza and nearly 200 countries.

I will never forget visiting the Polish Red Cross last year and seeing the thousands of paper registration cards kept by the Germans at their death camps. The Red Cross gained access to the cards to help family members find each other after the end of World War II. The Red Cross continues to reunify families separated through international crises and domestic disasters through the Family Links program.

We also heard how the Red Cross started a national blood program for the armed forces during World War II and added a civilian blood program after the war. The blood program supplies 40 percent of the blood and blood products in the country.

Photo courtesy of the author. Tiffany stained glass windows designed to "symbolize reconciliation following the Civil War."

THE CLIMATE CRISIS AS AN ORGANIZATIONAL PRIORITY

The work of the Red Cross has taken on increased importance because of the climate crisis, which disproportionately affects vulnerable communities. In the last 10 years, the number of billion-dollar U.S. disasters has increased by 85%. From 2016 to 2022, 122 separate billion-dollar disasters in the U.S. have killed at least 5,000 people and caused more than $1 trillion in damage.

Because of the climate crisis, the Red Cross launches nearly twice as many relief operations for major disasters as it did a decade ago, and it responds on a near-constant basis to disasters ranging from family fires to large-scale hurricanes.

A Climate Adaptation Program

During our visit, we also learned how the Red Cross has started a climate adaptation program that will be a role model for the future as a means of addressing equity in its services. Most people affected are among the most vulnerable in our country. The Red Cross partners with dozens of community organizations in the areas of health, hunger and housing to better prepare for the disasters.

Worldwide, the effects of the climate crisis include hotter temperatures; more severe storms; increased drought; a warming, rising ocean; loss of species; insufficient food; more health risks; poverty; and displacement. To help address this crisis globally, the International Red Cross is supporting a Climate Centre, which is hosted by the Netherlands Red Cross. The goal is to reduce the effect of climate change on vulnerable people by activating the best global scientific insights at the local level. The Climate Centre offers tools and guidance to Red Cross volunteers and managers specializing in disaster risk management and health.

GETTING INVOLVED

Today, Red Cross volunteers assist in five key program areas:

- 1) People affected by U.S. disasters
- 2) Support for military members and their families
- 3) Blood collection, processing, and distribution
- 4) Health and safety education and training
- 5) International relief and development

Although I have had the great privilege to serve in many capacities, having served during a number of disasters as a nurse has been the most gratifying work I have done.

The Red Cross always needs volunteers, and serving during disasters is a phenomenal way to give back to others. The organization provides training for nurses and for others interested in

volunteer aid work. With Clara Barton as our exemplar, I hope some of you will serve in this amazing organization.

retrieved 6/5/2024 https://ajnoffthecharts.com/at-red-cross-national-headquarters-a-vision-of-past-and-present-priorities/

Broken trust: Build a bridge to heal the healthcare workforce

May 3, 2024

Download PDF

By: Cynda Hylton Rushton, PhD, RN, FAAN, and Michelle Reina, PhD

Takeaways:

- The crisis of trust that existed between frontline nurses and leadership before the pandemic continues to worsen with evidence of physical, emotional, and moral suffering.

- Trust is innately abstract, but the Reina Three Dimensions of Trust—Trust of Character, Communication, and Capability —can serve as a behavioral-based blueprint that makes trust tangible, practical, and actionable.

The crisis of trust that existed in healthcare before the COVID-19 pandemic has become inescapable. Throughout the pandemic and before, we've experienced myriad examples of the costs of working in circumstances that call clinicians to go beyond what's physically, emotionally, spiritually, and morally justified or healthy. The evidence of physical depletion, burnout, moral suffering, compassion fatigue, degraded mental health, and suicide among clinicians is sobering.

We see examples of the deepening divide between leaders and frontline workers in narratives that reflect resentment, anger, despair, disengagement, grief, and quitting. Data documenting a pervasive erosion of trust and the resulting intensity of moral injury symptoms can't be ignored. The pattern of these dynamics invites us to ask why trust matters, how it's broken, and how can it be rebuilt.

