Exemplary Professional Practice

Ethics, Privacy, Security, and Confidentiality

EP23: Describe and demonstrate how nurses use available resources, such as the ANA Code of Ethics for Nurses (American Nurses Association, 2001b), to address complex ethical issues. Provide examples from different practice settings.

York Hospital nurses have a variety of resources available in assisting them as they address and navigate ethical issues with their patients, families and the healthcare delivery system. These resources are everything from a “real time” Bioethics consultation mechanism, to the Bioethics Committee, Palliative Consultation, Pastoral Care staff, Risk Management staff, Case Management/Social Worker staff, Bioethics and Nursing Grand Rounds, nursing education sessions, LMS resources, WSH, YH and nursing policies and guidelines, and most importantly, the ANA Code of Ethics with Interpretive statements, found on the INET.

The American Nurses Association Standards, the PA Nurse Practice Act, the Joint Commission Standards, Patient Bill of Rights, and the ANA Code of Ethics with Interpretative statements are the primary sources utilized in the establishment of our YH Professional Nursing Practice Model integrated with Relationship Based Care. The standards have served as an integral foundation for the development of the care delivery model through its inception. In addition, all of our nursing units utilize standards from nursing specialty organizations and other specialty accrediting bodies to assist in the referencing best practices for addressing complex ethical issues in the hospital setting.

Available Resources

Education Resources

The professional nursing staff at YH is educated about ethics and ethical decision making in a variety of venues and formats. Many of these educational offerings were facilitated through our SDM Professional Development Council via a needs assessment. These offerings include the following:

- Ethics specific grand rounds, educational sessions and LMS offerings include the following:
  - Palliative Care Boot Camp
    - Module 1 - Principles and Empowerment
    - Module 2 – Pain Assessment and Management
    - Module 3 – Common Physical Symptoms and Management
    - Module 4 – Goals of Care, Ethical Issues and Advance Directives
    - Module 5 – Cultural and Spiritual Considerations
    - Module 6 – Communication at the End of Life
    - Module 7 – Loss, Grief, and Bereavement
    - Module 8 – Care in the Final Hours
  - End of Life Decision Making in Intensive Care
  - In the Know: End of Life Care
  - Is Palliative Sedation Right for Your Patient?
  - Oncology Nurse Fellowship – Palliative Care
  - Palliative Care Core Liaison Training
  - Monthly Palliative Care Forum
- Peri-FACTS: Cesarean Deliveries on Maternal Request: Ethical Issues Case 846
- Update on Legal and Ethical Issues in Behavioral Health

**Bioethics Grand Rounds**
- 2009 - Judge Penny Blackwell - "Determining Patient Competence"
- 2010 - Timothy Quill, MD - "Discussing Treatment Preferences with Patients Who Want Everything"
- 2011 - Helen Stanton Chapple, PhD - "No Place for Dying: Hospitals and the Ideology of Rescue"
- 2012 - Leonard Fleck, PhD - "Just Caring: Health Care Rationing, Terminal Illness and the Medically least Well Off"

**Palliative Care Grand Rounds**
- 1/12/12 -- "Evidence Based Palliative Care in the ICU" - Dominic Glorioso, JR., D.O., FACOI, York Hospital Palliative Care Specialist/Lead Educator

**Palliative Care Forum Topics**
- 12/8/11 Advance Directives
- 10/13/11 – Consider the Conversation
- 9/8/11 – What Did You Read This Summer?
- 5/12/11 – A Palliative Care Approach to Reducing the Trajectory of Decline in the Elderly
- 4/14/11 – Palliative Care Pearls
- 3/10/11 – Ethical Issues with Nephrology Patients
- 2/10/11 – Introduction to New Drugs Being Used in Palliative Care

**New Nurse Employee Orientation (NNEO)**

The ANA Code of Ethics presentations are available for review and reference on our Nursing INET portal. Many additional educational presentations are available throughout the year. Self-Learning opportunities are introduced via several venues. The YH Intranet is easily accessible from all Wellspan computers and is an excellent resource for upcoming events and educational sessions; including newsletters, journal club offerings, SDM council meetings and events, policy and procedure access, EBP journal club, and library resources and references.

