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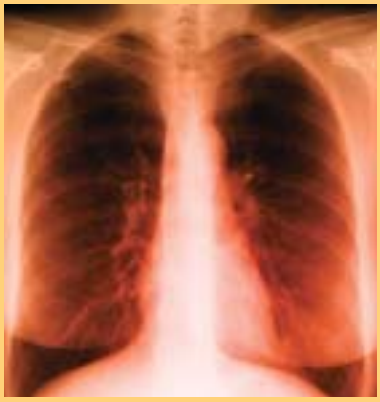
aacn ViewPoint
The Voice of Ambulatory Care Nursing

Managing Asthma

The disease is on the rise. Accurate assessment and patient education are key to successful treatment.



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In 1998, there were approximately 14 million outpatient visits for asthma to private physician offices and outpatient departments; 2 million visits to emergency departments; and about 500,000 asthma-related hospitalizations (Centers for Disease Control, 2000-2001). According to the U.S. Department of Health and Human Services (DHHS), asthma incidence has increased steadily in recent years and now affects 15 million Americans. Each year, the disease causes 4,500 deaths (DHHS, 2003).

Nurses and other members of the health care team have a role in caring for the patient with asthma. This article will explore the role of the ambulatory care nurse as well as effective treatments, resources, and barriers to care.

Patient Care

The 1991 National Institutes for Health (NIH) National Heart, Lung, and Blood Institute (NHLBI) Expert Panel Report, *Guidelines for the Diagnosis and Management of Asthma*, identified four components of effective asthma management:

1. Use of spirometry to assess the severity of asthma and to monitor the course of therapy
2. Environmental control measures to avoid or eliminate factors that precipitate asth-

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Inside

From the PRESIDENT

Reader Services

AAACN Viewpoint
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American Academy of Ambulatory Care Nursing

Real Nurses. Real Issues. Real Solutions.

Looking to the Future

Catherine J. Futch

As we move into 2004, I hope for each of you that the new year is filled with peace, love, prosperity, and the fulfillment of long-held dreams.

The year holds much promise for AAACN. On January 28, we launched another new feature for our members: our first Audio Conference. The first presentation was "Linking Performance and Staffing (or How To Prove Your Intuition is Right)." Karen Griffin, MSN, RN, CNAA, Associate Chief, Nursing Services and Suzette Anderson, MSN, RN, Nursing Quality Improvement Coordinator, both employed by South Texas VA Health Care System, served as faculty for this outstanding presentation.

Participants dialed in from their homes and work sites to join the conference (so conveniently!) while at the same time receiving 1.5 contact hours. Participants received valuable information about nursing report cards, solutions for achieving appropriate staffing levels that management will accept, and how to link performance to staffing. If you missed the audioconference, you can order it on CD-Rom at www.aaacn.org (click on "Store.")

The Audio Conferences are another step in our efforts to be responsive to the changing needs of our members. There will be more in the future as AAACN provides you with ongoing education that is affordable and easily accessible. Please e-mail us at aaacn@ajj.com to provide feedback and ideas.

Alliance Meeting

AAACN will be involved in another initiative to help transform the patient care experience. In November 2003, AAACN Executive Director Cyndee Nowicki, AAACN President-Elect Kathy Krone, and I attended the Nursing Organizations Alliance (The Alliance) meeting in Anaheim, CA. This was the Second Fall Summit for The Alliance. You may recall that AAACN is one of the founding members of this organization, which now includes 62 professional nursing organizations. The mission of The Alliance is to represent the interests of its members through communication, collaboration, education, and advocacy. It strengthens and supports the work of individual groups and the nursing profession.

Pam Thomson, Executive Director, American Organization of Nurse Executives (AONE), presented the AONE Nursing Workforce Model as one approach to meeting the workforce challenges facing all of us now and into the foreseeable future.

AONE has identified three major challenges that must be addressed by the profession. The challenges include:

- Financial incentives for health care that are misaligned and have led to a 'broken system.'

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Congress Mulls Landmark Bills

Several measures will directly affect nurses. Now is the time to act.

NURSES & Legislation
A Special Series

Part Four

Regina C. Phillips, MSN, RN

In January 2004, the 108th Congress convened for its second session. Slated for final approval are several legislative proposals that have important implications for nurses and the profession.

This final installment of the *Nurses & Legislation* series will explore these bills and describe how such measures call for action from the nursing community.

Series Recap

Viewpoint presented the *Nurses & Legislation* series to spark nurses' interest in the legislative process, demonstrate the importance of our collective voice, explain what nurses need to know about the legislative process and why this knowledge is important, and teach them how to get involved. For those of you who may have missed the previous installments, these are the topics we covered:

- Part One (May/June 2003, pp. 3-4): Nurses' crucial role in influencing health care policy, taking into consideration our expertise, knowledge, respect from the public, and strength in numbers.
- Part Two (July August 2003, pp. 6-7): The legislative process: tracking how a bill becomes law, including identifying key points in the process where nurses and citizens can exert the greatest influence into the success or failure of a law.
- Part Three (November/December 2003, pp. 6-7): Lobbying legislators: what lobbying is and how to do it effectively.

(Contact AAACN if you would like to obtain copies. See back cover for contact information.)

Pending Bills

The American Nurses Association (ANA) Web site (www.nursingworld.org/gova/) has identified the following topics as needing nursing action:

- A proposed $30 million increase for Nursing Workforce Development
- The amendment protecting overtime pay removed from funding bill
- The Registered Nurse Staffing Act of 2003
- A Medicare bill passed by Congress and opposed by ANA

The Details

Increase in Workforce Development Funds

The House and Senate negotiators released a summary of their conference agreement on the FY 2004 Omnibus Appropriation Act in November 2003. The House approved the bill on December 8, 2003, however the Senate failed to approve the bill before adjourning and this approval is needed to finalize the increase. The conference agreement includes a $30 million increase in the FY 2004 funding for nurse education, recruitment and retention programs, and includes the new programs authorized by the Nurse Reinvestment Act.

The funding boost would represent a major victory for nursing workforce development and is a testament to the persuasive force of all of the states' nurses associations and individual nurses who contacted their representatives in Congress to support increased funding for nursing (McKeon, 2003). Until both chambers act, the federal agencies will continue to operate under the FY 2003 funding levels.

It is imperative that nurses continue contacting their Senators to urge support and passage of the proposed increase in FY 2004. For more information on this proposed legislation visit www.nursingworld.org/update and vocusgr.vocus.com/grconvert1/webpub/ana/profileissue.asp?issue id=3529.