Why trust matters

Trust is reciprocal and built step-by-step over time. Because it fuels a core human need to connect—to trust and be trusted—it stirs emotions in everyone. Trust is innately abstract, but people feel the power of its presence and the pain of its absence.

When trust is present, energy is expansive. By trusting one another, clinicians continue to do the seemingly impossible—with heart, soul, and commitment. When that foundation of trust becomes vulnerable, people gradually lose confidence in the quality of care provided, doubt decisions, and ask, "How long can I continue?" and "Is this the place for me?" At the threshold of pain and confusion that comes with the erosion of trust, we ask the deepest question, "Is this my reason for being?" "Why did I become a nurse or physician?" These questions coincide with the existential questions that accompany moral injury, a corrosive form of moral suffering.

Trust meets a core human need for connection. People need to be seen, heard, and understood for who they are, what they represent, and for what they bring to their work and their life's calling. As the source for human connection, trust requires awareness, constant attention, and sound intent. Because trust can be broken so easily, we should never take it for granted.

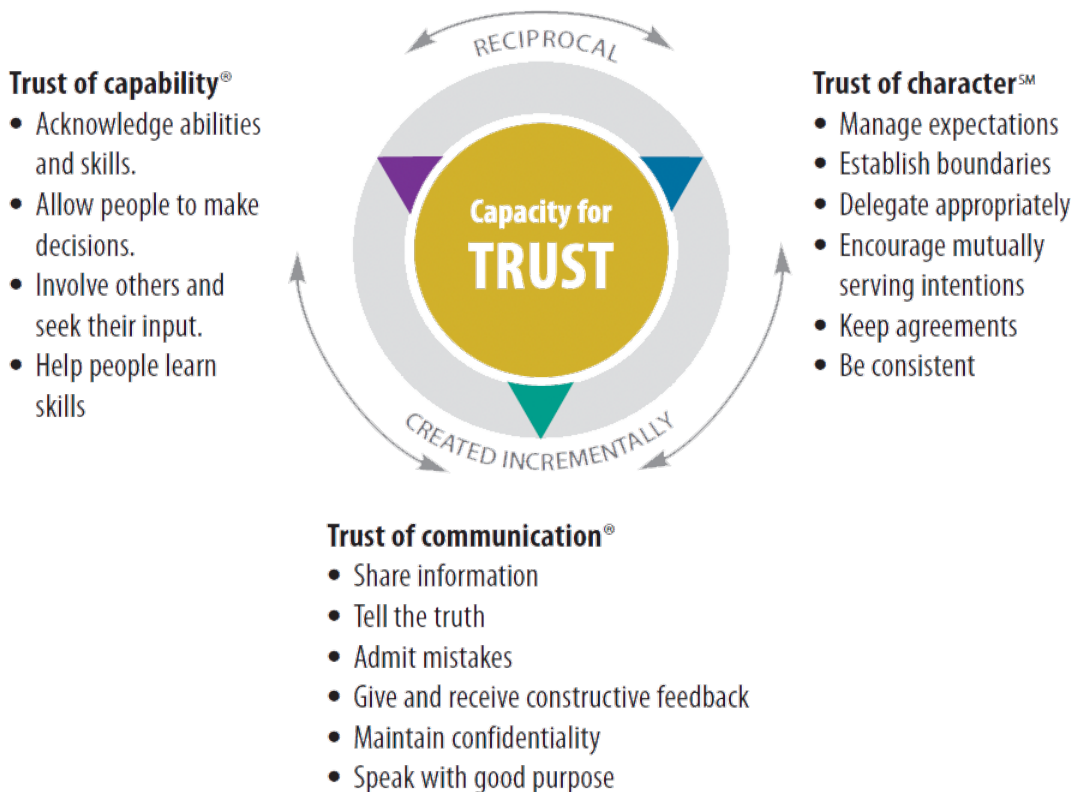
Understanding the vulnerability of trust requires us to first understand how trust is cultivated. We use the word "trust" easily and speak about it frequently. Some fall prey to the

assumption that our role, title, or expertise earns us the trust of others. In relationships, however, only one thing builds trust—how we show up and behave.