**ANA Code of Ethics for Nurses**

The nine tenets in the ANA Code of Ethics for Nurses encompasses and defines the obligations and commitments of nurses nationwide, not just those employed at YH. The Code of Ethics provides all nurses with standards on which ethical obligations are defined and expresses their responsibility/commitment to society as a whole. The Code of Ethics speaks to respect, dignity, advocacy, and oral reasoning. The Code also addresses professional domains of competency,
accountability, and professionalism. These nine tenets are demonstrated everyday in the clinical practice of YH nurses anywhere where nursing care is delivered.

YH Nurses demonstrate a great cognitive and practical understanding of the application of the ANA’s Code of Ethics for Nursing. Our nurses have been well positioned to appreciate patients and their families and the individualized needs that each brings to the hospital and/or clinical environment because of YH’s efforts in educating (Diversity Certification) and supporting clinical nursing staff in the application of ethical principles and practice. The nine tenets from the ANA Code of Ethics are demonstrated through our YH Nursing Philosophy statement, our YH Professional Nursing Practice Model vision and guiding principles, and our Relationship Based Care Delivery Model and guiding principles.

The YH Nursing philosophy statement, states the following:

“Professional nursing supports the mission of York Hospital and Wellspan Health through a Service Line model in an organized, systematic and integrated delivery system designed to ensure excellence in patient care and optimal patient outcomes. Each professional nurse accepts the accountability and responsibility for his/her professional practice, the utilization of the nursing process and ensuring his/her practice is based on nursing theory and research-based evidence. Nurses at York Hospital are lifelong learners who value continued professional development and education. They are committed to participating in decisions about the patients care, nursing practice and commit to uphold professional nursing standards at York Hospital, the State of Pennsylvania and the nursing profession”.

YH Nursing: Patient Care Delivery Model has the following vision:

“YH’s Patient Care Delivery Model is designed to treat the patient as a family member or friend. A highly trained, integrated care team including physicians, RN’s, LPN’s, nursing assistants, and unit secretaries are responsible for helping patients make decisions about their care, follow their care plan and support those health needs related to their body, mind and soul. A registered nurse leads the team and ensures the care is planned collaboratively with the physician, and is coordinated and evaluated for quality, efficiency and cost-effectiveness. Additionally, care is provided in a comfortable and friendly environment.”

The following chart demonstrates the adherence of the ANA Code of Ethics through our guiding principles of our YH Professional Practice Model and Relationship Based Care Delivery Model:

<table>
<thead>
<tr>
<th>Code of Ethics Statements</th>
<th>YH Professional Nursing Practice Model Guiding Principles</th>
<th>Care Delivery Model Guiding Principles (RBC)</th>
</tr>
</thead>
</table>
| 1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations | - Patient and family centered care  
- Shared Decision-Making for patients and staff | - Responsibility for Relationship and Decision-Making  
- Caring and Healing Practice Environment |
### Crosswalk of Code of Ethics, Professional Practice Model and Care Delivery

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| of social or economic status, personal attributes, or the nature of health problems      | ▪ Patient/family centered care  
▪ Patient and staff safety  
▪ Shared decision-making for staff, patients, and families                                                              | ▪ Responsibility for relationship and decision-making  
▪ Caring and Healing environment                                                                                           |
| 2. The Nurse’s primary commitment is to the patient, whether an individual, family, group, or community | ▪ Patient and family centered care  
▪ Patient and staff safety  
▪ Shared decision-making for staff, patients, and families                                                              | ▪ Responsibility for relationship and decision-making  
▪ Caring and Healing environment  
▪ Communication with the Health Care Team  
▪ Management of outcomes                                                                                                  |
| 3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient | ▪ Patient and family centered care  
▪ Patient and staff safety  
▪ Shared decision-making for staff, patients, and families                                                              | ▪ Responsibility for relationship and decision-making  
▪ Caring and Healing environment  
▪ Communication with the Health Care Team  
▪ Management of outcomes                                                                                                  |
| 4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care. | ▪ Professional Nursing Practice  
▪ Evidence Based Practice                                                                                                   | ▪ Work allocation and patient assignments  
▪ Leadership/Management                                                                                                       |
| 5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth. | ▪ Professional Nursing Practice  
▪ Evidence Based Practice  
▪ Interdisciplinary collaboration                                                                                           | ▪ Communication with the health care team  
▪ Leadership/Management  
▪ Caring and healing practice environment                                                                                   |
| 6. The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action. | ▪ Professional Nursing Practice  
▪ Interdisciplinary collaboration  
▪ Outcomes measurement                                                                                                     | ▪ Leadership/Management  
▪ Process Improvements  
▪ Communication with the health care team                                                                                   |
| 7. The nurse participates in the advancement of the profession through contributions to practice, education, | ▪ Professional Nursing Practice  
▪ Evidence Based Practice                                                                                                   | ▪ Leadership/Management  
▪ Process Improvements                                                                                                       |
Crosswalk of Code of Ethics, Professional Practice Model and Care Delivery

