The health care delivery paradigm is continuing its shift from the traditional inpatient and medical model to the outpatient health promotion/maintenance model. Nursing’s role is changing as well. For nurses to succeed and flourish in this new environment and paradigm, nursing will require the development of new roles and functions. Good mentors will make this transition smooth and rewarding for the nurses, the multidisciplinary staff in ambulatory care clinics, and the patients they serve. Brown and Draye’s stages in advancing autonomy (2003) are used as a model for mentoring nurses as they transition to this setting.

**The Evolving Role of Nursing in Ambulatory Care**

Traditionally, professional nursing education and practice have been based in acute care hospitals. Disease-focused care planning was based on the biopsychosocial model. Health was defined as the absence of illness or disease; the intended outcome of health care was the patient’s return to his or her former level of health care delivery paradigm is continuing its shift from the traditional inpatient and medical model to the outpatient health promotion/maintenance model. Nursing’s role is changing as well. For nurses to succeed and flourish in this new environment and paradigm, nursing will require the development of new roles and functions. Good mentors will make this transition smooth and rewarding for the nurses, the multidisciplinary staff in ambulatory care clinics, and the patients they serve. Brown and Draye’s stages in advancing autonomy (2003) are used as a model for mentoring nurses as they transition to this setting.

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Developing and Providing a Healthful Work Environment

One of the rewards of being president of AAACN is the opportunity to network with the leaders of other nursing organizations. Along with President-Elect Regina Phillips and Executive Director Cyndee Nowicki, I had the privilege of representing AAACN at the Nursing Organizations Alliance (the Alliance) 2004 Fall Summit. This was an incredibly thought-provoking and energizing experience. As leaders of over 60 nursing organizations, we identified issues of common concern and opportunities for collaboration.

The first day we worked on issues relevant to professional organizations. Common themes were membership, volunteerism, leadership development, diversity in organizations, public policy, funding, evidence-based practice, and demonstrating the value of professional nursing practice and professional organizations. The work sessions provided an open and non-competitive environment for leaders to share ideas. It was also an opportunity to identify potential partnerships for future initiatives.

We then shifted our focus to an issue of concern to us as a profession: healthful work environments. Following the 2003 Alliance meeting, a Work Environment Task Force was charged with identifying the principles and elements of a healthful work environment. The members of this task force spent the past year coming to consensus on essential core concepts. Nine principles of a healthful work environment and a beginning list of elements that define these principles were identified and are listed below.

1. Collaborative-Practice Culture
   - Respectful communication and behavior
   - Team orientation
   - Presence of trust
   - Respect for diversity

2. Communication-Rich Culture
   - Respectful
   - Open and trusting
   - Support of information technology

3. Adequate Numbers of Qualified Nurses
   - Quality care to meet client/patient’s needs
   - Work/home life balance

4. Recognition of the Value of Nursing’s Contribution
   - Reward and pay for performance
   - Career mobility and expansion

5. Expert, Competent, Credible, Visible Leadership
   - Advocate for nursing practice
   - Shared decision-making

6. A Culture of Accountability
   - Clear role expectations
   - Everyone is accountable

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Palo Alto Medical Foundation is a multi-specialty clinic that includes over 300 primary care, urgent care, and specialty providers in five clinic locations. Every year, from November to March, approximately 10 to 20% of the population will become ill with influenza, and many more will suffer from coughs and colds. This annual arrival of the flu season impacts clinics with increased numbers of ill patients and illness among staff members. The 2004-2005 flu season will present its own challenges as the nation faces a vaccine shortage. Though the full impact of the vaccine shortage is not known, the Infection Control Committee felt a revival of the Cover Your Cough strategy developed in 2003 would help the Palo Alto Medical Foundation be prepared. This article describes the implementation of the Cover Your Cough Infection Control Program for front office staff.

Cover Your Cough Campaign

In the Fall of 2003, the Infection Control Committee developed the Cover Your Cough Campaign to help the organization meet the challenges of the cough and cold season. When patients and visitors come to the clinic, the first person they meet is usually a patient services representative (PSR), a non-clinical member of the health care team. The Infection Control Committee realized there was an opportunity to interrupt the transmission of flu and other respiratory viruses by incorporating infection control strategies into reception procedures. The Cover Your Cough Campaign focused on three areas: immunization, hand hygiene, and respiratory etiquette.