Overtime Pay Amendment

The next topic affecting nurses is the Amendment Protecting Overtime Pay that included language protecting eligibility for overtime pay for nurses and other workers. The White House and lawmakers removed the amendment from the FY 2004 Labor, Health and Human Services spending bill (LHHS) (H.R.2660) that would have protected nurses and other workers from proposed new U.S. Department of Labor (DOL) regulations that would strip many of their eligibility for overtime pay. Once again the House approved the measure but the Senate failed to consider the bill before adjourning.*

ANA recently applauded the efforts of Senators Tom Harkin (D-IA) and Arlen Specter (R-PA) for their leadership on this issue (Donnellan, 2003). For more information on this proposed legislation visit the following Web sites, www.nursingworld.org/update and www.thomas.loc.gov.

**At press time, the Senate stopped this bill. Nurses now need to put pressure on President Bush not to block overtime pay when he signs the 2004 budget. Keep checking the Web sites listed above regarding the status of this important measure.*

‘Nurses’ powerful voice comes from their expertise, unity, and the public’s trust.’

Registered Nurse Staffing Act

ANA is encouraging nurses to ask their Senators to co-sponsor S. 991, the Registered Nurse Safe Staffing Act of 2003. S. 991 would require the development of staffing systems with the input of direct care registered nurses (RNs) and provides for whistle blower protection for RNs who speak out about patient care issues. A complimentary bill, The Quality Nursing Act of 2004 (H.R.3656) was introduced in the House December 8, 2003 by U.S. Represent-ative Lois Capps (D-CA). More information is available at the ANA Web site www.nursing world.org/gova and http://vocusgr.vocus.com/grconvert1/webpub/ana/profileissue.asp?issueid-3117.

ANA-Opposed Medicare Bill

Last but not least, Congress recently passed a bill that would enact the largest changes to the Medicare program since its inception. The Medicare Prescription Drug and Modernization Act of 2003 (H.R.1) was recently signed into law. ANA announced opposition to the bill during a recent press conference attended by House Minority Whip Steny Hoyer (D-MD), Representative Lois Capps, RN (D-CA), Carolyn McCarthy, LPN (D-NY), and Marion Berry (D-AR).

At the press conference, ANA CEO Linda Stierle explained that “ANA believes that Medicare must remain a broad-based, reliable, social-insurance program that is available to all eligible individuals regardless of income. Unfortunately, the conference agreement fails to uphold these basic principles and places the very promise of Medicare in jeopardy.”

The entire ANA statement can be viewed at www.capitolupdate.org/newsletter. Nurses are encouraged to explore this recent legislation and consider the impact it will have on senior patients and family members.

Conclusion

There is still time remaining for nurses to take action and potentially affect the pieces of legislation described above. It is important for all nurses to take time out of their busy schedules to familiarize themselves on policies that will change their lives and those of their patients and families.

Hopefully, this series on *Nurses & Legislation* has inspired AAACN members and other nurses to become involved in national policymaking, while providing tools and knowledge. For nurses who do get involved in the legislative process, the rewards are many and the results immeasurably valuable.

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Editor’s note: We’d like to hear your feedback on the *Nurses & Legislation* series. If you would like to share your thoughts, please e-mail Regina Phillips at rphillips1@humana.com.

Gallup Poll

Public Again Rates Nurses Most Honest, Ethical

Nurses once again scored the highest in an annual Gallup Poll of Americans rating the honesty and ethical standards of people in various professions.

Nurses topped the ranking of 23 professions in the November 14-16, 2003 poll, with 83% of respondents rating them “very high” or “high” for honesty and ethics, up from 79% last year. Doctors and veterinarians placed second at 68%, followed by pharmacists at 67%.

In 4 out of the 5 years nurses have been included in the poll, their profession has ranked the highest. The exception was in 2001, when firefighters scored higher following the terrorist attacks that fall.

The perceived honesty and ethical standards of medical doctors have been substantially higher in recent years than has been the case historically. The historical average from 1976 through 2003 stands at 56%. Doctors’ honesty ratings moved above the 60% level for the first time in 2000 and have remained high in each poll since.

The poll also found that a strong majority of Americans have positive opinions of dentists, college teachers, police, engineers, and the clergy. Lower ratings (between 20% and 38%) were given to psychiatrists, bankers, chiropractors, state governors, journalists, and senators.

“Nurses’ number one rating is a very special gift,” said AAACN President Catherine Futch, MN, RN, CNAA, CHE, CHC. “The gift comes from those who have received care to those who are entrusted with providing that care. The highest praise, the most believable praise, is praise that comes from people who have had direct experience with nurses and witness how they practice professionally.“

According to Futch, the key for the nursing profession is “to continue to take the steps necessary to maintain the public’s high esteem.”

Car salesmen scored lowest for honesty and ethics in the 2003 poll, followed by HMO managers. For more, go to http://www.gallup.com/.

Sources: American Hospital Association (AHA), 2003; The Gallup Organization/Gallup News Service, 2003.

Managing Symptoms at the End of Life

Sally Russell, MN, CMSRN

The following article is third in a series of reports on the End of Life Nursing Education Consortium (ELNEC), a far-ranging national project to educate nurses on end-of-life care.

In 1999, the American Association of Colleges of Nursing (AACN) and City of Hope National Medical Center combined efforts and launched the ELNEC program by training nursing continuing education providers. These providers were then tasked with integrating the latest information and resources about end-of-life care into continuing education activities for nurses. Sally Russell, AAACN's Education Director, attended ELNEC training programs last year and has been sharing the curriculum in this special Viewpoint series.

The ELNEC curriculum is supported by a grant from the Robert Wood Johnson Foundation to AACN and City of Hope.

Sally Russell

One of the nine modules included in the End of Life Nursing Education Consortium (ELNEC) curriculum focuses on symptom management and addresses symptoms other than pain that are common at the end of life. In addition, the module describes assessments and interventions that can prevent or diminish these symptoms.

A cornerstone of the module is the belief that nurses must work collaboratively with physicians and providers in other disciplines to manage symptoms effectively.

To provide the full range of patient care, it is common for nurses and physicians to work with physical therapists, respiratory therapists, social workers, pharmaceutical and/or IV providers, to mention only a few.

The task of coordinating these services often falls on the nurse, who must have the ability to support the family should they become overwhelmed with both the symptoms and the number of services necessary to alleviate those symptoms.