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| administration, and knowledge development | ▪ Interdisciplinary collaboration  
▪ Professional Nursing Practice | ▪ Communication with the health care team |
| 8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs | ▪ Professional Nursing Practice | ▪ Caring and healing practice environment |
| 9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy. | ▪ Professional Nursing Practice | ▪ Caring and healing practice environment |

Resources are made available to nurses if any questions or concerns arise regarding ethical issues in caring for their patients. There is an active Bioethics committee to support and review any questions concerning ethical practices and behaviors. Nurses have access to confidential reporting of any errors and/or safety issues they may identify when caring for their patients. Social Workers and Pastoral Care may be consulted, as needed as well for any ethical situations that may present themselves.

**Bioethics Committee**

Nurses are supported in applying ethical principles in their day to day nursing practice through participation in and/or consultation of the Bioethics Committee. Individuals may request such consultation, advice or guidance on bioethical issues by contacting the Bioethics Committee Chairman, Vice Chairman, the Vice President-Medical Affairs or his designee, or the Medical Affairs office. Consultation, advice or guidance is non-binding. Some of these consults have required full bioethics committee conferences, while others have been handled by phone consultation with Dr. Bruce Bushwick, chair of the Bioethics Committee.

RN’s have always had robust membership on the Bioethics committee. Their input is valued in their expertise and roles in patient care delivery.

The RN’s on Bioethics Committee for 2010-2011 were:
- Rhada Hartman, RN, Director of Palliative Care
- Diane Gerhart, BS, RN,CHPN  Education Coordinator
- Melissa Ilgen, RN, BSN,CHPN, Palliative Care Nurse
- Ellen Metzger, R.N., CHPN, Palliative Care Nurse
- Carole Wilkins, RN, BSN,CHPN, Palliative Care Nurse
Policy and Procedures as Resources

There are a plethora of policies in place for access by RNs and the healthcare team as they address ethical issues in patient care. The most pertinent of these policies are listed below:

1. **Bioethics Committee**
2. **Brain Death Criteria**
3. **Medically Ineffective Care**
4. **Advance Directives**
5. **Guidelines on Forgoing Life Sustaining treatment**
6. **Informed Consent**
7. **Patient Bill of Rights**
8. **Patient’s Right to Refuse Treatment or leave AMA**
9. **Organizational Ethics**
10. **Health Care Ethics Consultation Table**
11. **Making Ethical Choices in Cancer Care**

**Venues for Leadership by Nurses:**

Other venues that demonstrate how nurses are supported in applying ethical principles in nursing practice are the following:

- **Daily multidisciplinary rounds and/or physician rounds:** On many of our nursing units, the primary nurse and/or charge nurses conduct interdisciplinary rounds with other members of the health care team, including physicians and the primary medical service. Our physicians have started to partner with us to round more frequently with their patient’s primary nurse to increase patient satisfaction, especially in the domain of coordination of care.

- **Interdisciplinary family meetings to discuss patient’s plan of care:** Many times, throughout all nursing units, interdisciplinary meetings are facilitated and advocated by the patient’s primary nurse. The interdisciplinary team of providers presents the patient and family with comprehensive treatment plan, prognosis, discharge plan, and new medication regime to assist the patient and family with more accurate informed consent.
• Alleviation of pain and suffering: YH nursing staff has been provided many opportunities for nurse to nurse consultation and resources, particularly with end of life care and pain management. Clinical nursing staff collaborates on a daily basis with the patient’s doctors in charge of their care as well as requesting referrals from the palliative care team, pastoral care team, acute/chronic pain service, wound care, and other applicable services. There is an YH Pain Management Service which RNs consult with regularly in the management of pain for their patients.