Preliminary informal discussions with PSRs revealed that many employees feel uncomfortable when they interact with patients who may be coughing or sneezing. They worry about getting sick or bringing illness home to their families. They shared stories of patients coughing on them or handing them used tissues. The information these employees shared was incorporated into the program.

Organizational Support

Organization-wide support is critical for this type of strategy to be effective. The campaign was a collaborative effort that involved multiple departments throughout the organization. Materials Management was able to secure small individual packages of tissues to be available through our product ordering system. Department managers and supervisors arranged for the staff to attend training sessions. Clinical managers educated back office staff to support the PSRs and assist as needed. The Marketing Department produced an informational flyer to provide visual reminders at every reception desk. Marketing also included an article about respiratory hygiene and the Cover Your Cough Campaign in both the employee newsletter and the patient information mailer. The Web master put a section on the Web site explaining the program and advising patients they would be asked to "cover their coughs."

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**Good Health Habits**

Though the influenza vaccine remains the best flu prevention method, the Centers for Disease Control and Prevention (CDC) offers basic good health habits to help you stay healthy and stop the spread of germs at home, work, and school during the 2004-2005 flu season.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid close contact.</td>
<td>Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick, too.</td>
</tr>
<tr>
<td>Stay home when you are sick.</td>
<td>If possible, stay home from work, school, and errands when you are sick. You will help prevent others from catching your illness.</td>
</tr>
<tr>
<td>Cover your mouth and nose.</td>
<td>Cover your mouth and nose with a tissue when coughing or sneezing. It may prevent those around you from getting sick.</td>
</tr>
<tr>
<td>Clean your hands.</td>
<td>Washing your hands often will help protect you from germs.</td>
</tr>
<tr>
<td>Avoid touching your eyes, nose, or mouth.</td>
<td>Germs are often spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.</td>
</tr>
</tbody>
</table>


**Education and Training**

The **Cover Your Cough Campaign** was multifaceted, with education playing a large role. The Infection Control Coordinator and Training Specialist designed a training program for front office staff that provided background information about influenza, the influenza vaccine, and how viruses are transmitted. Part of the training covered hand hygiene efficacy and the use of tissues or facemasks to prevent viral transmission. Another portion of the training discussed communication techniques, which offered opportunities to role-play difficult situations and practice asking others to “cover that cough.” The first training programs were presented to the high-risk areas of Urgent Care, Internal Medicine, Family Practice, and Pediatrics. The program was then taken to every department of the clinic.

**Influenza and Flu Vaccine**

The training sessions were informal and interactive, with an average size of 6 employees and 2 trainers. The session began with an overview of influenza. Most of the participants were surprised to learn how far a cough can transmit particles, and how long someone remains contagious. Many of them had not had a flu shot even though the organization offers the influenza vaccine to employees at no cost. The class presented an ideal opportunity to answer questions about the vaccine and corrected any misconceptions. The most common reason for declining the vaccine was the mistaken idea that the flu shot would make them sick. Several employees chose to have a flu shot after attending a training class.

**Hand Hygiene**

Most of the staff understand the importance of hand washing. In fact, the inability to conveniently wash their hands throughout the day is a significant frustration expressed during the needs assessment. The training classes provided information about the efficacy of alcohol-based hand cleaners and an opportunity for participants to try them in the classroom setting. At the end of the training session, employees were given ordering information to keep their workstations and reception areas supplied with hand gel. Participants were given bottles of hand gel to take back to their work areas to begin using the hand hygiene techniques immediately.

**Respiratory Etiquette**

PSR staff expressed a real sense of helplessness when faced with coughing, sneezing patients. During the training sessions, they shared stories of patients and visitors using their pens and phones, being handed used tissues, and having patients cough in their faces. They expressed feelings of anger that patients weren’t considerate to staff, and feelings of helplessness because they felt there was no “nice way” to ask patients to stop coughing without covering their mouths.

