Volume 35, Number 6
NOVEMBER/DECEMBER 2013

aacn ViewPoint

The Voice of Ambulatory Care Nursing

Developing a Fair For Validating Skill Competence

Rebecca S. Bennett
Stacy A. Olson
Courtney E. Wilson
Mary Lee Barrett
Angela Pereira
Michael S. Janczy
Lou Yang

The Joint Commission (2010) standard for Ambulatory Care nursing practice states that all staff will be competent to perform their responsibilities. Their rationale for competency standards is, "The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization" (The Joint Commission, 2013). An element of performance for this standard requires that "those who work in the organization are competent to complete their assigned responsibilities" (The Joint Commission, 2013). The American Academy of Ambulatory Care Nursing (AAACN) (2010) also addresses competency in their standards of professional performance as a standard and criteria for practice. Registered nurses maintain their competency through life-long learning in diverse educational experiences and activities (AAACN, 2010). As professional nurses, we adhere to these standards and maintain or obtain the needed knowledge and skills for ambulatory care nursing practice.

The American Nurses' Association (ANA) (2010) defines competency as "an expected and measureable level of nursing performance that integrates knowledge, skills, abilities, and judgment based on established scientific knowledge and expectations for nursing practice" (p. 64). Additionally, competence is further defined as the quality of having sufficient knowledge, aptitude, judgment, skill, and ability to perform the duties and responsibilities of the position (U.S. Department of Veterans Affairs, Veterans Health Administration, & VA Great Lakes Health Care System, 2012). This policy requires that "competence of all employees is assessed, maintained, demonstrated, and improved upon initial employment…and on an ongoing basis" (U.S. Department of Veterans Affairs et al., 2012, p. 1).

Program Development

Members of the Primary Care Quality Improvement (QI) Council, a part of nursing shared governance structure at Clement J. Zablocki VA Medical Center, identified that a system for skill competency assessment specific to Primary Care nursing staff roles, or

continued on page 8

inside

AAACN extends holiday wishes to all of our members. At this time of year, we reflect on our accomplishments over the past year and know our achievements would not have been possible without your support of the association through your membership. We wish you and your family the very best of health and happiness in 2014.

from the president

AAACN's Core Business – Leadership!

Greetings from your Board of Directors

Susan M. Paschke

In this President's Message, I have the pleasure of giving you an update from the Summer/Fall Board of Directors Meeting held in August at the National Office in Pitman, New Jersey. It was a wonderful opportunity to work together with colleagues in person rather than our usual monthly telephone conference calls. We did a lot of work and balanced that with a lot of fun as well!

AAACN is involved in a multitude of initiatives and projects in addition to our everyday activities. The *RN Care Coordination and Transition Management (RN-CCTM) Core Curriculum* is in process. Author teams are busy completing the chapters that represent each of the nine core dimensions of care coordination identified by the previous expert panels. Publication of the *Core* is expected in mid-2014. We will soon being developing the RN-CCTM course consisting of online education modules.

We are considering a collaborative effort with a credentialing organization to offer an exam that would provide a "certificate" to the person completing the course. A certificate is an attestation that one has completed the coursework and passed an exam. This is ***not*** a certification, which would include additional credentials after one's name, but could possibly be the first step toward a certification in the future. Further discussion is needed prior to final decisions being made. Continued updates will be available in future Messages.

The *Ambulatory Care Certification Review Course (CRC)* is taking on a new look – it will be offered as part of the Intensive CE Series from Gannett Education as an online course consisting of four reading modules and five Webinars beginning early next year. The course is based upon the very successful CRC that has been offered over the past 13 years by AAACN. We expect to continue to offer the "live" CRC at the AAACN Annual Conference and on demand. Those interested in becoming certified will now have four ways to prepare for the exam: by taking a "live," in-person course; by purchasing the CRC DVD individually or as part of a site license in the Online Library; or by participating in the online Gannett Ambulatory Care Nursing Certification Intensive CE Series. I am hopeful that with these alternatives, we will see an increase in the number of ambulatory certified nurses in the near future!

In preparation for the Board meeting, members were asked to read *Road to Relevance* the sequel to *Race for Relevance*, which we read last year. Both books, published by the American Society of Association Executives, offer organizations the opportunity to evaluate their relevance and value to their members and to determine what will continue to keep them relevant in the future. As a result, we began a discussion about the "core business" of AAACN by asking, "What is our main focus or essential activity that sets us apart from other nursing and professional organizations?" The answer: LEADERSHIP and Leadership Development.

AAACN has developed nurses and leaders throughout its history – through annual conferences; networking and discussion groups; development of standards, a core curriculum, and a certification review course for ambulatory care and telehealth; Special Interest Groups (SIGs); continuing education; scholarships and awards; and numerous volunteer opportunities for personal and professional advancement. However, development of leaders does not happen on its own.

As an organization, we draw upon our core strengths and the areas in which we excel to promote leadership among all ambulatory care nurses. The Board is reviewing the products, services, and programs AAACN provides in light of our

continued on page 11

aaacn American Academy of Ambulatory Care Nursing

Many settings. Multiple roles. One unifying specialty.

Reader Services

AAACN ViewPoint
American Academy of Ambulatory Care Nursing
East Holly Avenue, Box 56
Pitman, NJ 08071-0056
(800) AMB-NURS
Fax: (856) 589-7463
Email: aaacn@ajj.com
Web site: www.aaacn.org

AAACN ViewPoint is a peer-reviewed, bimonthly newsletter that is owned and published by the American Academy of Ambulatory Care Nursing (AAACN). The newsletter is distributed to members as a direct benefit of membership. Postage paid at Deptford, NJ, and additional mailing offices.

Advertising
Contact Tom Greene, Advertising Representative, (856) 256-2367.

Back Issues
To order, call (800) AMB-NURS or (856) 256-2350.

Editorial Content
AAACN encourages the submission of news items and photos of interest to AAACN members. By virtue of your submission, you agree to the usage and editing of your submission for possible publication in AAACN's newsletter, Web site, and other promotional and educational materials.

For manuscript submission information, copy deadlines, and tips for authors, please download the Author Guidelines and Suggestions for Potential Authors available at www.aaacn.org/ViewPoint. Please send comments, questions, and article suggestions to Managing Editor Katie Brownlow at katie@ajj.com.

AAACN Publications and Products
To order, visit our Web site: www.aaacn.org.

Reprints
For permission to reprint an article, call (800) AMB-NURS or (856) 256-2350.

Subscriptions
We offer institutional subscriptions only. The cost per year is $80 U.S., $100 outside U.S. To subscribe, call (800) AMB-NURS or (856) 256-2350.

Indexing
AAACN ViewPoint is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL).

Publication Management is provided by Anthony J. Jannetti, Inc., which is accredited by the Association Management Company Institute.

Do you have a story that has been memorable or has had an impact on your practice? If you would like an opportunity to share it in the "Telehealth Trials & Triumphs" column, contact Kathryn Koehne at krkoehne@gundluth.org

Your Caller May Be a Victim

Intimate Partner Violence: Hidden Facts

Kathleen Swanson

Domestic violence, more recently called *intimate partner violence*, is alive and well in the United States. In fact, the Centers for Disease Control and Prevention (CDC) (2013) regard domestic violence as a "serious, preventable public health problem." According to the National Coalition Against Domestic Violence (NCADV) (2007), one in four women experience intimate partner violence, while one in seven men is a victim. Domestic violence crosses all socioeconomic boundaries, ages, sexual orientation, and races.

Domestic violence can take many forms. We are perhaps most familiar with physical violence, where bruises and injuries are apparent. Emotional and sexual abuse is just as real; however, due to the lack of outward physical signs, they are much more difficult to detect. Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics (CDC, 2013). Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. If your caller reveals any of these experiences, it is a red flag that he or she may be experiencing domestic violence.