The research-based construct of the Reina Three Dimensions of Trust® (the 3Cs)—Trust of Character, Communication, and Capability—provides a behavioral-based blueprint that makes trust tangible, practical, and actionable. All three are grounded in one's capacity for trust. The model has been applied in over 300 organizations, including financial services, technology, entertainment, transportation, federal government, and in healthcare. Normative data from psychometrically developed assessments that measure trust at the leadership, team, and organizational levels have demonstrated that focusing on targeted behaviors in these three areas is instrumental in building trust and rebuilding it when it's broken. (See *The 3Cs*.)

The 3Cs

The Reina Three Dimensions of Trust[SM] serve as a framework for enhancing organizational trust.



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Trust of character

Trust of character sets a tone and direction; it honors the needs of people to be and do their best. Consistently practicing the behaviors that build trust of character, enables people to know what's expected of them and what they can expect in return. They understand their roles and responsibilities, keep or renegotiate agreements, and support delegation with required resources. Consistently practicing the behaviors that foster trust of character provides stability, alignment, and care for the human experience during times of change and uncertainty. Without this consistent practice, doubt, confusion, and struggle take over.

Trust of communication

Trust of communication establishes transparency and safety for people to surface issues and concerns with the confidence that they'll be heard by those who can make a difference. In this atmosphere, people openly express their vulnerabilities and admit their mistakes with a curiosity for the lessons they can learn. Everyone has the information they need to carry out their responsibilities. Development and growth are nurtured through constructive feedback with positive intent rather than as a weapon that ignites fear and shame.

Trust of capability

Trust of capability allows people to leverage their own and one another's skills, knowledge, experience, and abilities. People involve each other and seek their input, particularly for decisions that affect their jobs and their lives. They take responsibility and support one another to help them learn skills needed to do their jobs and foster their adaptability of skills during extenuating circumstances of uncertainty.

Application of the 3Cs outside of healthcare has demonstrated that the power of human connection made possible through trust drives business performance and manages change. When practiced together, the interrelated 3Cs support the reciprocity of trust that carries the continuity of human connection through change and uncertainty.

Validated tools to measure these dimensions of trust in the context of individuals, teams, organizations, and leadership offer concrete directions for amplifying existing trust-building behaviors and focus attention on those that break trust. Leaders (n=1,248) who engaged in the Reina Leadership Trust Scale® 360-degree assessment identified where they struggle to practice trust-building behaviors. Feedback from 3,974 of their direct reports identified behaviors they experience their leaders struggling to demonstrate. Responses revealed several areas of congruence between leaders and their direct reports. (See *Leader vs. direct report appraisals*.)

Leader vs. direct report appraisals

When leaders (n=1,248) and direct reports (n=3,974) participated in the Reina Leadership Trust Scale® 360-degree assessment, several
areas of congruence came to light. Bold text reflects behavioral areas of struggle experienced by both leaders and their direct reports in descending order.

Trust-building behaviors that leaders report struggling to practice

- Receiving constructive feedback without getting defensive
- Giving constructive feedback to employees in ways that are timely and helpful
- Setting expectations that are appropriate and perceived as neither too high nor too low
- Providing coaching and feedback on performance when needed
- Giving people the benefit of the doubt
- Giving employees the training necessary to do their jobs
- Challenging employees in ways that motivate them to learn and grow

Trust-building behaviors that direct reports observe leaders struggling to practice

- Giving the benefit of the doubt
- Providing coaching and feedback on performance when needed
- Helping employees learn new skills
- Challenging employees in ways that motivate them to learn and grow
- Taking an active role in employees' advancement
- Giving employees the training necessary to do their jobs
- Giving constructive feedback to employees in ways that are timely and helpful

Trust serves as the bridge between the business need for performance and the human need for connection. It creates the conditions for mutually serving intentions, ensuring transparent communication, and leveraging the knowledge and skills of the workforce. Although the 3Cs have been applied to healthcare in limited ways, data indicate that we can measure how trust is built and broken in critical care settings. Researchers have used the model to diagnose where trust was being built and broken in a pediatric intensive care unit; consistent with normative data using the scale, communication trust in that unit was consistently the most vulnerable. The model also has been applied to patients and their