• Nurses Uphold Advance Directives: On admission patients are asked a series of questions (a part of the electronic medical record) pertaining to advanced directives, and every patient is given an informational packet “Advanced Directives: Important information about Living Wills, Durable Power of Attorney for Health Care, and Organ Donation”. Patients are asked if they currently have an advanced directive, and if that directive reflects the patient’s current wishes. If a patient has an advanced directive, they and their family members are encouraged to bring a current copy in to the hospital to be placed on the chart. If a previous copy remains in the patients old records, a copy of the advanced directive should placed on the patient’s current chart. For those patients who have no advanced directive and wish to create one, standard forms for a Living Will and Durable Power of Attorney for Health Care are included in the informational packet and are available for every patient.

Examples of Complex Ethical Situations in a Variety of Practice Settings:

Medical Unit:
An RN requested a phone consultation regarding a situation regarding the patient’s right to autonomy. She was caring for a 71 year old patient who had multiple chronic medical problems and was doing poorly after mitral valve repair surgery. The patient’s husband and daughter requested that the patient be given only comfort measures, based on conversations with the patient prior to the surgery. The patient was on ventilator support and was heavily sedated. She had specifically expressed to the daughter that she did not want to be “tied to machines.” There were no written advance directives or living will. The family discussed the patient’s wishes with the surgeon, who refused to comply, indicating that they did not have the right to make these decisions. The patient’s prognosis to return to a previous level of functioning was poor, and it was believed that although patient’s heart might recover, he/she may require lifelong dialysis, may not be able to be weaned from the ventilator and may have permanent neurologic damage. The nurse sympathized with the family but there was a conflict between the family and the doctor in charge. In this situation, the nurse was given suggestions on how to manage the situation from the nursing perspective. The family and doctor were able to come to an agreement. The care was transferred to another physician who followed the family’s wishes and the patient died shortly thereafter.

Intensive Care Unit:
An emergency bioethics consultation meeting was requested by the attending physician for an 84 year old patient who was hospitalized with multiple organ failure. The patient was in the ICU and was receiving dialysis and on a ventilator. The patient’s living will indicated that the patient did not want to be resuscitated, but the patient’s son believed that the patient had verbally annulled this decision in a decision regarding this decision as it related to their religious beliefs. The entire patient care team was in conflict as they viewed the care as futile, yet the family did not. The nurse felt that she was prolonging suffering for the patient as she provided the required nursing care. The patient care team and the family met with the emergency bioethics consultation team. The committee was able to provide guidance and support to the patient care team which helped them to follow the plan of treatment but not add any new treatments. A palliative care nurse was assigned to be the contact for the son.
Pre-Hospital Assessment Services:

One of the patients I was given the opportunity to assess was a young woman coming in for a cervical neck fusion because of a traumatic neck fracture. She was married with 2 small boys at home. She stated she was in a lot of pain but her husband and parents were helping her with the household chores and taking care of the children.

As part of the assessment, I asked her how she fractured 2 vertebrae in her neck. I thought she would tell me she was in an automobile accident or that she fell. But what she told me made a shiver run up my spine. Her exact words were, “my husband yanked my hair so hard that he ripped my hair out and fractured my neck.” She said it wasn’t the first time he was physically abusive and she was afraid for her children. When I asked her if she contacted the authorities, she said her husband never lets her leave the house, monitors her cell phone and goes everywhere with her, so she didn’t have the opportunity to talk with anyone. I asked her if she told her surgeon how this happened she said “yes he knows”. I then asked her if she wanted me to help her connect with Access York so they could help her. She said yes but was afraid her husband would come to the hospital on her surgery day and prevent any communication from happening. Concerned for her children, I asked who would have the children on her day of surgery. Her parents were keeping them safe at their house.

I told her I would do whatever I could to help and she should just come to the hospital as planned, we would take it from there. I went to my nurse manager and asked her to help me figure this out. Access York was notified and the Operating Room staff was included in this plan to connect the patient with Access York. The day of surgery was as she described, her husband was at her side at all times. As she was wheeled to the OR, the bed was detoured into an empty room where the Access York staff was waiting, ready to explain their purpose and how they could help her. The husband had no idea his wife was finally getting a chance to receive the help she so desperately wanted.

Due to privacy concerns, we were not told what the outcome was, or whether she accepted help from Access York. I want to believe she and her children are in a safe place enjoying life. Most importantly, we were able to give her the opportunity and choice to achieve that safe outcome.