Due to the private nature of this abuse and a sense of shame, the victim may conceal this crime. At times, victims are not even aware that what they are being subjected to is domestic violence. As nurses, it behooves us to understand what abuse is and how it can be manifested in a patient because most often, patients are not forthcoming about the abuse they are experiencing.

Your Caller May Share Her Secret with You

As a telephone triage nurse, you will undoubtedly have contact with victims of domestic violence. One study indicated that 25% of females patients seeking care at a primary care clinic were victims of some type of domestic violence within the past year (Minsky-Kelly, Hamberger, Pape, & Wolff, 2005). *How can you effectively assess for domestic violence?* Conveying a sense of support, respect, dignity, and empathy is important for all patients. Victims of domestic violence are especially sensitive to the nurse's attitude. These patients feel fearful, helpless, desperation, and self-loathing. They blame themselves and may feel that they deserve the treatment they receive. The nurse's communication style may determine if the patient feels safe to share her predicament.

A woman may call complaining of extreme anxiety and difficulty sleeping. Ask the typical questions about sleep habits and also ask about life circumstances. Rather than directly ask if the caller is experiencing abuse, it can be more helpful to inquire about relationships. Remember, she may not yet understand that what she is experiencing is abuse. "Do you have a supportive partner? Who helps you cope with your anxiety? What makes you feel more anxious?" These questions may prompt answers that reveal she is walking on eggshells and is being controlled by her partner.

If a caller is inquiring regarding a physical injury about which you have suspicions (for example, her explanation of how the injury occurred does not make sense and you suspect abuse), do a brief safety assessment. Does she feel safe at home? Has she experienced many injuries at home? You can remind her that it is never right for her to be injured by another person, and advise her to seek medical care and facilitate the process of her entry into the system.

Listen for comments the caller makes that indicate she is not free to make her own decisions regarding her body, her social activities, or finances. The caller may be asking you a question when suddenly her voice becomes much more cautious and you become aware that the perpetrator has entered the room. This is a signal that the caller does not have the liberty to speak freely to you.

Often the call is not made in regard to the domestic violence but is instead in regard to a "side effect" of the experience. Listen carefully for the question behind the question.

Be Prepared and Have a Plan

It is helpful to formulate a statement that provides information to a caller you suspect may be a victim of domestic violence. In this way, you can offer validation and resources in a non-threatening fashion. For example, you can share the definition of domestic violence and contact information for local domestic violence shelters. You could say, "It's important to be aware of the support and resources here in our community for domestic violence victims. Here is the phone number for our local agency, in case you need it." If your community does not have a local agency, be sure you have at hand the phone number of at least one national agency that offers toll-free telephone support for victims of domestic violence.

You May Have Your Own Secret

If you have been a victim of domestic violence yourself, you may suffer panic or flashbacks when you suspect a caller is experiencing abuse. It may be tempting to tell the patient what to do and that she needs to leave the situation immediately. However, professional boundaries must be observed. You may share an idea by stating, "Women in a

continued on page 15

Instructions for Continuing Nursing Education Contact Hours

Self-Injection Classes: Empowering Patients and Decreasing Nursing Workload

Deadline for Submission: December 31, 2015

To Obtain CNE Contact Hours

1. For those wishing to obtain CNE contact hours, you must read the article and complete the evaluation online in the AAACN Online Library. *ViewPoint* contact hours are free to AAACN members.
   - Visit www.aaacn.org/library and log in using your email address and password. (Use the same log in and password for your AAACN Web site account and Online Library account.)
   - Click *ViewPoint Articles* in the navigation bar.
   - Read the *ViewPoint* article of your choosing, complete the online evaluation for that article, and print your CNE certificate. Certificates are always available under *CNE Transcript* (left side of page).
2. Upon completion of the evaluation, a certificate for 1.3 contact hour(s) may be printed.

Fees

Member: FREE **Regular**: $20

Objectives

The purpose of this continuing nursing education article is to describe an educational initiative aimed at reducing nursing workload and improving timely access to care for patients in an ambulatory care setting. After reading and studying the information in this article, the participant will be able to:

1. Discuss the importance of decreasing nursing workload in the ambulatory care setting.
2. List two benefits of the self-injection program as implemented by The Villages VA Outpatient Clinic.
3. Identify one area where patient education might be utilized to decrease nursing workload in the reader's workplace or organization.

The author(s), editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

This educational activity has been co-provided by AAACN and Anthony J. Jannetti, Inc.

AAACN is provider approved by the California Board of Registered Nursing, provider number CEP 5366. Licensees in the state of California must retain this certificate for four years after the CNE activity is completed.

Anthony J. Jannetti, Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Self-Injection Classes: Empowering Patients and Decreasing Nursing Workload

Anne Solow
Julie Alban
Marion Conti-O'Hare

Historically, nursing workload has been the subject of professional interest and scrutiny. For the ambulatory care setting at The Villages Veterans Administration Outpatient Clinic in Central Florida, monitoring workload is a necessity. This clinic serves a unique population of patients in close proximity to The Villages, one of the largest retirement communities in the nation. The Villages is located one hour north of Orlando, Florida, and according to the United States Census Bureau (2013), the population there was 51,442 in 2010, with 69.8% of the population over 65 years of age. Presently, the clinic serves over 13,000 patients with an enrollment waiting list of over 400. Since the clinic opened in 2010, several performance improvement projects have been initiated to help improve patients' access to care as well as decrease nursing workload.

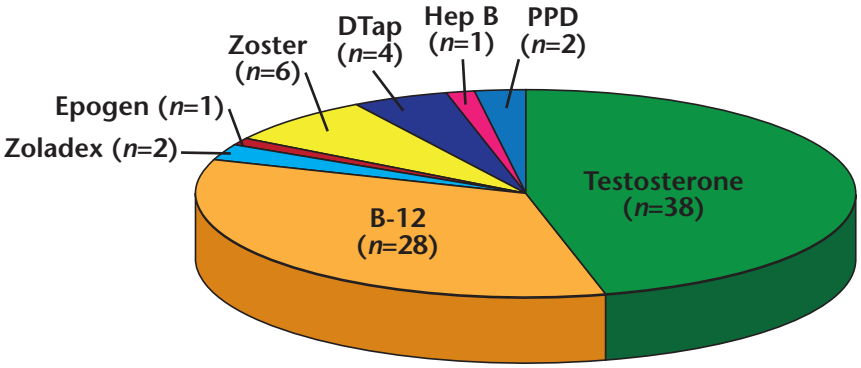
According to a study by Dickenson, Cramer, and Peckham (2010), data and metrics used to evaluate and document effectiveness of nursing workload may not accurately reflect staffing needs, which ultimately affects the delivery of safe patient care. These researchers noted that there were "many similarities in nurse work performed in disparate clinics, yet work processes and workflows varied based on the needs of differing patient populations" (p. 39).

In general, the ambulatory care setting utilizes registered nurses to serve a high volume of patients dealing with a variety of individual patient issues within a 24-hour period (Mastal, 2010, p. 267). Some challenges identified in ambulatory care settings include improving workflow efficiency, optimizing human and material resources in a cost-effective manner, and providing nursing services using a variety of high-tech methods in virtual environments in addition to traditional face-to-face care (Swan, 2008, p. 195). Since each primary care nurse at the clinic is responsible for up to 1,200 patients, the issue of workload becomes quite important.