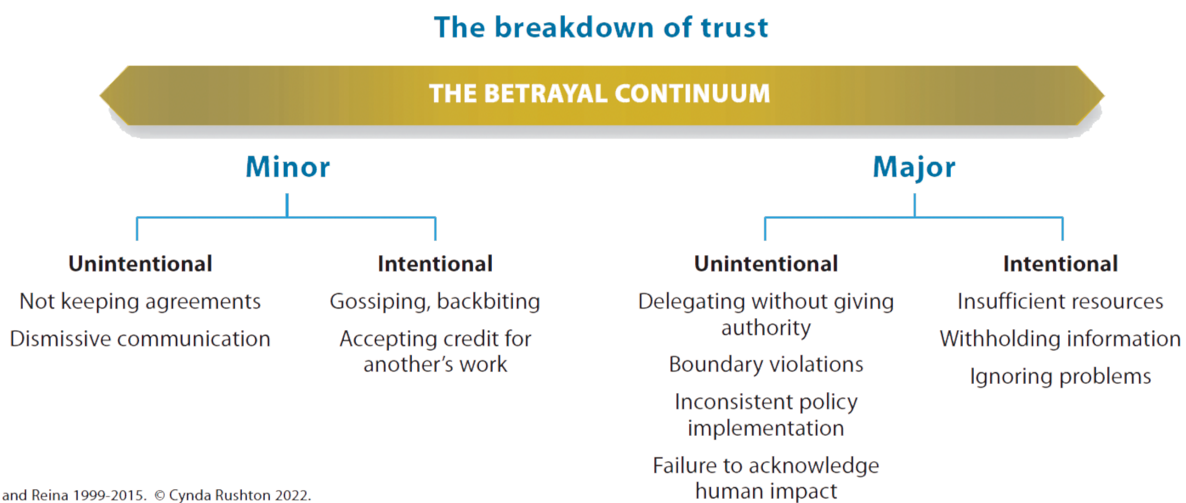
families, to clinical teams, and as an organizing framework for data analysis and balancing patient experience with staff safety.

How trust breaks

As human beings, we're imperfect, which makes trust inherently vulnerable. Inconsistently practicing the 3Cs erodes trust. Left unaddressed, people may feel betrayed. Betrayal, a breach of trust or the perception of a breach, occurs along a continuum from minor unintentional acts to major intentional acts. Major breaches cause trust to break down. However, according to Reina and Reina, in relationships, 90% of the events that erode trust are minor breaches that accumulate and become major. When seemingly innocent acts occur repeatedly, they erode trust by a thousand tiny cuts. Their accumulation takes the form of betrayal, which results in anger, resentment, and disengagement. (See *Betrayal continuum*.)

Betrayal continuum

Trust can break down over time as minor breaches accumulate. Rather than serve as a diagnostic tool, the betrayal continuum provides a reference point for understanding how betrayal emerges through patterns of minor and major breaches of trust.



The following story provides an example of broken trust during the pandemic and demonstrates how behaviors associated with the 3Cs can breech trust.

One nurse's experience

"I'm not sure what it means to be a nurse anymore," muses Reese, who's been working in critical care for the past 4 years—with only a year of experience at the beginning of the COVID-19 pandemic. Today, the second in a 3-day, 12-hour shift assignment, despite not feeling well, Reese decided to come in anyway because of short staffing. Accompanying Reese are two physicians who've been working long hours because of a surge of patients in the emergency department (ED), add-on surgery cases, and staff illnesses. The number of patients with COVID has eased slightly, but only after months of daily efforts to care for those who needed critical care. Now everyone is exhausted—some people are angry, others are going through the motions, and others are quitting.

At a town hall meeting, the hospital president expresses relief, saying, "We're now in the recovery phase of the pandemic." Mikaela, an ED physician, responds, "We may think we're in the recovery phase, but it didn't come without a significant toll on all of us, and we haven't recovered." The president declares, "This is just what we do! We always rise to every occasion and make things work!"