Common Symptoms

Dyspnea

Dyspnea is defined in *Mosby's Medical, Nursing, and Allied Health Dictionary* (2001) as "a shortness of breath or difficulty in breathing that may be caused by certain heart conditions, strenuous exercise, or anxiety" (p. 516). Other common diseases/disorders that may cause dyspnea are stroke, end stage renal disease, and lung cancer.

This symptom can be frightening to the patient and his/her family, as many people have described suffocation as the worst way to die.

Assessment of dyspnea is subjective because it is what the patient says it is. Assessment must include how dyspnea affects the ability to function, which factors improve or worsen the perception of dyspnea, the amount of pain associated with the experience, as well as lung sounds and oxygenation levels.

Treatment would include specifics for whatever disease or disorder is causing the dyspnea, but may also include teaching of strategies such as pursed lip breathing and energy conservation techniques. Using fans or opening windows may also decrease the patient's perception of not being able to breathe along with elevating the head of the bed when possible. Relaxation and distraction methods such as music or conversation may be beneficial as well.

Cough

Many people with cancer complain of this symptom, however those with lung cancer are those most commonly affected. Coughing can be very frustrating and debilitating often causing fatigue, pain, and insomnia. Assessment must include information about factors that increase or decrease incidence, related symptoms, and whether there is associated sputum production. Treatment may include cough suppressants or expectorants along with the use of humidifiers and elevating the head of the bed.

Anorexia and Cachexia

Mosby's Medical, Nursing, and Allied Health Dictionary (2001) defines anorexia as "Lack of or loss of appetite, resulting in the inability to eat" and cachexia as

"General ill health and malnutrition, marked by weakness and emaciation" (p. 94).

It has been learned that aggressive nutritional treatment does not improve quality of life and actually may cause more discomfort, which increases the difficulty for the nurse when planning care for these patients.

Assessment should include determining the amount of weight loss and whether muscle wasting has occurred; the impact on the patient's ability to function; and the patient's and family's perception on the quality of life related to this symptom.

Low albumin levels must be observed when reviewing laboratory data, as it takes 2-3 weeks for a protein deficit to be reflected in test results. Therefore, a low albumin level is a significant indicator of the severity of the anorexia and lack of protein intake. A dietary consult would be a first-line consideration when planning care for the anorexic patient, with appetite stimulants and antiemetics to relieve causes of the anorexia when necessary. Parenteral or enteral nutrition may be considered but must be weighed carefully due to cost and patient discomfort.

Along with many other responsibilities, nurses provide comfort and continuity of care.

Constipation

Constipation is a frequent patient complaint at the end of life. Disease-related causes – as well as treatment related ones – are typical and complicate assessing and treating this symptom.

Assessment must include a history of stool frequency and use of bowel medications, current as well as prior to the disease. Abdominal and rectal assessments should be performed to rule out physiologic causes along with a review of use of over-the-counter products and herbal medicines. Stool softeners and stimulants may be required to achieve some relief along with increasing fluids and using high-fiber foods if the patient is able to tolerate them.

Nausea and Vomiting

Nausea is very common in those with advanced diseases. Although frequency of vomiting may drop for patients at the end of life, nausea is still a distressing symptom.

With the advent of anti-nausea medications in the last few years, this symptom has become less of a problem but still requires nursing care and attention. Assessment should include past history of the symptom and any successful interventions. An abdominal examination should be performed along with listening carefully for bowel sounds to determine whether poor gastric motility is a contributing factor. Treatment will be determined by the cause and should start with the interventions that have been successful in the past.

Medications that may be used are anticholinergics, antihistamines, phenothiazines, steroids, antibiotics, butyrephenones, and benzodiazepines. Non-pharmacologic approaches may include distraction and relaxation techniques, small frequent meals as opposed to large bulky ones, and food served at room temperature rather than very hot or cold. Nasogastric tubes may infrequently be necessary to relieve pressure.

Fatigue

The *Eighth National Conference on the Classification of Nursing Diagnosis* (1989) defined fatigue as exhaustion so complete that normal activities are not possible. The fatigue state affects both thought and physical processes no matter how many hours of sleep were obtained.

Both subjective data (how long the fatigue lasts or if it affects daily functioning) and objective data (vital signs, muscle strength and endurance) need to be assessed. Hemoglobin, oxygenation status, and thyroid function may also give clues to physiologic causes. Erythropoietin may be pharmacologically indicated, and education about rest periods and physical and occupational therapy may be additional treatment options.

Depression

According to *Mosby's Medical, Nursing, and Allied Health Dictionary* (2001), depression manifests with a broad range of symptoms including "Feelings of sadness, despair, and discouragement resulting from and normally proportionate to some personal loss or tragedy to an abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness, and hopelessness that are inappropriate and out of proportion to reality" (p. 460).

Certainly depression may be disease-related, treatment-related and psychologically induced because of fear and loss of independence. Assessment must include observing the situational factors involved, any previous history of depression, presence of risk factors for depression, and a suicide assessment. Treatment may include antidepressants and non-pharmacologic interventions such as promoting as much autonomy as possible, grief counseling, and maximizing symptom management.

Anxiety

Anxiety is a subjective feeling of apprehension or tension which cannot be attributed to a specific cause or event. Many medications have been associated with depression, leading to a need for a thorough medication history. Strategies to help patients suffering from anxiety include prescribing anti-anxiety agents; allowing patients to verbalize their concerns and emotions; providing as much education and information as possible; promoting relaxation; and suggesting counselors who specialize in working with people and families involved in the end-of-life experience.

continued next page

American Association of Colleges of Nursing (AACN) Releases Fact Sheet on 'The Impact of Education on Nursing Practice'

The following is a summary of the American Association of Colleges of Nursing Fact Sheet released October 9, 2003. Full text is available at http://www.aacn.nche.edu/EdImpact/.

Education has a significant impact on the knowledge and competencies of the nurse clinician, as it does for all health care providers, according to the American Association of Colleges of Nursing (AACN).

In a fact sheet entitled "The Impact of Education on Nursing Practice," AACN states that "Nurses with Bachelor of Science in Nursing (BSN) degrees are well-prepared to meet the demands placed on today's nurse. BSN nurses are prized for their skills in critical thinking, leadership, case management, and health promotion, and for their ability to practice across a variety of inpatient and outpatient settings. Nurse executives, federal agencies, the military, leading nursing organizations, health care foundations, magnet hospitals, and minority nurse advocacy groups all recognize the unique value that baccalaureate-prepared nurses bring to the practice setting."