At the clinic, the current patient flow process is the following. Physicians see patients every 30 minutes. The primary care nurse working with each physician assesses each patient prior to the physician visit. This process takes approximately 15 minutes and includes vital signs, evaluation and administration of immunizations, procedures (such as EKGs), and required health screenings. Areas of additional assessment include falls, post-traumatic stress disorder (PTSD), and depression, among others. One patient may have up to 15 of these additional assessments to evaluate. Patients are asked to arrive for their physician appointments 30 minutes early, allowing the RN to complete the assessment process before the patient's meeting with the doctor. Unfortunately, patients often arrive exactly at the scheduled appointment time or they arrive late, leaving little or no time for the RN to complete the necessary nursing assessments and procedures.

In addition to conducting preliminary patient assessments for the physician, RNs conduct separately scheduled 30-minute "nurse visits." Injections, health education, equipment training, and any other required follow up occur during these appointments. An RN typically has one nurse visit in the morning and one in the afternoon. However, RNs routinely have to "overbook" these nurse visits, completing several each day, to accommodate patient needs. The above factors all contribute to an unacceptable workload for the RN and a lack of access to care for the patients.

Figure 1.
Injection Type Pie Chart
January to February 2011



Assessment

Plan-Do-Check-Act (PDCA) is a performance improvement (PI) model used for designing new and modifying current processes. In the ***Plan*** phase of the cycle, a need to improve a process is identified. Data are then analyzed, and theories are tested and implemented in the ***Do*** part of the cycle. Results and effectiveness are measured in the ***Check*** section, and lastly, in ***Act,*** plans are made to hold onto the gains made, or an act to improve and standardize improvements is implemented. In the VA system, this method is used to support and enhance the implementation of PI, with the ultimate goal to continually improve current systems and achieve excellence in meeting the needs of patients through improved outcomes.

In 2011, a PDCA model, "Improving Access to Care for Patients with Non-VA Prescriptions" (Pelkey et al., 2011) was created at the facility because patients requesting their non-VA prescriptions be filled at the clinic must be evaluated by a primary care nurse. This analysis of the PDCA revealed that 40% of all nurse visits at the clinic from January 1, 2011, to February 28, 2011, were made for injections. In addition, results indicated that 80% of all injections given in this same time period were either for testosterone or vitamin B12 injections (see Figure 1).

A contributing factor to the need for addressing the injection volume included the high rate of physicians ordering these two injectable medications for The Villages patient population. Current research has shown the benefits of vitamin B12 and testosterone replacement therapy, especially in the aging population. For example, vitamin B12 has been shown to decrease the incidence of depression in older adults (Skarupski et al., 2010). Other studies have associated vitamin B12 therapy with an increase of cognitive function in older adults (Donovan, Horigan, & McNulty, 2011). Further, testosterone replacement has been widely used for treatment of erectile dysfunction (ED), low energy, and several other symptoms related to low serum testosterone in older adult patients (Khera, Morgentaler, & McCullough, 2011).

Armed with this information, nursing administration chose to further evaluate opportunities for workflow improvement due to the inability of the RNs to accommodate the large volume of patient visits. This led to an initiative for reducing nursing workload by teaching patients self-injection of these medications.

Plan

The assistant chief nurse and the nurse manager of primary care determined that teaching self-injection to patients of these selected two medications would reduce the total number of injections given monthly at nurse clinic visits, thereby reducing the demand for this particular nurse visit appointment, freeing up RN time for other patient care responsibilities, and improving access to care. Other benefits of teaching patients self-injection included fostering patients' feelings of independence, empowerment, and the ability to travel more easily (Hiley, Homer, & Clifford, 2008).

Other injectable medications, such as insulin, were not included in this initiative because they required individual patient health teaching related to a specific diagnosis. A classroom format was chosen because only one nurse would be required to teach a large number of patients.

Implementation

The self-injection class included a PowerPoint™ presentation, demonstration, actual practice with return demonstration, and a take-home booklet giving comprehensive injection instructions to those patients interested in and able to perform self-injection. The PowerPoint presentation and booklet were approved by the Chair of Patient Education in North Florida/South Georgia Veterans Health System (NF/SGVHS), of which the clinic is a part. This approval process included ensuring that the class content and patient handouts were written at a fifth grade level or lower, a current standard for patient education at the Veterans Administration. All injection procedure content was derived from the current *Lippincott Nursing Procedure Manual.*

Primary care nurses and providers screened and referred patients for self-injection based on the need for frequent injections of testosterone and vitamin B12. Classes were then scheduled for the second Thursday of every month from 2:00 p.m. to 3:00 p.m. Patients and spouses or significant others were given 30 minutes of didactic education, including proper subcutaneous and intramuscular injection technique and medication safety. Approximately one out of three patients who felt uncomfortable about self-injection requested that their significant other or caregiver be trained to administer home injections.

Thirty minutes of practical instruction and return demonstration using injection equipment and oranges for practice followed the didactic session. Since administering injections is a psy-

chomotor skill, patients were evaluated during class by observing their performance of motor skills and assessing the cognitive skills essential for the adaptation of the procedure for safe practice (McDonald, 2007). If patients were unable or unwilling to safely perform the injection techniques due to physical, psychological, or cognitive factors, they would remain on the nurse injection schedule at the clinic. These options were presented to patients at the beginning of each class to help reduce anxiety.

Documentation of class attendance was entered into the individual medical records, noting patients had completed the class and were then deemed competent to perform self-injection. After satisfactory completion of the self-injection class, the patient's primary care providers and nurses were alerted to this fact. Providers would then write orders for medication and supplies, and the nurse would be able to follow up with patients and observe their first self-injection, if needed. Patients were removed from the clinic injection schedule, and began to receive their medications and injection supplies at home through the U.S. mail. They were given the option to keep their next nurse visit if they felt the need to be supervised during their first self-injection. In addition, patients were encouraged to call the clinic and their primary nurse if they had any questions or problems.

Evaluation

Evaluation forms were created. Using a Likert scale, patients were asked to rate the presenter and the class content, as well as evaluate themselves on their level of understanding of the subject matter and their injection skills following the class. Specifically, patients were asked to evaluate the content, speaker's level of knowledge and presentation style, timing and organization of the class, and the quality of the handout. In addition, patients were asked to evaluate the topics discussed in the class, which included medication safety, differences between subcutaneous and IM injection, proper injection technique, and how to dispose of needles. Subjective data was also collected for ongoing analysis of the effectiveness of the self-injection program. Patient feedback from classes to date has been overwhelmingly positive, and patients and their significant other or caregiver have expressed gratitude for the instruction. For example, patients often wrote they appreciated learning how to "do it right" and they now "feel confident to inject" themselves.

Comments included:

"Hands-on training was great."

"The most helpful part of the class was getting to know the difference between Sub-Q and IM."

"I learned how to do it (injection) correctly."

"It was most beneficial to learn about correct injection sites."

"Learning about the proper technique for injection was most helpful."

"I learned about proper needle safety."

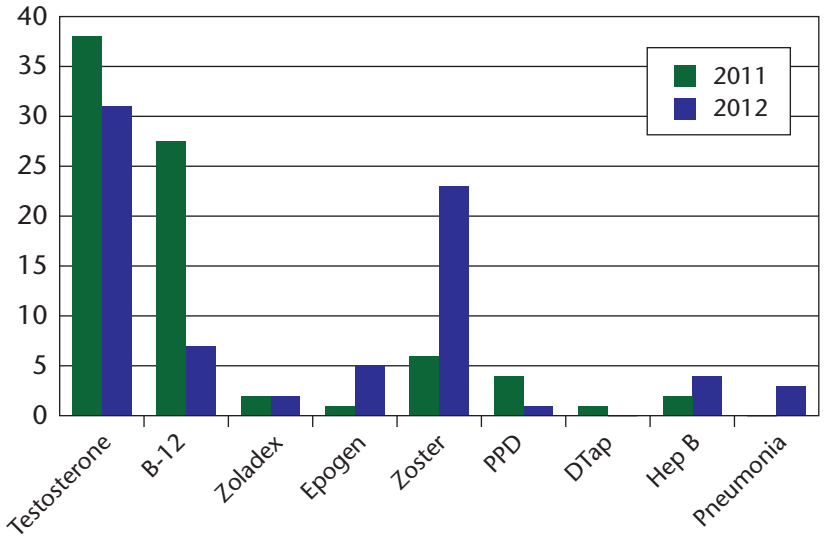
"It was helpful to see it live."