The training class used facts to support the validity of the recommended techniques. Participants learned that when someone with a virus coughs, sneezes, or speaks, he or she sends the virus into the air, and a strong cough can propel particles up to 25 feet. The training presented the concept of respiratory etiquette as a standard to employ among staff, patients, and visitors. Respiratory etiquette means covering the mouth and nose when one coughs or sneezes. It is a courtesy to others to...
use tissues when coughing or sneezing, and to distribute tissues to patients and visitors. When coughing or sneezing, when one coughs or sneezes. When someone with a virusAir, and a strong cough can propel particles up to 25 feet.9

Program Support

Initial support of the PSRs included providing the tools needed to implement the Cover Your Cough Campaign. These tools were identified as training, supplies (such as tissues and hand gel), and visual reminders in the form of posters and flyers. Support also came in the form of publicity. Articles in employee and patient newsletters served to introduce the concepts of the campaign, allowing the PSRs to assume the comfortable role of helping and supporting rather than informing or teaching.

Ongoing support was very important. The Infection Control Coordinator made many visits to the front desks, where they talked to staff, asked questions, observed interactions, and assisted as needed. The Marketing Department made new posters to refresh the visual cues in the departments. These were distributed four to six weeks after the first posters were placed.

Program Evaluation

Did the Cover Your Cough Campaign make a difference in the transmission of viruses? Numbers of patient visits did not differ significantly from previous years. The number of employee absences due to illness were tracked for the Nursing Float Department, and from October through December, employee absences were less than the previous year. Though this was the only department tracked, the results encouraged continued support for the program.

The Cover Your Cough Campaign was successfully implemented and incorporated into work practices. One year later, there are bottles of alcohol-based hand cleaner available for staff and patients at every reception desk. The topic of respiratory hygiene is included in customer service training for all new PSRs. Many times, PSRs are overheard saying some variation of, “Here are some tissues for your cough, Mr. Smith. You can put the used ones in the trash right over there.” That feels like success, indeed!


Peggy Kaminsky, BSN, RNC, is an Infection Control Coordinator at Palo Alto Medical Foundation, Palo Alto, CA. She may be contacted by e-mail at kaminsp@pamf.org.

Reference


2005 Cover Photo Contest

Capture the spirit of AAACN Viewpoint while promoting your institution! The publication is sponsoring a photography contest for AAACN members and friends of ambulatory care nursing. The first prize winner will receive a $100 gift certificate good towards the purchase of any AAACN education program or product. Honorable mention photographs will also be selected. Award-winning photographs will be featured on the cover of future issues of Viewpoint.

Photos may be submitted by individuals or institutions through their public relations department or agency, and should represent nurses in a professional setting.

All entries become the property of Viewpoint and will not be returned. For further information, contact:

Carol Ford, Managing Editor
AAACN Viewpoint
East Holly Avenue Box 56, Pitman, NJ 08071-0056
(856)256-2433 • FAX (856)589-7463 • e-mail: fordc@ajj.com
This article describes some of the findings from a project conducted by the Medical Emergency Preparedness Committee at the University Physicians Healthcare in Tucson, AZ. The project consisted of installing fully automated external defibrillators (AEDs) in the facility’s freestanding clinics and the training of staff in AED use. A Medical Emergency Preparedness (MEP) committee guides emergency policies for University Physicians Healthcare. Clinical Services Director Cindy Schultz, BA, RN, described the MEP program as follows: “the heart of the medical emergency program” is a committee that includes physician participation and a focus on quality medical management of emergencies’ through policy and education (Schultz, 2001, p. 14). It was through the MEP committee that this initiative was carried out.

Legal Considerations
When we purchased our defibrillators, we began by reviewing the Public Access Defibrillation Programs in the State of Arizona (Operation Heartbeat Implementation Committee, 2001), a booklet that described Arizona’s statutes for use of public access defibrillators. We learned that the Arizona statutes only applied to defibrillators used in the public domain. It is important to know if your state has any legal statutes for utilizing AEDs. In our case, keeping the AED accessible only to clinic-trained staff negated the “public domain status” of AEDs in our clinics.