The fact sheet outlines the following:

- Different Approaches to Nursing Education. AACN describes the three routes to becoming a registered nurse: a 3-year diploma program typically administered in hospitals; a 2- to 3-year associate degree usually offered at community colleges; and the 4-year baccalaureate degree offered at senior colleges and universities. Graduates of all three programs sit for the same NCLEX-RN®, licensing examination.

  This section of the fact sheet includes information on how education and training relate to nurses' responsibilities and the implications for the future.

- Recognizing Differences Among Nursing Program Graduates. There is a growing body of evidence that shows that BSN graduates bring unique skills to their work as nursing clinicians and play an important role in the delivery of safe patient care.

  AACN lists the results of key research studies on education as it relates to hiring practices, outcomes, patient safety, medical errors, competence, and quality of care.

- A New Model of Care: Differentiated Nursing Practice. Differentiated practice models are frameworks of clinical nursing practice that are defined or differentiated by level of education, expected clinical skills or competencies, job descriptions, compensation, and participation in decision making. These practice models have been implemented in acute care inpatient settings, rural community nursing centers, and acute care operating rooms.

  AACN explores the implications of practice models as they relate to job satisfaction, staffing costs, nurse turnover rates, and other issues. Related documents and policies on scope of practice, salaries, and other issues are cited.

- Public and Private Support for BSN-Prepared Nurses. The federal government, the military, nurse executives, health care foundations, and nursing organizations and practice settings acknowledge the unique value of baccalaureate-prepared nurses and advocate for an increase in the number of BSN nurses across clinical settings.

  AACN lists the education preferences and requirements of military and government organizations, national nursing councils, and nursing associations. Results from public and private studies regarding nursing education are listed; international trends are included.

Source: American Association of Colleges of Nursing. (2003). Fact Sheet: The Impact of Education on Nursing Practice. Washington, DC: AACN.

Managing Symptoms at End of Life

continued from previous page

Conclusion

These symptoms are only a few of the most common experienced by patients at the end of life. Nurses have a vital role, as the plan of care must be constantly adjusted to achieve quality of life.

The nurse functions as patient advocate by providing education about symptoms and explaining the implications of accepting or declining certain treatments. Other key nursing roles include assessing for the causes and manifestations of symptoms and assisting with pharmacologic and non-pharmacologic options.

Along with these other responsibilities, the nurse offers comfort and continuity of care. In the end, it is the nurses' compassion and familiar face that patients and families most value.

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Letter to the EDITOR

National Council Responds to Case of Nurse Who Admitted Killing Patients

To the Editor

January 5, 2003

The National Council of State Boards of Nursing (NCSBN) is dismayed by the recent tragic events surrounding the Charles Cullen case, a nurse [from Bethlehem, PA] who admitted to killing patients while on duty (see box below).

The vast majority of licensed nurses are highly respected professionals, truly worthy of the public's trust and accolades. Regrettably, it is the tragedies invoked by this case that lead us to examine the important work of nurse regulators in protecting the public.

Nursing regulation is the governmental oversight of nursing practice, carried out by the 60 state and territorial boards of nursing. Nurses are a regulated profession because of the potential for harm if practiced by someone who is unprepared or incompetent. Boards of nursing protect the public by:

- Carrying out requirements of the state Nurse Practice Act (or laws governing nursing)
- Setting nurse license requirements for safe nurse practice (along with other regulated titles)
- Issuing nurse licenses to appropriately prepared individuals
- Determining violations of the Nurse Practice Act for potential disciplinary action against the nurse's license
- Receiving and investigating complaints from the public (i.e., employers, patients and family members) on violations of the Nurse Practice Act, in which issues of incompetent or inappropriate nursing care may exist
- Taking action against the license of the nurse who is found guilty of violating the Nurse Practice Act

It is very important that employers, nurses, and the public at large report nurses to their state or territorial board of nursing when warranted. Without receiving complaints regarding possible Nurse Practice Act violations, boards of nursing cannot take action to protect the public. These complaints of nursing practice violations help insure that regulators can investigate substandard nurse practice and take disciplinary or other appropriate action as needed.

If you need information on how to report nurses to boards of nursing when appropriate, please contact your local state or territorial board. A complete list of contact information can be accessed at: http://www.ncsbn.org/public/regulation/boards_of_nursing_board.htm.

Employers (and the public) can also verify a nurse's license through their state's nursing board or NCSBN's Nursys™ Licensure QuickConfirm database. Employers can also use this database to obtain additional information on nurses they hire and continue to employ. For information on participating nursing boards and available data see https://www.nursys.com/. In addition to the license verification, discipline against a nurse's license is public and the state nursing board or Nursys Licensure QuickConfirm would also contain that valuable information.

NCSBN understands that employers and regulators share the same desire to best protect the public from harm. By working together, nursing regulation and employers can be proactive in making sure that the public has access to competent and well-prepared nurses for a safe and effective health care system.

Sincerely,
Donna Dorsey, RN, MSN, FAAN
NCSBN President

Cullen Case Prompts Calls for National Data Bank

Responding to the case of Charles Cullen, the former nurse who admitted to killing as many as 40 patients, New Jersey Senators Jon S. Corzine and Frank Lautenberg have called for a mandatory national tracking system for firings and sanctions against nurses.

The system would require hospitals to report disciplinary actions and firings of nurses to a database. The information would then be used for background checks during hiring. The senators also requested congressional hearings and a sweeping investigation by the General Accounting Office to determine if there are similar tracking lapses nationwide.

Cullen, 43, from Bethlehem, PA, has claimed that the killings spanned 16 years and occurred at at least 10 medical facilities in New Jersey and Pennsylvania. After he was arrested and charged with killing a Catholic priest in December, Cullen surrendered his New Jersey nursing license. Although Cullen had been fired several times and his behavior had been questioned in the New Jersey institutions where he worked, there were no complaints filed with the state's nursing board.

Cullen's Pennsylvania license was suspended after his arrest, and that state's records showed one complaint from a hospital reporting that Cullen had stolen drugs.

Senators Corzine and Lautenberg recommended that nurses be included in the National Practitioner Data Bank. Under federal law, hospitals must report to the data bank all disciplinary actions of more than 30 days against doctors. The data bank also logs outcomes of doctors' malpractice cases. Another federal database, the Healthcare Integrity and Protection Data Bank does include information on nurses and other health care providers regarding criminal convictions, license suspensions, and medical fraud convictions, but it is not open to hospitals or the public.