"Being able to do it myself."

A benefit of the program was increased convenience for the patient by reducing the frequency of clinic visits. This outcome was not reported specifically in class evaluations; however, informal feedback to primary care nurses over the months following class attendance validated this finding. Since the inception of the program, only 6% of patients have opted to return to scheduling clinic visits for injections.

Injection data were again collected from January 1, 2012, to February 28, 2012, and compared to matching data from the same time frame in 2011. Results showed that since beginning the self-injection program, the total number of nurse visits had decreased by 30%, and the total number of testosterone and B12 injection appointments decreased by 74%. These results suggest that the self-injection class has positively impacted nursing workload over the last year (see Figure 2). With a decreased injection workload, RNs at the clinic have had more time to track high-risk patients with chronic problems, such as uncontrolled hypertension and high hemoglobin A1c levels for diabetes. Nurses are then able to intervene through education and individualized follow up, allowing them to use their expertise in disease management and prevention.

Figure 2.
Injection Chart



Expanding Our Influence

Since the inception of the self-injection class, the content including the PowerPoint/booklet has been placed on the NF/SGVHS Web site under Patient Education and has been accepted as the standard content for self-injection education throughout NF/SGVHS. Handouts from this site can be downloaded and distributed to patients.

Another opportunity the VA used to further implement this program is the use of telehealth technology, where audiovisual equipment is used to facilitate simultaneous patient edu-

cation in multiple locations. According to Coyle, Duffy, and Martin (2007), use of telehealth technology increases patient access to care and can be used to provide education, treatment follow up, data collection, and promotes increased communication between patients and their health care team. In conjunction with recent national VA mandates, The Villages clinic has established several telehealth provider clinics and patient education opportunities. Self-injection classes have been included in this initiative, and the clinic has been broadcasting these classes monthly to other local clinics within the system. Clinics receiving the class transmission have assigned an LPN telehealth technician to assist in observing the patient's injection techniques in real time during class. The LPN telehealth technician also actively communicates with primary care teams in their respective clinics and helps the primary care nurses identify patients for self-injection class. Patient participation is documented at each site, and class evaluations are completed and returned to the RN instructor at The Villages' clinic.

Conclusion

Patient injections, specifically testosterone and vitamin B12, constituted 80% of the total injections given at The Villages VA Outpatient Clinic during the period between January to February 2011 (Pelkey et al., 2011). By providing self-injection classes to patients receiving these medications, the demand for the associated nurse visit appointment decreased by 74%. Training patients to give themselves these injections has also allowed them to be more independent in this area of their health care. In addition, using telehealth technology and standardizing the self-injection program throughout the NF/SGVHS, more veterans and nurses will be able to take advantage of this education.

The goals and values of this VA-initiated program can be beneficial to other health care organizations. By increasing access to care, improving workflow efficiency and decreasing their workload, nurses are freed to take on more complex responsibilities, while maximizing patient care outcomes.

References

Coyle, M.K., Duffy, J.R., & Martin, E.M. (2007). Teaching/learning health-promoting behavior through telehealth. *Nursing Education Perspectives*, *28*(1), 18-23.

Dickson, K.L., Cramer, A.M., & Peckham, C.M. (2010). Nursing workload measurement in ambulatory care. *Nursing Economics*, *28*(1), 37-43.

Donovan, C.O., Horigan, G., & McNulty, H. (2011). B-vitamin status and cognitive function in older people. *Journal of Human Nutrition and Dietetics, 24*, 281-282.

Hiley, J., Homer, D., & Clifford, C. (2008). Patient self-injection of methotrexate for inflammatory arthritis: A study evaluating the introduction of a new type of syringe and exploring patients' sense of empowerment. *Musculoskeletal Care*, *6*(1), 15-30.

Khera, M., Morgentaler, A., & McCullough, A. (2011). Long-acting testosterone therapy in clinical practice. *Urology Times*, 2-7.

Mastal, M.F. (2010). Ambulatory care nursing: Growth as a professional specialty. *Nursing Economic$*, *28*(4), 267-275.

McDonald, M.E (2007). *The nurse educator's guide to assessing learning outcomes* (2nd ed.) Sudbury, MA: Jones & Bartlett Publishers

Pelkey, M.E., Alban, J., Farrell, E., Rivera-Melendez, L., Coffey, S., Loza, B., … Dhanpat, R. (2011, May). *Improving access to care for patients with non-VA prescriptions.* Poster session presented at the 37th Annual Conference of the American Academy of Ambulatory Care Nursing; Lake Buena Vista, FL.

Skarupski, K.A., Tangney, C., Li, H., Ouyang, B., Evans, D.A., & Morris, M.C. (2010). Longitudinal association of vitamin B-6, folate, and vitamin B-12 with depressive symptoms along older adultsover time. *American Journal of Clinical Nutrition*, *92*, 330-335.

Swan, B.A. (2008). Making nursing-sensitive quality indicators real in ambulatory care. *Nursing Economic$*, *26*(3) 195-201,205.

United States Census Bureau. (2013). *State and county QuickFacts [data file].* Retrieved from http://quickfacts.census.gov/qfd/states/12/1271625.html

Anne Solow, MSN, RN-BC, *is a Primary Care PACT RN, The Villages VA Outpatient Clinic, The Villages, FL.*

Julie Alban, MSN, MPH, RN-BC, *is a PACT Care Coordinator, The Villages VA Outpatient Clinic, The Villages, FL.*

Marion Conti-O'Hare PhD, RN, *is an Online Nursing Instructor, Fruitland Park, FL.*

M. Elizabeth Greenberg Appointed to AAACN Board of Directors

M. Elizabeth Greenberg

M. Elizabeth "Liz" Greenberg, RN-BC, C-TNP, PhD, has been appointed to the Board of Directors effective at the close of the AAACN 2014 Annual Conference. Liz will complete the remaining two-year term of Nancy May, MSN, RN-BC, who will vacate her Director position to serve as President-Elect of AAACN. Liz was a candidate on the 2013 ballot.

Liz is Assistant Clinical Professor at Northern Arizona University School of Nursing and a nationally recognized leader in the field of telehealth nursing. Liz has been a volunteer leader in AAACN for several years. She is currently serving as a member of the *ViewPoint* Editorial Board. Liz's 30 years of nursing experience in telephone nursing practice, management, and research will be a definite asset to the board.

Skill Competence

continued from page 1

patient population, had not been established. The council recognized that the lack of such validation and documentation of staff's knowledge and ability to perform patient care was a deviation from the AAACN and The Joint Commission standards for competency, as well as from organizational policy and best practice.

Through discussion among council members, clinic management, and clinical staff, two areas of concern arose: 1) not all staff performed skills in the same manner, and 2) some staff were not aware of hospital policy and procedures specific to Primary Care. Conversations with staff members and direct observations of patient care revealed a variance in skill performance, as well as a knowledge deficit of organizational policy and procedure in several areas. Based on the knowledge that quality of care is directly related to the competency of staff (The Joint Commission, 2010), the QI Council decided to focus on skill competence in Primary Care as a priority for quality assurance.