Interdisciplinary Team

The following narrative describes the interdisciplinary collaboration for an oncology patient on 7 South, members of the team caring for this particular patient are as follows: Mindee Conway, Social Worker; Sue Witmyer, RN - Case Management; Dan Sotirescu, MD – Oncologist; John Blotzer, MD; Rajwinder Kaur, MD; Richard Kiok, MD; Mathew Benson, RPh - Pain Management; Katherine Dawson, CRNP, Palliative Care; Margaret Thoman, RN, Palliative Care and the nursing staff of 7 South. This story was submitted and the 7 South nursing staff and team members identified above were awarded the interdisciplinary team award for 2012 for the care of this patient.

The following account highlights an exemplary Interdisciplinary collaborative effort, in which all team members made essential and meaningful contributions in achieving an optimal outcome. Mrs. R. was a 48 year Latino woman admitted with intractable back pain, nausea and vomiting. She was diagnosed with Stage 4, Breast CA with mets to her bones and liver, approximately 5-6 weeks prior to admission. Following diagnosis she was started on Tamoxifen and Zoledronic acid. She was a full team patient and had pending surgery within a couple of days of admission.

Initially, Mrs. R was awake, alert and appropriate. Her family and friends were very supportive and involved in her care. She received an extensive work-up and numerous consults were ordered to address her unique needs, they included: Cardiology, Neurology, Oncology, Radiation Oncology, Palliative Care and Pain Management. The MRI of the brain revealed multiple ischemic events. She
developed encephalopathy which did not resolve. Unfortunately, within a couple of days of admission, she began to experience a very rapid decline. Mrs. R became very agitated, confused, yelling out, pulled out her minicath, and was attempting to get OOB although her lower extremities were very weak.

It was very distressing for her family to see her in this condition. In order to maintain her safety, she was placed in restraints until the agitation resolved. In the meantime, the residents ordered a pain management consult. The pain management team changed her meds to PO Haldol & liquid Morphine which thankfully provided pain relief and resolved the agitation and allowed us to remove the restraints. It was a great relief to the children and extended family and friends to see their loved one resting more comfortably.

Mrs. R's children were informed that she was not a candidate for chemo or radiation, and were encouraged to consider hospice services. Mrs. R was changed to a DNR status, with comfort care measures. On admission, her children thought they were taking their mother home and now they were faced with such difficult decisions. It was very complicated and there were many issues that needed to be addressed. Mrs. R was married two times, and had a total of 7 children. The first 3 children are in their late twenties and reside in Maryland. Her younger 4 children are ages 23, 21, 20, and 10 and reside locally.

Mrs. R had verbalized that in the event she was unable to care for her 10 year old son she wanted him to live with his 21 year old brother but there was no legal document in place to uphold her wishes. The father of the younger children is currently serving a life sentence in prison. Obtaining guardianship for the 10 year old was urgent to prevent him from being placed with Children services until it could be resolved within the judicial system. An Interdisciplinary approach was paramount in addressing Mrs. R's complex needs and developing a plan of care that involved her as well as her family members.

A family meeting was held with all of the children, the following disciplines were present: nursing, SW, CM, residents, the attending, palliative care and the oncologist. It was necessary to ensure all of the siblings were in agreement of having their 10 year old brother live with their 21 year old brother, and that there was consensus among all the siblings. In addition, there was consensus that the 20 year old daughter, who lived locally, would be the spokesperson and decision maker on behalf of their mother. The Oncologist reviewed Mrs. R's medical status and prognosis, this was especially important for the older children who had just arrived from Maryland and were not aware of the gravity of the situation.

There was concern regarding a possible genetic predisposition and the need or benefit of possible genetic counseling. Dr. S. strongly suggested genetic testing and referred them to follow up with his office. The children were concerned about insurance coverage for genetic counseling and Dr. S. offered to do so pro bono if their insurance company did not cover the service. The family session was heart wrenching, many questions were answered, many tears were shed, much emotional support was provided and the family left with a unified plan. The SW and CM nurse immediately started making phone calls to facilitate guardianship. They made numerous phone calls, contacted the York County Bar association and ultimately succeeded in securing a representative from the Mid Penn Legal Services who provided their services pro-bono. Within 24 hours the legal representative contacted the biological father in prison, he waived his rights and gave consent for the 10 year old to reside with his older brother. A temporary guardianship document was drafted and completed just in time. Mrs. R passed away the next day but her wishes were upheld and the family did not need to experience further separation at a time when they needed each other the most.
**Cardiovascular**