State licensing boards have tracking systems, however some are more stringent than others. In some states, complaints are not always made public and reporting of problem nurses and firings is not always mandatory.

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AAACN NEWS

AAACN Members Invited to Participate in National Alcohol Screening Day

CEUs and Free Screening Materials Will Be Available

AAACN would like to encourage members to participate in National Alcohol Screening Day (NASD), a free program that offers nurses the chance to educate the public about alcohol's impact on health.

Held nationally on April 8, 2004, the theme of this year's NASD program is "Alcohol and Your Health: Where Do You Draw the Line?"

Participating sites will be given screening forms as well as materials to educate patients about the effects of alcohol on overall health, a message relevant to anyone who drinks. NASD is offering continuing education credits (CEUs) for participating physicians, nurses, psychologists and social workers. CEUs can be obtained by holding a screening event and completing a brief self-test based on the NASD education materials.

The NASD 2004 primary care kit includes the one-page NASD screening form, a validated screening tool that addresses the full range of alcohol use disorders from at-risk drinking to dependence; the video "Alcohol and Your Health: Where Do You Draw the Line?"; and education materials for clinicians, including the newly released National Institute on Alcohol Abuse and Alcoholism/National Institutes of Health (NIAAA/NIH) guide, *Helping Patients with Alcohol Problems: A Health Practitioner's Guide*.

In addition to holding a screening event on April 8, sites are encouraged to incorporate screening forms and materials into their everyday practice so as to increase early intervention and recognition of at-risk drinking of their patients.

NASD is a free program of the nonprofit Screening for Mental Health, with funding provided by the NIAAA and the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services.

To register for this free program, visit www.NationalAlcoholScreeningDay.org or call (800) 253-7658.

Member-Get-A-Member Campaign Closes with 94 New Members!

Thanks to all AAACN members who recruited colleagues under the Member-Get-A-Member Campaign held April 13-December 31, 2003.

The winner of the contest was E. Mary Johnson of Macedonia, OH, who recruited nine new members. Runners up were Emily A. Sharp with seven new members, and Carol Rutenberg with six.

As a result of her efforts, E. Mary won free registration, airfare, and hotel accommodations to AAACN's 2004 conference in Phoenix, AZ, in March. Emily and Carol each received a $100 certificate toward AAACN products, membership, and education offerings.

Think of those colleagues you could have recruited, and watch for more information on the 2004 Member-Get-A-Member Campaign!

For a full list of our new members and recruiters, visit the AAACN Web site at www.aaacn.org.

AAACN Endorses Joint Commission Safety Protocol

AAACN is one of over 40 organizations to endorse the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

The protocol is the result of a summit held in May 2003 and will become effective July 1, 2004. For more information, see the JCAHO press release on the AAACN Web site, www.aaacn.org. The protocol and its accompanying Guidelines for Implementation are posted on the JCAHO Web site, www.jcaho.org/accredited+organizations/patient+safety/universal+protocol/wss_universal+protocol.htm

Nancy Kowal Wins Nurse in Washington Scholarship

Nancy Kowal

Nancy R. Kowal, MS, RN, C, NP, a former director on the AAACN Board, is the winner of the 2004 Nursing Organizations Alliance Nurse in Washington Internship (NIWI) scholarship.

The Alliance, a coalition of 62 professional nursing organizations including AAACN, announced their 2004 awards in December. The NIWI award is one of several given by the Alliance and is a full scholarship.

In addition to AAACN, Nancy is a member of the American Society of Pain Management Nurses (ASPMN), another Alliance organization. Currently, she is co-chair of AAACN's Practice, Evaluation, and Research Committee.

Nancy is an adjunct professor in the Department of Anesthesia at the University of Massachusetts Memorial Healthcare System. In her home state of Massachusetts, she has provided testimony to the state legislature and served as a political activist for the Massachusetts Coalition for Nurse Practitioners. She has been a member of the Massachusetts Pain Initiative for 20 years, advocating for quality pain management. Nancy has also provided testimony to the Federal Drug Administration on issues related to nurses and to pain management. As ASPMN president, she provided testimony against the Hyde-Nicols Pain bill.

According to The Alliance, the NIWI program provides nurses the opportunity to learn how to influence health care through the legislative and regulatory processes. Participants learn from health policy experts and government officials, network with other nurses, and visit members of Congress. NIWI will be held February 29-March 3, 2004 in Washington, DC.

From the President

continued from page 2

- Care that is no longer delivered the way it was 10 years ago, but the health care system hasn't changed to accommodate shifting care delivery sites.
- The workforce shortages that are changing everything.

The AONE Nursing Workforce Model is built on the philosophy associated with three primary sets of organizations: world-class organizations, magnet hospitals, and the 100 best companies to work for. These three sets of organizations reflected a common philosophy in their approach to the work to be done and in their approach to building a satisfying work environment.

The common themes were building a learning organization; developing a joyful workplace, and achieving patient/client-focused environments. What do these common themes involve? They include having employees that are valued, supported, respected, involved, and accountable; understanding that teams are important to getting the work done; assuring leadership is competent and credible; creating balance in the work environment; recognizing that relationships are the currency of work; expecting that everyone will grow and develop; and assuring there is quality and pride in what is produced.

The Alliance reached consensus that its primary focus for 2004 would be to build on the work of AONE and others to accomplish three specific goals:

- Identify common attributes of a healthy (healing) work environment.
- Build consensus among the member organizations around these attributes.
- Invite individual member organizations to share the attributes identified with their members and advocate for inclusion of the attributes in all environments in which nurses work.

We believe this is meaningful work for The Alliance. When some 62 professional nursing organizations advocate for the core attributes of a healthy workplace, they will do much to transform the patient experience…. for both patient and nurse. AAACN is proud to be part of The Alliance and to participate in this initiative.

Catherine Futch, MN, RN, CNAA, CHE, CHC, *is AAACN President and Regional Compliance Officer, Kaiser Permanente, Smyrna, GA. She can be reached at catherine.futch@kp.org.*

Managing Asthma

continued from page 1

ma symptoms or exacerbations

3. Use of medications for long-term control designed to reverse and prevent the airway inflammation characteristic of asthma as well as pharmacologic therapy to manage asthma exacerbations
4. Patient education that fosters a partnership among the patient and his/her family and clinician

Patient education is an essential component of successful asthma management. Education should begin at the time of diagnosis and be integrated into every step of clinical care. Teaching should be tailored to the needs of the patient, and any cultural or language issues should be addressed.