Safety Considerations
Supplementary oxygen should be moved at least four feet away from the patient when the defibrillator is in use. This new recommendation was preceded by findings reported in the national news as well as in professional literature over the last few years. At St. George’s Hospital in London, Robertshaw and McNulty (1998) measured oxygen concentrations at 12 different points around a practice mannequin to determine if increased oxygen concentrations might contribute to the risk of combustion from arching defibrillator paddles. The authors established that the oxygen source needed to be at least one meter (39.7 inches) away from the defibrillator. They concluded that it is dangerous to continue to leave the oxygen outlet discharging on the pillow. Theodorou, Gutierrez, and Berg (2003) described a fire that occurred when a 10-day old baby was being defibrillated. The authors related, “A fire can occur during a defibrillation attempt because a spark can be generated in an oxygen-enriched environment” (p. 677). In January 2004, the death of a woman was reported in the national news. She was burned in an ambulance while being rushed to medical care. Ryan (2004) reported, “a defibrillator sparked a fire that ignited the patient’s clothes and burned her face” (p. 1).

The American Heart Association (AHA) (2001) directs the rescuer to prepare the skin before placing the electrode pads securely on the patient’s chest. Failure to prepare the skin may result in a misreading of the patient’s heart rhythm or arcing by the AED. The skin preparation includes placing the electrode pads on a dry chest; making sure that the patient is not lying in any liquid; that all medication patches have been removed; that any residual medication has been wiped off the chest; and if the chest is hairy, that hair has been removed (a safety razor comes with the AED). If the patient has an implanted defibrillator (ICD), the electrode pad must be placed at least one inch to the side of the defibrillator. “If the ICD is delivering shocks, allow 30 to 60 seconds for the ICD to complete the treatment cycle before delivering a shock from the AED” (AHA, 2001, p.98).

Use of an MRI in conjunction with an AED is contraindicated according to the Medtronic Operating Manual (Medtronic Physio-Control Corporation, 2002-2003) and the potential for hazard reported by the United States Food and
Drug Administration Report (Pressly, 1997). If an AED is placed in a clinic with an MRI, collaboration between the MRI company and the AED manufacturer needs to be made to determine proper distance between the AED and the MRI.

The manufacturer of the AED, Medtronic, advises against the use of cellular phones (or diathermy equipment or cautery) within four feet of the AED because electromagnetic or radio frequency interference can affect the performance of the defibrillator (Medtronic Physio-Control Corporation, 2002-2003). Cellular phones are the most likely problem because their use with employees and patients is quite common. In an emergency situation, it is likely that such devices might be within four feet of the AED. The cellular phone could distort the EKG reading of the AED and might result in a failure of the AED to detect a shockable rhythm. Use of pulse oximeters are contraindicated when a patient is being defibrillated due to the potential for skin burns (Medtronic Physio-Control Corporation, 2002-2003).

Training Considerations

There are two major factors affecting outcome in resuscitating a patient in ventricular tachycardia or ventricular defibrillation: 1. Number of compressions given. 2. Reaction time to CPR and to defibrillation. The number of compressions given is limited by three factors: interruption of compressions for ventilation, delay by rescuer, and delay time built into the AED expert system for rhythm analysis. Chamberlain, Handley, and the Executive Committee European Resuscitation Council (2004) reported that “time without compressions causes a deterioration in the waveform of ventricular fibrillation and a fall in coronary pressure,” which is associated with “decreased prospects for successful outcome after a defibrillation shock” (p. 14). Currently, if nurses were to follow the AHA guidelines and provide airway management, nurses cannot limit any factor except those imposed by the rescuer. In an evaluation of out-of-hospital cardiac arrests, Eftestol, Sunde, and Steen, (2002) demonstrated that the probability of spontaneous circulation restoration decreased during hands-off time. Researchers advised that during resuscitation, the period of time between discontinuation of chest compressions and shock delivery should be minimized. Noted cardiac researcher, Dr. Gordon Ewy, recommended use of metronomes set at 100 beats per minute to count the number of compressions so that the optimum amount can be given both in practice and real emergency situations (Medical Emergency Preparedness Committee, 2004). Such a strategy of audio prompting of chest compressions has been shown to be an effective tool for improving training and performance (Chamberlain, Hazinski, European Resuscitation Council, American Heart Association, Heart and Stroke Foundation of Canada, Resuscitation Council of Southern Africa et al., 2003).