The QI Council began with a literature search related to the development of a competency validation program. Four articles were retrieved and evaluated with the assistance of a doctoral-prepared nurse researcher employed by the organization to facilitate evidence-based practice and research projects. Jankouskas and colleagues (2008) described a successful process for development of skill competencies. The council used this article in preparation of the fair. Additionally, the council determined that the style of a fair for education and skill validation would be most conducive to the needs of the Primary Care Department. The relaxed atmosphere of a "fair" setting decreases anxiety adult learners may experience during testing and skill demonstration (Ford, 1992). Finally, with concerns among health care professionals of the need to demonstrate nursing skill competency in relation to the provision of quality of care and consumer protection (Minarik, 2005), the council believed this was a meaningful project. The program would establish a baseline competency validation of skills performed in Primary Care by clinical staff. It could then be refined to address the evolving learning needs of the department.

Plan

Since sufficient evidence was found in the literature to support the development and implementation of a skills fair to validate staff competency in performing specific procedures, the council decided to progress with the project. The Plan, Do, Study, Act (PDSA) model was used to develop the skills fair with the goal of validating competence of skill performance in 100% of clinical staff in Primary Care. The initial step in the PDSA was the formation of a team to create and implement the skill competency validation program. The team's core was the Primary Care QI Council. Based on the competencies selected for validation, other specialties were invited to participate in selected skill stations, including Employee Health and Laboratory Science.

Table 1.

Skills Identified for Primary Care Clinical Staff Competency Validation

1.	Calling the rapid response team (parameters and process for calling for a critically ill patient)
2.	Ear irrigation
3.	ECG performance (focused on lead placement and rationale)
4.	Glucometer testing
5.	Handheld nebulizer administration
6.	Intramuscular and subcutaneous injections
7.	RN assessment tool (algorithm for thorough/complete documentation of assessments)
8.	Tuberculin skin test administration and interpretation
9.	Bladder ultrasound
10.	Blood pressure measurement
11.	Clean catch urine specimen collection
12.	Indwelling catheter insertion, care and urine specimen collection
13.	Phlebotomy
14.	Postural vital signs measurement
15.	Visual acuity

Council members identified 15 skills specific to the Primary Care clinics (see Table 1). Prioritization of skills was determined through discussions with managers and physicians, peer interviewing, and direct observation of skills performed. Examples included improperly placed ECG leads, incorrect oxygen flow rate used in hand held nebulizer administration, incomplete documentation of telephone assessments, and intramuscular injections into sites not approved by policy.

Due to the small size and composition of the council, they were limited in their ability to implement the education and validation for all 15 identified skills at one fair. The council also felt it may be too overwhelming to present all of the skills at once. Therefore, it was determined the skills fair would be split into two "phases." Phase one would consist of the most frequently performed skills or those determined to be of higher risk and with observed variability. These included skills 1-8 in Table 1. The remaining skills, 9-15 (see Table 1), were planned for implementation in Phase Two. Individuals in each clinical role would be required to complete the skill competencies within the scope of their practice.

The Primary Care QI Council's goal was to have the fair developed within six months from the initiation of the idea. The project began in April with the intent of having the education completed in October. The Primary Care Department does not have a nurse educator or other education support personnel; therefore, council members created the educational presentations and skill competency validation methods for the program. The hospital's evidence-based policies, the approved online procedure book, and evidence from the literature review were used to

develop learning objectives, educational and skill content, and return demonstration or test.

The council attempted to accommodate multiple styles of learning to best convey the educational content and skill demonstration (Jankouskas et al., 2008; Sprenger, 2008). Each skill was presented at an individual station and included a poster presentation (visual learning style), live presenters at each station (audio learning style), and if applicable, simulation or actual return demonstration of the skill being taught (hands-on learning style). The council created dynamic and engaging educational posters by referencing an evidence-based presentation on poster development that was held at their facility.

The council developed the method by which each skill would be evaluated. This was based on the information being taught and how best to have the learner demonstrate competency or retain this knowledge. Validation methods included a passing score of 85% or higher on a written test and return demonstration of the skill (if applicable to content). Printed handouts were given to the learner for future reference to reinforce education. All clinical staff were required to attend and successfully complete all skills.

Implementation (Do)

To meet the mandatory attendance requirement, multiple fairs were held to accommodate any potential schedule conflicts staff members may have. Five separate skills fairs were hosted, one for each of the five clinics to coincide with their protected time (non-patient care time allotted once monthly for educational purposes). The fairs were held over six weeks. Four fairs were held in an education/conference room in the hospital. The fifth fair was conducted at the off-site clinic. A two-hour time period was allotted to complete the fair, allowing the participants an average of 15 minutes at each skill station. Staff were able to complete the education and competencies at their own pace.

Upon arriving at the fair, participants received a skill validation checklist and a post-fair evaluation form. The validation checklist became part of the employee's personnel record. This form listed each of the skills, the method of validation, and the printed name, initials, and signature of the presenter. To obtain a validation signature from each skill station's instructor, staff had to successfully complete the educational content, test, or return demonstration. Additionally, staff were instructed to anonymously complete an evaluation form after all requirements were met and leave it in the classroom for review by the council.

Outcomes (Study)

All 56 clinical staff (100%) participated, and all participants achieved 100% skill competency validation, meeting the PDSA goal. Data were summarized from the post-fair evaluation forms of the 48 participants who completed at least part of the form. All evaluations were positive and reflected the efforts put into the different educational methods (see Table 2).

Table 2.

Evaluations from Participants in the Skills Fair (*N* = 48 Respondents)

Question	Response (%)
1. Information was applicable.	100
2. Learned something new to utilize in my practice.	98
3. Materials were easy to understand.	100
4. Adequate time was allowed.	98

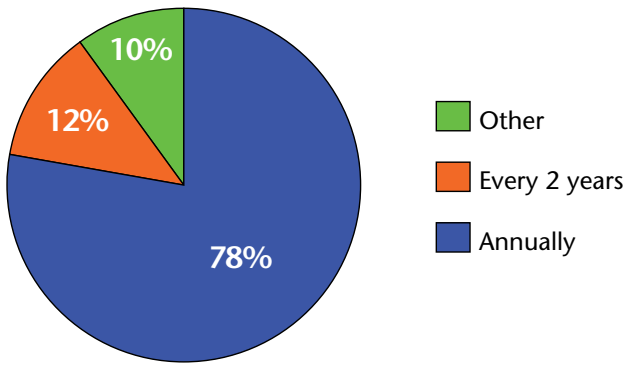
Recommendations (Act)

The skills fair for Primary Care clinical staff was successful in meeting the aim of 100% skill competency. Having protected education time in the clinics was critical to its success. The positive feedback from participants provides additional evidence this is an effective means for validation of skills. Some questions were asked to gather feedback about staff members' self-assessment of their learning needs. One question addressed their desired frequency for a skills fair (see Figure 1). The majority of participant feedback supported an annual fair for education and skill competency. This result was also supported by administration and will allow the council to address all skills on a more frequent basis. Future fairs will address validation of skills (numbers 9 to 15 in Table 1), as well as those identified by participants in their evaluation recommendations, such as wound care, dressing changes, and intravenous catheter insertion and care. Based on this experience and participant recommendations, future skills fairs will be in a larger, cooler room, and have more presenters assisting at certain stations. Stations identified as needing additional presenters were those requiring return demonstration of skills in addition to content, such as tuberculin skin test and ECG lead placement.

The skills fair took nine months to complete, from initial idea to the final fair, exceeding the original goal of six months. One barrier to achieving a six-month goal was the

Figure 1.

Participant Preferences for Frequency of a Skills Fair



lack of available time away from direct patient care for the staff on the council. Council members were not always able to attend every meeting due to scheduled patient care during these time periods. It was also difficult for the majority of staff to allot time specifically for the development of the education presentations. Despite having protected time, many of those periods contain pre-scheduled training programs and presentations, which council members are required to attend. The organization has since approved designated time away from assigned duties for all shared governance council members and leaders to support their activities at the unit level. Council chairpersons and members now receive on a monthly basis eight and four hours, respectively, of non-direct care time for shared governance activities.