This doesn't ring true to Reese. She thinks, "How could we be in the recovery phase without enough support staff to draw blood, deliver supplies, or transport patients?" Recent talk of the financial impact of the pandemic on the hospital, despite federal relief, leads Reese to wonder, "No one is talking about the impact on the workforce of 'doing whatever it takes.'" In addition, Reese recently heard about a possible reorganization, which will mean budget cuts and continuing to do more with less. "No one has asked us about what WE think ought to be cut," thinks Reese. "Instead, we're informed of the decisions of others." A recently released video illustrating all the great people in the organization and describing them as heroes struck a chord with Reese, causing her to ask, "How can we be heroes and be asked to work under these circumstances?"

Reese recognizes symptoms of post-traumatic stress disorder and knows she needs help. Reese raises the issue with her nurse manager, who says, "We can't afford to have anyone else out on sick leave!" She refers Reese to the employee assistance program and offers an extra day off. After trying to get an appointment with a mental health professional for 2 weeks, Reese tells the nurse manager that she needs to take a leave of absence or she'll have to quit. Reluctantly, the manager grants the leave. Reese tries again to access mental health services through the hospital but has no luck. Only after a mental health colleague intervenes can Reese get an appointment.

Healthcare professionals at all levels of responsibility can see themselves in this story. Perhaps you can relate to the executive who's attempting to reassure the staff that the worst is

behind them. Or you're a nurse or physician unable to share the positive attitude of the executive as the strain of doing more with less threatens care quality. Or maybe you see yourself as Reese, who's so depleted and morally injured that she doubts her capacity to function in the emerging status quo.

Regardless of your role, healthcare workers share common ground—the call to serve a higher purpose; to care for the sick, disabled, or dying; to provide care while avoiding harm; and to deliver fair and equitable care. Our professional oaths ground our commitment to respond to the needs of humanity, frequently at great personal sacrifice. This ethos has been lauded as a hallmark of heroes, but as the pandemic has highlighted, it has limitations and vulnerabilities. Leaders betray trust when they take for granted that clinicians will always step up (no matter what) and when systems depend on continuing heroic effort. In addition, clinicians' deeply held values and commitments can be corrupted to the point where they intentionally or unintentionally undermine behaviors associated with the 3Cs in relation to their leaders, colleagues, and even their patients.

During the pandemic, the lack of uniform standards of care, the uncertain accuracy of information, and the scarcity of resources necessitated undesirable ethical trade-offs and produced a pattern of inconsistency that resulted in unrelenting stress and fear. Clinicians faced unrealistic expectations when tasked with meeting the volume and acuity of their patients but without the usual resources or guidelines and without the opportunity for negotiation. Leaders also faced strain as they bore the responsibility of maintaining the strategic and operational health of their organization.

The vulnerability of trust

Reese's story reveals the vulnerability of trust. When people feel invisible or unheard, Trust of Communication breaks down. This undermines the human need of those who deliver care to be seen and understood, particularly during this steady state of struggle. In a well-functioning healthcare system, a reciprocal Trust of Character unifies clinicians, their leaders, their organizations, and the public they serve. Amidst the pandemic, when connection and shared purpose were most essential, they eroded.

Reese and her colleagues experienced repeated violations of trust. In the absence of mutually serving intentions, the unrelenting expectation of self-sacrifice degraded clinicians' mental, emotional, spiritual, and moral health and well-being, which was made increasingly untenable as it became the norm. Eventually, the toll of doing "whatever it takes" unravels clinicians' Trust of Capability in themselves and their colleagues. When accumulating moral residue goes unrelieved, moral suffering ensues, trust contracts, and patient care and relationships suffer.

The promise of resources, including mental health services, set an expectation of support that wasn't delivered. Reese had been told each year during open enrollment that she could access a broad array of resources. When she needed them, they evaporated. This, coupled with a guilt-inducing and unsupportive response by her leader, deepened the breach of Trust of Character and Communication that Reese experienced.