At every opportunity, the ambulatory care nurse should reinforce the basic facts about asthma and provide appropriate information about any medications prescribed. In addition, the nurse should explain and demonstrate proper peak flow and inhaler technique.

It is also important for the nurse to build a partnership with patients and families by promoting communication using open-ended questions. Effective communication also includes:

- Listening without judgement or interruption.
- Summarizing what the patient has said.
- Being an effective 'coach' by keeping the information simple and providing the necessary tools for success.

Assessing the Patient with Asthma

Mark Millard, MD, a pulmonologist and Medical Director on the medical staff at Baylor Asthma and Pulmonary Rehabilitation Center, developed the Rules of Two™ to determine if patients need more powerful asthma medicine. Patients who answer "yes" to any of the questions listed below are advised to speak with their physician:

- Do you use a quick-relief inhaler more than TWO times a week?
- Do you wake up at night with asthma more than TWO times a month?
- Do you refill your inhaler* prescription more than TWO times a year?

***Editors note:** The asthma disease managers who wrote this article interpret this reference to inhaler to mean the patient's rescue, not preventive, inhaler. Please note that this distinction is the authors', not the original Rules of Two.*

Source: http://www.bhcs.com/healthservices/asthma pulm/C_asthma_programs.htm.
(Rules of Two™ is a trademark of Baylor Health Care System.)

Addressing the Rules of Two questions at each visit will help both patient and health care provider quickly identify uncontrolled asthma. To gather even more information, the nurse can also ask specific questions such as "How many times in a week do you need your 'rescue' (albuterol) inhaler?" and "How many nights have you awakened with asthma symptoms in the last month?"

Barriers to Care

■ Education ■
■ Denial ■
■ Fear of steroid medication ■
■ Finances ■
■ Chronic condition ■

Using a rescue medication more than 2 times a week (not including before exercise) and waking up more than 2 nights a month could indicate that the patient's asthma may not be controlled.

Treatment Challenges

There are some common barriers that prevent compliance with effective asthma management. Asthma is a chronic condition and frequency of symptoms and severity can change. Inadequate patient adherence to prescribed treatments remains an ongoing challenge.

Although guidelines exist to help the health professional provide appropriate treatment, there is evidence of poor adherence to these guidelines. There seems to be a lack of understanding in how to implement preventive treatment and lung function testing in general practice. A study done by S. Ting in the United States explored barriers to clinicians using the asthma guidelines. Common reasons cited by primary care providers for poor adherence to the asthma guidelines included: do not remember the exact classification of asthma severity, do not remember the various brands of inhaled steroids and their exact dosages for different asthma severity, do not remember to ask about various triggers of asthma, and do not have sufficient time or resources to teach patients how to use inhalers or provide asthma education and an asthma action plan" (Ting, 2002).

Spirometry (lung function testing) helps diagnose and assess the severity of asthma. The test helps the health care provider decide if treatment is effective or if a change is needed. Spirometry is recommended:

1. At the initial assessment
2. After treatment is initiated and when symptoms and peak flow have stabilized
3 At least every 1-2 years

(NIH, 1997)

With today's soaring health care costs, patients must often choose which medicines they can afford. Those who cannot pay for higher priced medications choose less costly rescue drugs. In addition, newly diagnosed persistent asthma patients often have a shopping list of necessary medical equipment and medications to obtain at the first visit. These include peak flow meter, spacer, rescue medication, and inhaled corticosteroid controller medication. For those with extrinsic asthma – asthma triggered by external agents such as pollen or chemicals – a nasal steroid or antihistamine is also needed. One can easily see that any financial stresses that already exist on a patient may make it difficult for him/her to adhere to the pro-

posed action plan.

All members of the health care team can help patients overcome many of the barriers to effective asthma management by working together to reinforce the same message. Written materials in addition to verbal instructions can increase adherence. Education should promote a partnership in asthma care and goals should be developed jointly.

Communication should be kept open between health care staff and patient to establish mutual goal-setting strategies at regular scheduled visits.

Case Studies

Below are several types of cases illustrating everyday clinical encounters and opportunities to help patients manage their asthma.

Case 1

J.M., a 29-year-old Caucasian male enters your clinic after calling that morning requesting an appointment for his asthma. He said he has had asthma "since I was a baby." His blood pressure is 126/84, Temp 98.8, Pulse 76, Respirators 18. Pulse oximeter is 92% on room air; peak flow reading is 250.

The patient is coughing and his lungs have scattered wheezes at the bases, which clear with a deep cough. He says he has been sick for 2 days, afebrile, and waking up 2-3 times per night for a week with wheezing, a runny nose, and a nonproductive cough. J.M. has doubled his inhaled corticosteroid, he is rinsing his mouth after using his medication, and he is using a spacer. He says he is using his rescue medication albuterol "a lot," specifically 4-6 puffs every 1-2 hours. When asked about his usual rate of albuterol use, J.M. says he commonly takes two puffs at least 3 times a day.

J.M. is currently working two jobs. He is primarily a roofer and works part-time at a package delivery company. He has a wife and three children. Although J.M. is allergic to his dog, the pet sleeps in his bedroom.

How can we apply the four components of effective asthma management to J.M.'s case?

Discussion

- First, the patient's acute respiratory status is assessed.
- Spirometry and peak flow readings may help establish asthma severity and response to therapy. He is on an inhaled corticosteroid controller medication and uses correct inhaler technique. J.M. correctly increased his medication with a cold. He may need to increase his controller medication, change his medication, and or add an additional medication.
- The Rules of Two questions reveal that the patient is using his albuterol more than 2 times a week and waking up more than 2 nights a month. It is evidence that his asthma is out of control.
- Environmentally, sleeping with the dog that he is allergic to may increase his asthma symptoms. Negotiating the dog out of the bedroom through education may decrease his need for albuterol.

Asthma Resources

National Heart, Lung, Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma
www.nhbisupport.com/asthma
The NHLBI site offers a complete summary of the guidelines as well as essential information for health care providers.

Krames, Health and Safety Education
www.krames.com
Clinic staff may like to teach with illustrated, easy-to-read asthma booklets while their families are in the office. Krames offers a booklet, *Asthma and Your Child*, in both English and Spanish versions that contains information for parents and children. The booklet is $1.79 and can be ordered on the Web site.