The assistance of a doctoral-prepared nurse was beneficial in evaluating the literature. However, if an organization does not have this type of resource, other masters-prepared nurses (such as clinical nurse specialists, clinical nurse leaders, nurse educators, or faculty) may be available to staff as consultants in appraising the literature and applying evidence to implement a program. Additionally, for future skills fairs or other educational events, it may be beneficial to have a graduate-level nurse educator review materials or assist with program evaluation. Of note, the organization has instituted a formal staff competency validation that verifies performance during patient care. A skills fair is a stepping-stone to actual performance validation, as it can be an effective tool for providing the necessary education and practice to be able to apply knowledge and skill to a real environment.

The QI Council will invite the Primary Care Education Council to partner in presenting future fairs because the goal of the skills fair is within the scope of the Nursing Shared Governance Education Council. The Education Council will be able to align the fair with staff development goals, and the QI Council will then focus on initiating additional quality improvement projects.

Conclusion

The use of a skills fair as an educational method was well received by colleagues. Collaboration with staff in other specialties having the required expertise proved to be an effective utilization of resources; for example, the employee health nurse assisted with the tuberculin skin test station. The initial fair was a positive learning experience for the council as planners and teachers. Future fairs will require significantly less preparation time because of council members' acquired knowledge and skill in this process. The educational plans and materials are already in place, so minimal time would be required to review and update the material with any changes in policy or best practice. This process has become a reality, with the Phase Two skills fair being held at the time of this writing. This second fair took six months from the council's decision to the last fair, a marked decrease in time commitment. The addition of scheduled non-patient care time was essential for members of the council to complete their competency education materials in a much shorter period of time.

The types of skills held at future fairs will be evaluated on an annual basis by the council, which will continue to gather data from participants, managers, and clinic staff. Potential problem prone areas that could be addressed in future competencies may be identified from quality reports, such as laboratory data, patient satisfaction surveys, or from observation of daily work, to determine the current learning needs of the department and identify opportunities for future fairs or other educational programs.

In summary, the QI Council for Primary Care was able to develop an effective program for skill competency validation. In doing this, the Primary Care Department is compliant with organizational policy for competency standards, as well as The Joint Commission and AAACN standards for competency.

References

American Academy of Ambulatory Care Nursing (AAACN). (2010). *Scope and standards of practice for professional ambulatory care nursing* (8th ed.). Pitman, NJ: Author.

American Nurses Association (ANA). (2010). *Nursing: Scope and standards of practice* (2nd ed.). Silver Spring, MD: Author.

Ford, L., Wickham, V., & Colver, C. (1992). Developing a skills fair workshop: enhancing competency performance. *Dimensions of Critical Care Nursing, 11*(6) 340-346.

Jankouskas, T., Dugan, R., Fisher, T., Freeman, K., Marconi, S., Miller, H., …Zoller, D. (2008). Annual competencies through self-governance and evidence-based learning. *Journal for Nurses in Staff Development, 24*(4), E9-E12.

Joint Commission, The. (2013). *Comprehensive accreditation manuals* [E-dition v5.1.0.0. Ambulatory Care: LD.03.06.01]. Oakbrook Terrace, IL: Author.

Minarik, P. (2005). Issue: Competence assessment and competency assurance of healthcare professionals. *Clinical Nurse Specialist, 19*(4), 180-183.

Sprenger, M. (2008). In: *Differentiation through learning styles and memory* (2nd ed., pp. 1-48). Thousand Oaks, CA: Corwin Press.

U.S. Department of Veterans Affairs, Veterans Health Administration, & VA Great Lakes Health Care System. (2012). *VISN policy memorandum 10N12-00-07 (rev 5): Assessment of employee competence.* Chicago, IL: Author.

Rebecca S. Bennett, BSN, RN-BC, *is a Staff RN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Stacy A. Olson, BSN, RN-BC, *is a Staff RN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Courtney E. Wilson, BSN, RN-BC, *is a Staff RN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Mary Lee Barrett, BSN, RN, *is a Staff RN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Angela Pereira, RN, *is a Staff RN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Michael S. Janczy, LPN, *is a Staff LPN, at Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Lou Yang, LPN, *is a Staff LPN, Clement J. Zablocki VA Medical Center, Milwaukee, WI.*

Authors' Note: *No funding was received for this project. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the U.S. government.*

Acknowledgement: *Appreciation is extended to Mary Hagle, PhD, RN, WCC, Nurse Scientist at Clement J. Zablocki VA Medical Center for her encouragement and assistance.*

Plan Ahead for AAACN

May 19-22, 2014

Now is the time to plan ahead for the upcoming 2014 AAACN Annual Conference! Here's a quick peak into what is being planned for you for the conference.

The pre-conference is scheduled for Monday, May 19, 2014 entitled, "Best Practices in Caring: Creating Positive Presence and Peace in Nursing". The pre-conference will be led by co-presenters Barb Pacca, BSN, RN, CPN, HTP, Children's Hospital of Philadelphia along with Mary Laffey Adams, MSN, RN, St. Louis Children's Hospital. The presentation will address the concepts of mindfulness, nursing presence and the nurse as an instrument of healing along with evidence based effects of mindfulness on the mind, body, and spirit.

After the opening address by Susan Paschke, MSN, RN-BC, NEA-BC, President, our keynote speaker, Donna Wright, MS, RN, will follow with an engaging discussion to keep our spirits high and our enthusiasm peaked for the speakers to come. Donna is a consultant with Creative Healthcare Management. She has spoken to national and international nursing audiences on the topics of relationship based care, Nursing Magnet© certification, leadership, and competency assessment.

Stay tuned for more updates of the upcoming conference in future issues of *ViewPoint!*

Carol Ann Attwood
Member, Program Planning Committee

President's Message

continued from page 2

care business in an effort to substantiate their value and benefit to our membership.

The final day of the meeting was spent reviewing and updating the AAACN Strategic Plan. The plan has served us well over the past three years in providing direction and guidance for our organization. Board members were energized by the "core business discussion" that served to validate our strategic plan as a good roadmap for the future! We believe AAACN is well-positioned to continue to serve our members, expand our influence, and strengthen our core given the challenges ahead. These are exciting times for our organization and for all of our members! Many opportunities exist for increasing your involvement – find one that is a good fit and go for it!

Susan M. Paschke, MSN, RN-BC, NEA-BC, *is Chief Quality Officer, Visiting Nurse Association of Ohio, Cleveland, OH. She may be contacted at spaschke@vnaohio.org*

Interested in Writing For *ViewPoint*?

Consider sharing your ambulatory care or telehealth nursing expertise by writing an article for *ViewPoint!* Download author guidelines, copy deadlines, and tips for authors at www.aaacn.org/viewpoint

aacn Corporate Members

eHealth Technologies
140 Allens Creek Road, Rochester, NY 14618
www.ehealthtechnologies.com

LVM Systems, Inc.
4262 E. Florian Avenue, Mesa, AZ 85206
www.lvmsystems.com

aacn Corporate Affiliate

48 Franklin Street, Framingham, MA 01702
www.nightnursetriage.com

Night Nurse has delivered reliable telephone triage services to the pediatric medical community since 1999. Patients receive the highest standard of timely triage from experienced RNs and NPs averaging 18 years of pediatric clinical experience. Advanced systems and cost efficient operations support the competency of our nurse professionals, resulting in affordable, quality triage services for growing numbers of Night Nurse subscribers and their patients.

Corporate members and affiliates receive recognition in *ViewPoint*, on AAACN's Web site, and in various conference-related publications, as well as priority booth placement at AAACN's Annual Conference. For more information about Corporate Member or Affiliate benefits and fees, please contact Marketing Director Tom Greene at tom.greene@ajj.com or 856-256-2367.