Mikaela lost Trust of Communication when she highlighted the costs of providing care with limited resources and was met with an overly optimistic or dismissive response. Messages of brighter times ahead are experienced as hollow and offensive, rather than supportive and encouraging. Superficial messages, such as "The worst is over" or "We're in the recovery phase," overlook the lingering impact of years of doing more with less and contribute to another breach of trust.

The erosion of trust that arises from failing to acknowledge the depth of challenge clinicians faced and continue to confront impacts both the quality of patient care and the quality of clinicians' lives. Leaders may believe that they're motivating clinicians by directing them to connect to their purpose, but such statements have the unintended consequences of discounting their sacrifices and exploiting the sanctity of their commitment to their patients. Other leaders may be aware of this effect but still resort to the methods of justification that have worked in the past to achieve their goals without recognizing the cost.

Reese lamented that major organizational decisions were being made without the input of the people expected to implement them. Operational decisions during the pandemic needed to be made quickly and without sufficient or reliable information. Perhaps as an unavoidable consequence, clinicians were left out of decisions that impacted work life and quality of care, were assigned tasks without the authority necessary to fulfill them, and were deployed to unfamiliar wards and duties without sufficient training. Taken together, these conditions inevitably eroded all three spheres of trust.

In a steady state of betrayal, questioning and doubt take over. Feeling their best interests are no longer considered, clinicians begin to question the higher calling that brought them into their profession. Without enough support staff to draw blood, deliver supplies, or transport patients, the costs accumulate, and the concurrent narratives of clinicians and leaders "doing whatever it takes" diverge.

Forced to reconcile actions they appraise as disrespectful, unjust, or harmful, clinicians lose touch with the values they profess and the identity they rely on. They begin to believe that the economic force of numbers that demonstrate profit has corrupted their service. In some instances, moral residue, distress, and injury ensue. Feeling irrelevant, unappreciated, stripped down to their core, and perceiving they have no power, control, or choice, clinicians may choose to leave their role, their job, or their profession. Others may stay, go

through the motions, assume a state of detached resignation, or join the ranks of the working wounded.

How to rebuild trust

The breakdowns of trust illustrated in Reese's story require intentional actions and behaviors to rebuild it. The Seven Steps for Rebuilding Trust®, a foundational framework used in other sectors, helps leaders and others demonstrate courage and take concrete, constructive, and compassionate action. In the healthcare setting, the process can help heal the betrayals experienced during the pandemic. (See Rebuild trust: Step by step.)

1. Observe and acknowledge what's happened

Healing a breach of trust begins by facing the reality of the violation. In Reese's case, the pandemic assailed clinicians' trust in their leaders, their organization, their colleagues, and themselves. To address those betrayals, leaders must expressly recognize the tremendous toll on the workforce. System leaders must acknowledge the broken promise of resources and mental health support they failed to provide. In addition, clinicians must face and name the compromises to the care they provided to their patients and themselves.

2. Allow feelings to surface

People experience the impact of a breach of trust embedded in change as a loss—the loss of what was or what could have been. Loss and betrayal can engender a range of feelings, including anger, resentment, blame, shame, guilt, anxiety, or self-righteous indignation. Clinicians require a forum in which they can express these negative and discomforting emotions. Leaders must bear witness to these reactions without rationalization, excessive explanation, or justification.

3. Get and give support

Support helps us gain perspective and move through the pain of lost trust to trust again. Leaders must create psychologically safe and confidential environments for clinicians to express the emotions that accompany betrayal without fixing or consoling. Focus groups, team meetings, and one-on-one conversations create safe forums to ensure that employees' emotions don't go underground. The use of a skilled facilitator may help. Leaders are human beings, too. They know that the decisions they make come with consequences. To support themselves, leaders may want to access a trusted advisor or executive coach to promote their own healing and prepare them to hold the discomforting revelations of their staff.

4. Reframe the experience

Sharing and listening with compassion allow clinicians and leaders the opportunity to take on new perspectives. Clinicians can learn about the larger context of extenuating circumstances and business reasons behind a set of decisions. Leaders can appreciate the intended or unintended consequences of their decisions on the workforce. When supported, people can reframe betrayal as a gift or a teacher. Reframing hardship together defines the challenge and builds a foundation for co-creating the steps to address it together.