Additional Useful Web Sites

Mothers of Asthmatics, "Breatherville, USA"
www.aanma.org

Internet asthma club for children ages 9-12
www.asthmabusters.org

American Lung Association, "Asthma in Children"
www.lungusa.org/asthma

Asthma & Allergy Foundation of America
www.aafa.org

American Academy of Allergy, Asthma, & Immunology
(Site features National Allergy Bureau with information on pollen and mold counts in areas across the country.)
http://www.aaaai.org

National Jewish Hospital Lung Line
(800) 222-5864

Case 2

Joseph, a 10-year-old Hispanic boy, is brought by his mother to the clinic for a routine exam. The nurse opens Joseph's electronic medical record (EMR) to begin documentation and to review any medications Joseph is currently receiving. Because the EMR includes a history of prescribed medications that have been dispensed in the pharmacy, the nurse can verify this information and quickly copy it into the progress note. Joseph's mother reports that the only medication he currently takes is an albuterol inhaler and she adds that they need a refill. By reviewing the medication history, the nurse notices that two canisters of albuterol have been refilled approximately every 6 weeks for the past year. Since the nurse is aware that frequency of albuterol use for rescue is an indicator for asthma control, she asks Joseph and his mother how often he is having asthma symptoms and how often he is taking albuterol, his "rescue" medication. Joseph has

been taking albuterol at least twice a day in the morning and before bed. If he does not take it at those times he is usually coughing in the morning and all night. He keeps an albuterol inhaler at school and he uses it before gym twice a week.

Discussion

- Spirometry is recommended on the routine yearly visit
- The Rules of Two indicate Joseph's asthma is out of control. He is using his rescue medication 2 times per day and waking up at night coughing. An inhaled corticosteroid is recommended for daily asthma symptoms to control his asthma.
- Additional information about asthma triggers and environmental concerns need to be addressed.
- Education for patient and family needs to begin at the time of this visit.

Case 3

Teresa, a 38-year-old white female, was diagnosed with mild intermittent asthma 1 year ago. She calls the Advice Nurse Line and complains of wheezing with exercise and waking up at night coughing for the past 3 months. Teresa has recently moved to a new apartment. She has an albuterol inhaler and has used it 1-2 times in the past month. She has a history of seasonal allergies and allergy tested positive to ragweed, cats, and dogs. She has no pets, is a nonsmoker, and has a history of gastroesophageal reflux (GERD).

Discussion

- Environmental exposures to previous animal dander in her apartment or exercising outside during allergy season may increase asthma symptoms. Educating the patient about pretreating with albuterol before exercise may eliminate wheezing during exercise. Uncontrolled GERD may cause night-time coughing and increased asthma symptoms.
- The severity of Teresa's asthma may have changed. Spirometry may indicate obstruction in the airways. Pharmacologically, an inhaled corticosteroid may need to be started.
- The Rules of Two reveal that Teresa's nocturnal waking indicates uncontrolled asthma.
- Teresa's diagnosis is relatively recent, thus education can begin with this phone call.

Conclusion

From telephone triage to office visit, every member of the health care team has an opportunity to make a difference in the life of an asthma patient. During patient interviews, it is essential to ask about frequency of asthma symptoms, triggers, and medication usage. As part of the physical assessment, spirometry should be performed at least every 1-2 years to reassess obstruction and asthma severity. Taking into account all of the information provided by patients and testing, medications can be adjusted as needed.

Throughout the treatment and education process, the nurse and other health care team members should work to build a relationship with the patient and family, as it is this relationship that is the cornerstone of successful care. It is through a strong provider/patient rapport that the door opens for communication and negotiation in dealing with this chronic, yet controllable disease.

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Resources

National Asthma Education and Prevention Program Report: Guidelines for the Diagnosis and Management of Asthma Update on Selected Topics. (2002).

Asthma Disease Managers at Kaiser Permanente in Colorado are (from left, front row) Cindy Martin and Jan Hoban; (middle row) Cindy Lamb, Sandra Hay; (back row) Jeannine Dotts and Catherine Tacinas. (Not pictured: Laura Glaves.)

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Janice Hoban, RN, AE-C
Cynthia Martin, BSN, RN, AE-C

***AE-C: Asthma Educator-certified**

AAACN 2004 Confer

Forging New Partnerships and Championi

Phoenix, Arizona • March 18-22, 2004 • www.

AAACN's 29th Annual Conference will be held in Phoenix, AZ, March 18-22, 2004, at the Hyatt Regency Phoenix. The conference will address the accelerating changes in health care with sessions that range from nursing in a middle-eastern country to political advocacy.

The skills that ambulatory care nurses must have today have never been more varied and challenging, so AAACN has designed the conference with a wide spectrum of exceptional education sessions and speakers. The conference theme, "Forging New Partnerships and Championing Change," sets the stage for participants to connect with colleagues, share ideas, and learn about the latest advances in practice.

Program

On Thursday, March 18, Virginia R. Beeson, MSN, RN, CNA, will present a special pre-conference workshop, Let's Get the 'Lead' Out of Leadership. Ms. Beeson will explore the hurdles leaders face and methods to overcome them. Also that day, Sandra W. Reifsteck, MS, RN, CNAA, FACMPE, will discuss end-of-life care during her session Care Not Cure: Dialogues at the Transition – A Palliative Care Workshop.

On Friday, March 19, Cathy Rick, RN, CNAA, FACHE, will deliver the conference Keynote Address. Ms. Rick will describe the final report of the Committee on the Quality of Health Care in America chartered by the Institute of Medicine, a hallmark project that addresses health care reform to ensure safe and effective patient care.

Concurrent sessions will run from March 19-21 and include the following:

- Emergency preparedness – how health care organizations can fit with statewide programs
- The JCAHO survey process for 2004 – issues specific to ambulatory care settings
- Caring for multilingual and multicultural populations – the nurse's role
- SARS – the 2003 outbreak in Toronto; treatment strategies
- Ambulatory care nursing in Saudi Arabia – skills, training, local customs
- Politics and health care – the political process at state and national levels; advocacy strategies
- "Show Me The Money" – who pays for health care today

During the closing session on Sunday, March 21, AAACN Past-President E. Mary Johnson, BSN, RN,C, CNA, will host Sharing of Nursing Stories. During this special interactive event, participants will tell their most moving and unforgettable nursing experiences.

Post-conference workshops on Monday, March 22, include the Ambulatory Care Nursing Certification Review Course, an overview of the potential content of the ambulatory care nursing certification exam, and the AAACN TeleHealth Nursing Practice Core Course (TNPCC), a comprehensive session designed for nurses who handle telephone/telehealth inquiries from patients in any practice setting. This course will also prepare participants for the NCC Telephone Nursing Practice Certification Exam.