Opportunities for the Uninsured to Access Affordable Health Insurance and Care

There continues to be marked confusion about the status of the Affordable Care Act (ACA) that was passed in 2010. The Republicans in the U.S. Congress have tried to repeal the ACA more than 40 times, and their efforts have been unsuccessful. Staunch conservatives have ramped up pressure on Republicans in Congress and the Senate to make efforts to repeal the ACA before its major provisions go into effect in 2014. The results of so many ACA repeal sound bites have many Americans thinking the ACA has been repealed, and consequently, some may not have been using or seeking benefits, such as private insurance through state insurance exchanges. Some say conservatives are highly concerned that the ACA will be successful providing health care access and in cutting costs, thereby creating satisfaction with the ACA among voters. This could be a major issue in the 2016 presidential campaign. The Obama Administration has begun to do public service announcements and Webcasts to enhance Americans' understanding of what the benefits of the ACA are and how they can obtain them. Many are concerned that these efforts are too little and coming too late in the game.

Ambulatory care nurses and other providers in ambulatory care settings need to be conversant on both ACA benefits and how to access and use the state-based insurance exchanges. Private foundations, such as the Kaiser Family Foundation (KFF), have designed their Web sites for ease of use and provide many up-to-date issue briefs, slide sets, videos, and analyses that will be summarized in this column. The KFF document "An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014" (Cox, Claxton, Levitt, & Khosla, 2013) provides insurance information and tables that spell out actual costs and cost savings for persons with low incomes.

The ACA provisions provide the opportunity for individuals and families to purchase private insurance coverage through new state-based exchanges, also called "Marketplaces," which opened in October 2013 and offer coverage beginning January 1, 2014. Some states have opted not to set up their own exchanges, and in these states, the federal government will either run the exchange or work in partnership with the state to create an exchange. "Regardless of whether an exchange is state-run or federally facilitated, enrollees with family incomes from one to four times the federal poverty level (about $24,000 to $94,000 for a family of four) may qualify for tax credits that will lower the cost of coverage through reduced premiums, and in some cases, also be eligible for subsidies to reduce their out-of-pocket costs" (Cox et al., 2013, p. 1). The KFF report looks at insurer participation and exchange premiums – both before and after tax credits – for enrollees in 17 states plus the District of Columbia that have released data on rates or the rate filings submitted by insurers (Cox et al., 2013). Of those presented, 11 states operate their own exchanges, and seven have a federally facilitated exchange.

In January 2014, the ACA will provide three major benefits: private insurance at affordable prices, a ban on annual limits for coverage, and coverage for those with pre-existing conditions. Plans offered in the state exchanges, as well as insurance coverage sold to individual and small businesses outside the exchanges, must meet several new regulatory requirements (Fernandez/Congressional Research Service, 2011). The ACA provisions state that insurers must cover a minimum set of services called "essential health benefits." At a minimum, essential health benefits "must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services (including oral and vision care)" (Fernandez/Congressional Research Service, 2011, p. 2). Further, insurance carriers must organize plan offerings into five levels of patient cost sharing (catastrophic, bronze, silver, gold, and platinum, ranging from least to most protective). Insurers will only be able to vary premiums by age (to a limited extent), tobacco status, geographic region, and family size (Cox et al., 2013).

The KFF (Cox et al., 2013) explains considerations that impact cost of an insurance premium and offers examples of typical premiums. Bronze plans cover 60% of health care costs when averaged across all enrollees, have the most cost sharing, and therefore, represent the lowest level of coverage available through exchanges. Consequently, bronze plans typically have the lowest premiums; they vary significantly across geographical areas and by age but are also significantly reduced by subsidies for low-income populations. Catastrophic plans will be sold on the state exchanges, but will only be available to people who are under 30 years of age or would have to spend more than 8% of their household income on a bronze plan (Cox et al., 2013).

What impact will state insurance exchanges have on premiums for individuals and families who do not quality for subsidies? A recent *New York Times* article highlights, "State insurance regulators say they have approved rates for 2014 that are at least 50% lower on average than those currently available in New York. Beginning in October, individuals in New York City who now pay $1,000 a month or more for coverage will be able to shop for health insurance for as little as $308 monthly. With federal subsidies, the cost will be even lower" (Rabin & Abelson, 2013).

continued on page 14

health bytes

- Tobacco use still remains the number-one cause of preventable disease in the United States, with one out of five Americans currently using tobacco products. The third Thursday in November was the Great American Smokeout sponsored by the American Cancer Society. However, the decision to quit smoking does not have to be limited to one day. For a full set of resources, including table tents, posters, or other supplies, to share with your patients, visit http://www.cancer.org/healthy/stayawayfromtobacco/greatamericansmokeout/toolsandresources/index

- Pre-diabetes is becoming epidemic in all age groups. For additional information on diabetes risk factors, screenings, and weight loss and dietary suggestions, refer to materials from the National Diabetes Prevention Center (in both English and Spanish) at http://diabetes.niddk.nih.gov/dm/pubs/prediabetes_ES/Pre_Diabetes_EN_SP_508.pdf

- Alzheimer's disease and other dementias are often called "the forgetting disease." When family members need extra support on how to cope with the family member who has dementia, direct them to the Alzheimer's Association Web site (http://www.alz.org/apps/findus.asp) to find local support groups.

- Gastroesophageal reflux disease (GERD) can cause symptoms of burning, irritation and heartburn. To help to explain the symptoms and treatment for GERD, refer your patients to the MedlinePlus tutorial they can watch online (http://www.nlm.nih.gov/medlineplus/tutorials/gerd/htm/index.htm).

***Carol Ann Attwood, MLS, AHIP, MPH, RN,C**, is a Medical Librarian, Patient Health and Education Library, Mayo Clinic Arizona, Scottsdale, AZ. She can be contacted at attwood.carol@mayo.edu*

member spotlight

Charlene Morris

Charlene Morris, MSN/ED, RN, is the Coordinator for Supplemental Staffing at Virginia Commonwealth University Health Systems in Richmond, Virginia, and supports over 70 ambulatory care practices. She trains and supervises staff to ensure that competent and skilled nurses provide excellent care to patients and families in their various complex clinics.

As a new AAACN member this year, Charlene has realized that the strength of AAACN is its knack for developing leaders while maintaining ongoing support of their delivery care model in ambulatory care. AAACN and its leaders strongly embrace nurse empowerment and autonomy through its values. She is scheduled to take the ambulatory care certification exam shortly, and has been reviewing the *Core Curriculum for Ambulatory Care Nursing* and the *Scope and Standards of Practice for Professional Ambulatory Care Nursing* – these have been resources for practice and her upcoming certification.

According to Charlene, what she likes most about working in ambulatory care is "living the important transitions of cultural diversity and partnerships between the nurses, family, community, and health care providers to ensure that the best and most accessible care is provided."

Her job satisfaction is stimulated by the positive feedback from patients, families, and research that provides evidence-based support to bring about change and better outcomes. This positive feedback also enhances staff satisfaction with their peers and colleagues.

Charlene's biggest challenge as a nurse is staffing her organization's complex, high-volume clinics. She is responsible for finding the right staff mix to achieve effective outcomes while supporting their multidisciplinary teams. Selecting the proper staff mix requires assurance of competency and training. She is also challenged to create the best staffing plan that helps to reduce nurse burn out and dissatisfaction in the workplace.

On a personal note, Charlene enjoys spending time with her 16-year-old son, family, and community. She enjoys reading, watching her son play basketball, and participating in community outreach. Her future plans are to begin teaching in spring 2014 as a nursing instructor at a community college. Teaching full-time and working as a legal nurse consultant is her ultimate goal as she continues to grow and learn in her current leadership role.