5. Take responsibility

Healing to rebuild trust asks that each person own up to their role. Integrity requires that everyone acknowledge how they respond and co-create the path forward. Even when you're responsible for what happened, practicing the 3Cs can help you take responsibility for your own path forward and empower others to do so as well. Everyone may need to check their assumptions, suspend judgment, and ask questions for perspective and understanding. Taking responsibility may include an authentic apology, identifying lessons learned, taking actions to improve the current situation, and establishing safeguards to avoid similar situations in the future.

6. Forgive yourself and others

Forgiveness is the inner work of healing. Forgiving doesn't mean excusing; it means acknowledging the impact of broken trust and agreeing not only to move through it but also to learn from it. Forgiveness takes time and can't be forced. It's essential to restoring integrity and healing after a betrayal. Each person's capacity to forgive themselves and others reflects their history of trust built and broken. Through forgiveness, people can release bitterness, resentment, and doubt. Rather than remaining stuck in the past or current struggle, they look ahead.

7. Help people let go and move on

As humans, we tend to hold onto resentments, hurts, and betrayals. Our nervous system continues to detect threats, which makes it more difficult to release negative emotions and move forward. Accepting what's happened doesn't mean that we agree with or overlook its significance. Clinicians won't forget what happened, but they can choose to look forward rather than remain stuck in the past. Letting go and moving on cements the insights, lessons, and perspective gained through healing.

Restore humanity and trust

Trust sits at the center of the human dynamic within healthcare, which makes it innately vulnerable. Change, uncertainty, and ambiguity further punctuate that vulnerability. However, these challenging dynamics don't have to erode trust permanently. The Three Dimensions of Trust raise awareness of human behavior and provide a common language and shared understanding to help people at all levels of responsibility openly and constructively talk about trust-related dynamics. With the benefit of insight and a behavioral construct that can take action to build trust, the 3Cs offer a promising framework for identifying areas where robust trust behaviors exist and also where trust is broken. Commitment to practicing the Three Dimensions of Trust with sound intent as well as stepping into and working through the Seven Steps to Rebuild Trust honor the human need to heal and renew the spirit of relationships. These steps also support organizational leadership as it sets a course for trust sustained over time. Together, clinicians and leaders have an opportunity to transform the betrayals exacerbated by the pandemic and co-create practice environments where humanity and trust are restored.

Cynda Hylton Rushton is the Anne and George L. Bunting Professor of Clinical Ethics and Nursing at Johns Hopkins University in Baltimore, Maryland. Michelle Reina is the CEO and co-founder of Reina Trust Building, a global consultancy based in in Stowe, Vermont.

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Key words: trust, broken trust, COVID-19, pandemic, frontline nurses, moral injury, compassion fatigue

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RISK EDUCATION

Protect yourself from secret recording

Article by: Georgia Reiner, MS, CPHRM, Risk Analyst, NSO

A nurse accidentally discovers a recording of himself giving patient care posted on the Facebook page of a patient's family member. Another nurse receives a notice that a State Board of Nursing complaint has been filed against her for disparaging comments she made about a patient without knowing that the patient was recording her on his cellphone.

As smart phones and social media have become ubiquitous, the number of recordings posted online have grown exponentially. Most nurses now know the dangers of posting patient-related content online, but what happens when the reverse occurs and a patient or patient family member posts videos, photos, or content about the nurse? What rights does the nurse have? And what happens when a voice-control device captures a nurse's inappropriate comment? Is the nurse at risk?

These are not hypothetical questions. A 2018 survey of 52 nurses found that several had experienced unapproved postings related to their professional actions, leaving them feeling "violated" and "disrespected."

Understanding the issues surrounding secret recording can help you avoid possible damage to your career and emotional health.

UBIQUITOUS RECORDING

Recordings are occurring in a wide variety of settings. Patients and families may be recording care in hospitals, in long-term-care and assisted-living facilities, and in the home. In some cases, these recordings may be sanctioned by the state. For example, many states have laws that require skilled nursing facilities to allow residents to install monitoring equipment ("granny cams") to document care. Requirements associated with the law may include obtaining consent from the patient's roommate, posting a sign that recording is in progress, and making the resident responsible for camera equipment costs.