FB was a patient that was admitted to the hospital with LLE extremity cellulitis, from a cat bite, in July 2011. During her admission she developed chest pain, had a cardiac cath and it was discovered that she had significant coronary artery disease that required OH surgery. Her surgery was uncomplicated; however her post op recovery period was not as smooth. FB’s condition necessitated that she stay in the ICU for 1 week and by the time she was transferred to T2, her mental outlook was not very positive. She was depressed because she had been in the hospital for what she thought was a simple cat bite and ended up having open heart surgery!

She continued to become more disconnected from her recovery and began to refuse physical care from the nursing staff, batting away with her arms any attempt to take vital signs, refusing medications, bathing, walking, and even assistance eating. More concerning however was that she began to emotionally disconnect from her surroundings. She would not let the nursing staff talk to her about her concerns; she refused to allow visitors and would not listen to education about her condition that was provided by the staff. One nurse attempted to read her Get Well cards to her and she told her to stop and throw them away. It became clear that she was clinically depressed and needed to be seen by Psychiatry. Questions arose as to whether we could force this patient to take her meds and provide care when she clearly was stating that she wanted all care to stop and for everyone to let her alone so she could die. Did she have the capacity to make these decisions and should she be involuntarily committed?

The attending physician ordered a consult with psychiatry. The patient was seen by Psychiatry and diagnosed with depression. The psychiatrist felt that she still had capacity to make decisions and was not a candidate for a 302, involuntary commitment. The nursing staff felt frustrated with their inability to help this patient both physically and emotionally. In an effort to support the patient’s desires, the nurse talked with the surgeon and obtained a Do Not Resuscitate order. Even with the DNR order, nursing continued to feel that more should be done for this patient. A second Psych evaluation was ordered and a suggestion was made that this case be referred to the Ethics Committee. Ironically, the day the DNR order was obtained; the patient had a potentially lethal arrhythmia and during the event told the nursing staff that she wanted everything done to save her life. The patient was transferred to ICU where she was intubated, a second Psych consult was done and the case was brought before the Ethics Committee.

The Ethics committee meeting was attended by the CT Surgeon, Palliative Care, Case Management, Risk Management, Psychiatry, Family Practice, OHICU nursing staff and Tower 2 nursing staff. A review of her past medical history was done, focusing on her past mental health. The CT surgeon reported that this was an uncomplicated case that should have an uncomplicated recovery period. However, OH surgery may cause depression in some individuals. When the initial Psych consult was done, it was unclear to Psych that the surgeons wanted them to determine whether or not the patient was competent. This pointed out that there was not clear communication between the attending and consulting physician.

There was general discussion among all members of the team talking about the behavior of the patient that led up to her deteriorating condition. The Ethics Committee provided a forum for all parties to discuss what each discipline could have done differently to provide care that met the physical and emotional needs of the patient. Specifically, nursing questioned whether or not they should have forced the patient to bathe and toilet. The Ethics Committee discussed the fine line that nurses walk when
they are supportive of the patient’s care decisions but also provide the most basic of care to the patient, including changing their sheets and bathing them despite the patients’ refusal.

Unfortunately, FB’s course in the ICU continued to deteriorate. She had gotten to a point where the decisions she made about refusing her care affected her physical outcomes. FB was transferred to LTACH where she died approximately 2 months after her initial admission.

SAFE Team

When the York Hospital (YH) Forensic Nurse Examiner Team (FNET) was established in 1998, the scope of services solely included caring for victims of sexual assault if the assault had occurred within the last three days. The nurses that performed evaluations were referred to as sexual assault forensic examiners (SAFE). The program coordinator recognized that the nurses and the community viewed SAFE nurses as evidence technicians rather than as forensic nurses. A first step in morphing the program required educating the organization and the community on the importance of the extensive process involved in this holistic program. The combination of the medical training of a nurse with the investigative prowess of a police detective and the legal training of a lawyer creates a formidable force for improving the health and safety of the individual and the community. Building on the mission of York Hospital to improve the health of communities, partners were identified to provide exceptional service to victims, ensuring they remain healthy members of society.