Deborah A. Smith, DNP, RN, *is an Associate Professor, Georgia Regents University (formerly Georgia Health Sciences University), College of Nursing, Augusta, GA, and Editor of the "Member Spotlight" column. She can be contacted at dsmith5@gru.edu*

Health Care Reform

continued from page 12

There are several other resources available on Web sites. The U.S. Department of Health and Human Services (DHHS) (2013) offers on its Web site the opportunity to click on a state to learn about current insurance statistics and benefits available. KFF (n.d.) offers a subsidy calculator that can assist patients with determining what level of subsidy they may qualify for when purchasing health insurance at a state insurance exchange. The National Association of Insurance Commissioners (2010) offers on its Web site an excellent set of frequently asked questions (FAQs) by consumers and employers with very concise answers. This FAQ site can be used as a resource to inform providers and be shared with patients and families. Ambulatory care nurses are only too aware of the need for reasonably priced health insurance for patients and families. The United States finally has an Act, the ACA, that offers the opportunity for access to health insurance and health care, but we must do much more to spread the word and assist patients and families with this new opportunity.

Sheila Haas, PhD, RN, FAAN, *is a Professor, Niehoff School of Nursing, Loyola University of Chicago, Chicago, IL. She can be contacted at shaas@luc.edu*

References

Cox, C., Claxton, G., Levitt, L., & Khosla, A. (2013). *An early look at premiums and insurer participation in health insurance marketplaces.* Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2013/09/early-look-at-premiums-and-participation-in-marketplaces.pdf

Fernandez/Congressional Research Service. (2011, January 3). *Grandfathered health plans under the Patient Protection and Affordable Care Act (PPACA).* Retrieved from http://assets.opencrs.com/rpts/R41166_20110103.pdf

Kaiser Family Foundation (KFF). (n.d.). *Subsidy calculator: Premium assistance for coverage in exchanges.* Retrieved from http://kff.org/interactive/subsidy-calculator

National Association of Insurance Commissioners. (2010). *Health care reform frequently asked questions (FAQ).* Retrieved from http://www.naic.org/index_health_reform_faq.htm

Rabin, R.C., & Abelson, R. (2013, July 16). Health plan cost for New Yorkers set to fall 50%. *New York Times.* Retrieved from http://www.nytimes.com/2013/07/17/health/health-plan-cost-for-new-yorkers-set-to-fall-50.html

U.S. Department of Health and Human Services (DHHS). (2013). *How the health care law is making a difference for the people of Illinois.* Retrieved from http://www.hhs.gov/healthcare/facts/bystate/il.html

safety corner

Providing health care is a complex process involving the patient, his or her family, and a team of health care professionals. Although everyone strives to provide safe, high-quality care, the best intentions can often fall short of this goal. It is not a matter of "if" you will commit a medication error, misdirect a lab report that delays appropriate treatment, or fail to intervene before an at-risk patient falls and suffers injury. It is a matter of "when" it will happen to you.

Nearly a decade ago, nurses were recognized as an integral component of maintaining a safe patient care environment within health care organizations (Institute of Medicine, 2004). Unless aligned to large organizations that designate staff and resources to monitor and report safety issues, ambulatory care nurses may feel they are "on their own" to promote safety. While recognizing the need to share safer care initiatives with a wider audience than their own setting, the time or perceived expertise required to publish a full article may seem overwhelming.

ViewPoint is initiating a designated column to address targeted safety topics called "Safety Corner." The column will be limited to 1,000 words (about 2 pages when published). Evidence-based strategies that you use to address actual or near-miss events should be the focus. Keep it simple as you describe the safety topic you are passionate about sharing. Please include who, what, when, where, and why this is applicable to ambulatory, as well as how to monitor effectiveness of the initiative.

For our official "Submission Tips," check out the *ViewPoint* page on the AAACN Web site (www.aaacn.org/viewpoint). Share your questions, ideas, or submissions with Sarah Muegge, MSN, RN, at Sarah.Muegge@coxhealth.com

Reference

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Washington, DC: National Academy Press. Retrieved from http://www.iom.edu/Reports/2003/Keeping-Patients-Safe-Transforming-the-Work-Environment-of-Nurses.aspx

Sarah Muegge, MSN, RN, *is an Instructor, Regional Services, CoxHealth, Springfield, MO, and a member of the ViewPoint Manuscript Review Panel. She can be contacted via email at sarah.muegge@coxhealth.com*

Telehealth Trials & Triumphs

continued from page 3

situation like yours often find it helpful to…" This normalizes the situation somewhat, so that the woman knows she is not the only person to experience domestic violence, and that help is available. It is important to not divulge details of your own experience because this is a professional setting, and your job is to offer validation and resources.

Guiding Your Caller to Help

As you assess patients throughout your workday, listen for the question behind the question the caller may be asking you. Remember that while abuse may be clear to you, the victim is often slow to identify it or admit it. The path to recognition of abuse is often long and winding for the victim. However, if we recognize it, we must be prepared to offer emotional support and resource options. We may not be able to rescue victims of domestic violence, but we can make every attempt by directing them to avenues of support, which may lead to escape from the situation.

References

Centers for Disease Control and Prevention (CDC). (2013). *Intimate partner violence.* Retrieved from http://www.cdc.gov/violenceprevention/intimatepartnerviolence

Minsky-Kelly, D., Hamberger, L.K., Pape, D.A., & Wolff, M. (2005). We've had training, now what? Qualitative analysis of barriers to domestic violence screening and referral in a health care setting. *Journal of Interpersonal Violence, 20*(10), 1288-1309.

National Coalition Against Domestic Violence (NCADV). (2007). Domestic violence facts. Retrieved from http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf

Kathleen Swanson, BSN, RN, *is Adjunct Faculty in a practical nursing program. She is currently enrolled in the Doctor of Nursing Program at the University of Minnesota in the specialty of Health Innovation and Leadership. She has personal experience as a victim of domestic violence.*

American Academy of Ambulatory Care Nursing
Many settings. Multiple roles. One unifying specialty.

East Holly Avenue, Box 56
Pitman, NJ 08071-0056

CHANGE SERVICE REQUESTED

Presorted Standard
U.S. Postage
PAID
Deptford, NJ
Permit #142

Volume 35, Number 6

ViewPoint
The Voice of Ambulatory Care Nursing

ViewPoint **is published by the American Academy of Ambulatory Care Nursing (AAACN)**

AJJ-1013-V-17C

AAACN is a welcoming, unifying community for registered nurses in all ambulatory care settings. Our mission is to advance the art and science of ambulatory care nursing.

Members Testify in Massachusetts in Favor Of the Nurse Licensure Compact

Through AAACN's affiliation with the National Council State Boards of Nursing (NCSBN) Nurse Licensure Compact Coalition, members Kathleen Damian, RN, and Tami Regan, RN, CHT, testified at the Massachusetts State House on October 29 in favor of the Nurse Licensure Compact (NLC). Representatives from the Massachusetts Hospital Association, Lahey Hospital and Medical Center, Cambride Health Alliance, and Organization of Nurse Leaders (MA and RI) also gave strong and compelling testimony in favor of the compact. The National Military Families Association sent a letter to each member of the Joint Committee supporting the NLC legislation. Opposing testimony came from the President of the Massachusetts Nurses Association.

Kathleen said, "It was a wonderful opportunity to educate our legislators about the actual nuts and bolts of caring for patients telephonically and the Massachusetts regulation governing nursing practice using telecommunications technology."

A vote was not taken at the hearing. Next steps for the legislation will be announced in the future. AAACN has urged our MA telehealth nurse members to contact members of the Joint Committee on Public Health to tell them why the NLC legislation is important to them.

Stuart Pologe, COO, Night Nurse, and AAACN member Tami Regan