In the home, voice-control or "smart speaker" devices such as the Amazon Echo or Google Home may not just be reminding patients to take their medication; they may also be recording what people in the room are saying. Additionally, home security camera systems

such as Ring or Google Nest may be recording people as they arrive, leave, and move about the home.

Unfortunately, nurses may not know they are being recorded. A survey of the general public in the UK found that 15% had secretly recorded a clinic office visit. The most common reason was simply to improve understanding of medical information and to share with family members.

In the US, these types of recordings may violate wiretapping laws. The federal wiretapping laws (18 U.S. Code§ 2511) only require one party to agree to a recording, but many states have "all-party" requirements, which means all parties must consent to the recording. Typically, the more restrictive state law would take precedent over the federal law.

WHEN PRIVATE GOES PUBLIC

When evidence of healthcare professionals behaving inappropriately goes public, it can result in significant professional harm, including possible legal action, for those involved. In 2015, for example, a patient used his phone to record post-discharge instructions for a colonoscopy. He neglected to turn off the recording and was later shocked to hear disparaging comments made by the surgeon during the procedure, while the patient was under anesthesia. The patient subsequently won a $500,000 lawsuit.

Failing to speak up when inappropriate behavior occurs does not protect you from legal action. For example, the anesthesiologist in a video created by a surgeon who was dancing during surgery has been named in a lawsuit.

IN THE COURTS

The admissibility of recordings in court cases varies by jurisdiction, and legal parameters surrounding these issues are still being developed. It is also important to be aware that federal and state legal thresholds may differ, affecting court decisions.

Recordings may also impact the types and amount of damages awarded as a result of legal action because of the perception that what is said, or tone of voice used, in the audio or video clip reveals a lack of "feeling" by the defendant. This perception can also be an issue when it comes to settlements. For example, if minor patient harm occurred but the nurse is recorded making negative comments about the patient, there might be a push for a higher payment.

SELF-PROTECTION

Nurses can take steps to protect themselves from negative consequences of being recorded. (See Reducing recording risks.) Keep in mind that Provision 5 of the American Nurses Association Code of Ethics for Nurses with Interpretive Statements notes that "…the same duties we owe to others we owe to ourselves." You should expect patients and

families to respect your privacy in the same way you respect theirs. Setting boundaries related to recording is a reasonable step to take. This, combined with not making inappropriate comments or taking inappropriate action that could be detected by recording devices, will help you avoid litigation while providing quality care.

REDUCING RECORDING RISKS

Both organizations and individual nurses can take steps to help avoid legal action stemming from recordings made by patients and families.

Organizations

- Establish policies regarding use of cell phone, tablet, and other recording devices by patients and families.
- Educate staff and volunteers about photo and video rules and policies.
- Post notifications for patients and families to see that restrict use of cell phones and other devices capable of recording.
- Provide patients and families with written information about organizational policies related to recording.

Nurses

- Survey the room before delivering care. Note if there are any cell phones, tablets, or voice-activated devices present.
- Request that devices be removed or turned off. Let patients know that devices can be distracting to care delivery and refer to relevant organizational policies as needed.
- Do not pose for photos with patients or patient family members; these photos could end up on social media. If a family member is making a recording of patient care, ask them to stop, explaining that he or she is violating the patient's right for privacy under the Health Insurance Portability and Accountability Act.
- Report inappropriate social media posts about you. If you see such a post, take a screen shot or record the posting (for evidence in any potential court case) and report the posting to the social media outlet.
- If you become involved in a lawsuit related to a recording showing you engaged in inappropriate behavior, be honest with your insurer and attorney about the entire scope of the recording. For example, just because only part of a video was posted online doesn't mean that additional footage won't appear during a court case.
- Keep in mind that good communication helps reassure patients and families that quality care is being delivered, removing the motivation to record in order to ensure the patient is receiving excellent care.

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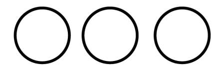

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