Special Interest Groups

AAACN's Special Interest Groups (SIGs) also meet during the conference. These groups represent Pediatrics, Staff Education, Telehealth Nursing Practice, Tri-Service Military, and Veterans Affairs. Three new SIGs will debut: Geriatric, Nursing Management, and Patient Education. On Wednesday, March 17, from 8:00 am - 5:00 pm, the Tri-Service Military SIG will hold a pre-conference, Military Contributions to Forging New Partnerships and Championing Change, during which United States Army, Navy, and Air Force Nurse Corps Chiefs will brief attendees on the current status of the nurse corps and visions for the future.

Continuing Education

Participants have the opportunity to earn up to 19.3 contact hours for the 3-day conference. Additional hours will be given for the poster sessions and the pre-and post-conference workshops, ranging from 1.2 to 9.1 contact hours for each.

Registration

Complete conference information and on-line registration are available on AAACN's Web site, www.aaacn.org. For additional registration information, contact the AAACN National Office, East Holly Avenue, Box 56, Pitman, NJ 08071-0056; phone 1-800-AMB-NURS or (856) 256-2350; fax (856) 589-7463; e-mail aaacn@ajj.com.

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ng Change

aaacn.org

You Won't Want to Miss...

...The Bidding at Our Exciting Silent Auction

The Silent Auction will again take place as part of the opening reception for the 2004 annual conference. This event, held Thursday evening, March 18, has been immensely popular at past conferences.

It is not too early to begin thinking about participating in the silent auction, either as a donor or bidder, or both! Items in previous auctions have included gift baskets, nursing memorabilia, cookbooks, and vintage nursing books, pictures, and crafts. At the 2003 silent auction, jewelry, a stained glass piece, and hand made bird houses were very popular among the bidders. If you choose to donate something, keep in mind that your item(s) should be portable and easy to carry in a suitcase.

The Silent Auction raises monies for the AAACN Scholarship Program which provides funding for academic and professional activities. More information on the scholarship program can be obtained from the AAACN National Office at (800) AMB-NURS; e-mail aaacn@ajj.com.

For more information about the Silent Auction, please contact Pam Del Monte at Pamela.DelMonte@med.va.gov, or Sana Savage at lcdr-sana.savage@cnet.navy.mil.

Tri-Service Military SIG to Hold Preconference

The annual meeting of the AAACN Tri-Service Military Special Interest Group (SIG) will be on March 17, 2004, in Phoenix, AZ, from 8:00 am - 5:00 pm.

Each of the U.S. Army, Navy, and Air Force Nurse Corps Chiefs will brief attendees on the current status of the nurse corps and the vision for the future. Additional briefings will provide insight into strategies and programs supporting the future of military medicine.

Registration is open to all AAACN members. Please note there is a separate registration form, mailing address, and fee of $100 in advance/$125 on-site for this meeting. Download the registration form from the "Events" tab on the AAACN Web site, www.aaacn.org, or request a registration form from CDR Sara Marks, NC, USN at marks@nwdc.navy.mil, Col Monica Secula, USA, NC, at monica.secula@amedd.army.mil, or Lt Col Carol Andrews, USAF, NC at Carol.Andrews@lakenheath.af.mil.

...Sharing Your Nursing Stories

So when exactly did it happen for you? Do you remember the exact moment you felt like you were a real nurse? Or the patient or staff member who made your day by saying "Thank you. I couldn't have gone through it without you." What about a funny event on your unit – humor that made your belly hurt – or a special memory that always brings a smile to your face?

AAACN is looking for just these stories and asking you to share them at our Closing Session. The conference registration packet will have a special insert or you can e-mail a brief synopsis to Pat Reichart at reichartp@ajj.com by March 1, 2004. If you are not sure you want to present your story out loud, simply write it down and we will have someone present it for you. Story presentations should take no more than 5 minutes.

AAACN has plans for your stories; we may create a AAACN scrapbook (this could even become a Silent Auction item!), a CD, or publish the memories in Viewpoint. The possibilities are endless, but we need your input. This event is a networking opportunity that holds a common theme and spirit: joining hands and hearts. We hope to hear from you.

E. Mary Johnson, RN, BSN, C, CNA
AAACN Past-President

...The Excitement of Moderating a Session

AAACN program planners are currently seeking moderators for the 2004 Annual Conference in Phoenix.

A moderator introduces the speaker, distributes handouts, keeps the session on time, facilitates discussions, and trouble-shoots room or AV problems.

If you are going to the conference and would like to volunteer to be a moderator, please contact Pat Reichart at reichartp@ajj.com. When you receive your registration brochure, contact Pat to let her know which sessions you would like to moderate.Your help in making the annual conference a success is greatly appreciated!

Unable to attend the conference in **Phoenix**?
Plan to join us in **San Diego** at the
Westin Horton Plaza, April 7-11, 2005.
Interested in speaking? Obtain the
Call for Abstracts at www.aaacn.org.

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MISSION STATEMENT

Advance the art and science of ambulatory care nursing

AAACN Election Results

The 2003-2004 AAACN Nominating Committee, chaired by Past-President Candia Baker Laughlin, MS, RN, C, is pleased to announce the results of the 2004 elections. There were 234 AAACN members (17.8%) who returned the ballots.

Elected officials will assume their positions at the close of AAACN's 19th Annual Conference, March 18-22, 2004, in Phoenix, AZ. The new board members for 2004-2005 begin their terms that day as well. The new AAACN officials are:

President-Elect
Regina C. Phillips, MSN, RN

Board of Directors
Beth Ann Swan, PhD, CRNP
Sara Marks, CDR, NC, USN
Charlene Williams, MBA, BSN, RN, BC

Nominating Committee
Cynthia Pacek, MBA, RN, CNA

Congratulations to our new AAACN officers. The Nominating Committee and the Board of Directors thank everyone who ran for office for their tremendous willingness to serve as AAACN volunteers.

Candia Baker Laughlin, MS, RN, C
AAACN Nominating Committee Chair

2004-2005 Board of Directors

President
Katherine P. Krone, MS, RN

President-Elect
Regina C. Phillips, MSN, RN

Immediate Past-President
Catherine Futch, MN, RN, CNAA, CHE, CHC

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Director
Sara Marks, CDR, NC, USN

Director
Beth Ann Swan, PhD, CRNP

Director
Charlene Williams, MBA, BSN, RN, BC