More than three quarters of all sexual assaults go unreported. When a sexual assault goes unreported, unfortunately, the victim may not receive all the medical and legal services that are available. There are multiple reasons a person may not report sexual assault. Reporting may be “hindered by the perceived outcomes of dealing with the police and criminal justice system, impaired cognitive processing, and the victim/offender relationship” (Jones, et al 2009). Patients may present to the Emergency Department reporting sexual assault, but if they would not speak to law enforcement we did not collect physical evidence. The SAFE nurses at YH feel that healthcare providers have a mutual responsibility to meet both the patient’s medical and forensic needs and asked themselves are we meeting our responsibilities to the patient and the public we serve? Individuals may not seek medical care following an assault because of the perception that they would have to talk to law enforcement. If the person did not speak to law enforcement then we were losing time sensitive physical evidence.

The forensic examiner team asked, what if we offered patients time to rest, think, and shower, time to eat and drink, time to speak to others, time to sleep, sober up, or anything else they might need to do to regain some strength. What if we allowed the opportunity for patients to process information and find support in order to make decisions? What if we immediately connected patients with victim advocacy, health care and other services and then explained that time-sensitive evidence would be collected and properly stored in order to preserve their option to report later? By answering what if, now we can remove some of the barriers to seeking services following an assault.

The forensic examiner team led the effort across York County to establish a procedure for Anonymous/ “Jane/John Doe” reporting for sexual assault victims. Anonymous/ “Jane/John Doe” is an avenue for victims to seek services and to have evidence collected without needing to decide immediately about speaking with police. Even if a victim is unsure about talking to law enforcement, the evidence is preserved properly. This evidence may be used in a physical evidence-based prosecution when/if the victim becomes ready to report to law enforcement.

This effort required collaboration with multiple community based service providers all looking at how we could attain the shared goal of providing the best services to victims of sexual assault. Law enforcement, healthcare and victim services worked together to develop a protocol that addressed the
public health and public safety implications for our community.

“Jane/John Doe Evidence Kit” is the common name for the forensic evidence collected during a sexual assault examination for a victim who chooses to remain anonymous. A “Jane/John Doe Evidence Kit” enables a victim to have forensic evidence collected without revealing identifying information. Victims are given a code number they use to identify themselves if they choose to report later, and they are not required to cooperate with law enforcement or criminal justice authorities.

The multidisciplinary team recognized there are disadvantages to providing an anonymous reporting option. The forensic examiner team focused on developing the protocol so that the patient would be able to make an autonomous, informed decision: Anonymous Reporting is a way for the victim to have a forensic medical examination where evidence is collected without reporting their assault to law enforcement. The hospital can collect potential evidence and assign a number to it. The evidence with the number only (not name) will be given to county law enforcement to hold for 6 months. If you change the victim changes their mind about reporting to law enforcement during the 6 month time, their evidence has been preserved and the police can use it. Below is an example of the consent used by the SAFE nurses for this complex patient population.

**EP23.2 SAFE Nurse: Anonymous Reporting Document**

I ____________________________ am requesting Sexual Assault Evidence Collection and I do not want to report to law enforcement at this time.

I have read and understand the following:

A. The benefits of reporting to law enforcement today:
   1. Law enforcement will have an opportunity to collect evidence from the suspect, and from other possible crime scenes. The sooner an investigation begins the better.
   2. I may be eligible for help from the Pennsylvania Crime Victim Compensation Program, which helps pay for expenses beyond the forensic examination.

B. By delaying reporting to law enforcement, I risk:
   1. Evidence that would normally be collected by law enforcement may be permanently lost.
   2. Chances of a successful investigation and prosecution in the future may be reduced.

**Summary**

York Hospital nurses have a variety of resources available to assist them as they address and navigate ethical issues with their patients, families and the healthcare delivery system. These resources are everything from a “real time” Bioethics Committee, Palliative Care, Pastoral Care staff, Risk Management staff, Case Management/Social Worker staff and Nursing Grand Rounds, nursing education sessions, LMS resources, WSH, YH and nursing policies and guidelines, and most importantly, the ANA Code of Ethics with Interpretive statements. All of our nursing units utilize
standards from nursing specialty organizations and other specialty accrediting bodies to assist in the referencing best practices for addressing complex ethical issues in the hospital setting. The PPM and Care Delivery models also align with and provide support to the nursing staff assess, intervene, implement and evaluate patients responses to these ethical situations and do so with the caring these complex patients deserve.