In order to minimize reaction time to CPR and defibrillation, clinic staff are encouraged to be prepared to act. Frequent, brief reviews of emergency procedures occur to assure timely response to emergent situations. The EMS Deputy Fire Chief in Tucson, AZ, views the University Physicians Healthcare clinics as “low frequency-high risk” for patient-cardiac arrest. He encouraged clinic staff to conduct brief reviews of clinic emergency procedures. In this way, staff members, who are trained in Basic Life Support every two years, can have the benefit of this enhanced preparedness to act. The facility has also placed a requirement that every clinic provides one-way mouth shields in or immediately accessible to every examination and waiting room. This decision was made after a mock code revealed that it took up to two minutes to bring the emergency cart with oxygen masks to the site of the emergency.

Chamberlain (2004) highlighted the importance of response time in terms of a positive outcome. Data was re-presented from a Seattle cardiac rehabilitation program, and it was stated that “the survival rate was almost 100 % if patients with ventricular fibrillation are treated at once, the success rate falls to 15 to 40 % by 4 to 5 minutes, and to 5 to 10% by 8 to 15 minutes” (Chamberlain, 2004, p.9). Use of the defibrillator in less than 3 minutes from the time of arrest has been supported in the University Physicians Healthcare clinics by placing the AED in a location where it can be obtained and brought to the site in less than three minutes (round trip). When staff members are prepared, there should be no limitation on the ability to act. During an AED training in one of our clinics, a staff member who was asked to obtain the AED hesitated and stated that she had recently injured her knee and could not be depended on to obtain the AED in an expedient fashion. The trainer encouraged professionals who find themselves with any limitation to immediately delegate another staff member to obtain the AED. Small, seemingly inconsequential details can mean the difference between a positive and a negative outcome. Every second counts.

Margaret Devany Burns, EdD, MSN, MPH, RN, is the Medical Emergency Preparedness Committee Coordinator, University Physicians Healthcare, Tucson, AZ. She may be reached at mburns@upiaz.org

Medical Emergency Preparedness members: Kathy Knak, RN; Suzanne Konigsfeld, RN; Donna Mobley, RN; Eve Saenz, RN; Cindy Schultz, BSN, RN; and Patty Stumbo, MBA, RN.

Physician members: Kathryn Bowen, MD; Colleen Cagno, MD; Gordon Ewy, MD; Ronald Wheeland, MD; Mark Williams, MD; and John Sullivan, MD, ex-officio.

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References


“A fire can occur during a defibrillation attempt because a spark can be generated in an oxygen-enriched environment.”

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There’s Something for Everyone in San Diego!

There is no place like this on earth. From its near-idyllic climate, pristine beaches, and dazzling array of world-class family attractions to its fine restaurants and exciting nightlife, San Diego offers something for everyone. San Diego’s 27 miles of waterfront, shops, parks, and attractions are all near the Westin Horton Plaza Hotel, the site of AAACN’s 30th Annual Conference (April 7-11, 2005). Look for the convention registration brochure in your mailbox and on AAACN’s Web site. Make plans now to attend! Listed below are some popular attractions to visit while at the AAACN Conference.

Attractions/Sightseeing. San Diego Bay is San Diego’s biggest attraction, hosting many events in a variety of venues year-round. Discover some of San Diego’s history and visit Old Town, Cabrillo National Monument, the Gaslamp Quarter, or one of the region’s many missions. Enjoy some time at the world-famous San Diego Zoo and Wild Animal Park, and SeaWorld San Diego. San Diego County also features 92 golf courses and a variety of exciting participatory and spectator sports, luxury spas, lush botanical gardens, and beautiful wineries.

Dining. San Diego is home to over 6,000 restaurants that offer everything from new taste sensations to traditional favorites. From elegant oceanview dining to ethnic takeout, local chefs use the region’s freshest ingredients to create hearty and intriguing dishes. The Gaslamp Quarter is Southern California’s premier dining, shopping, and entertainment district, where you will find a truly eclectic blend of food, fun, and culture all within one of San Diego’s most historic areas.

Transportation. In addition to city buses and taxis, there are charter buses, open-air trolleys, pedicabs, horse-drawn carriages, ferries, and water taxis to move you around town. The San Diego Trolley connects downtown with Mexico, East County communities, and links downtown.

Weather. San Diego’s southern coastal location combines the warm, dry air of the desert with the cool breezes of the Pacific. The result is a fabulous climate. In April, expect a high of 68 and a low of 55 degrees.

For more information about San Diego and all the city has to offer, visit the San Diego Convention and Visitors’ Bureau Web site at www.sandiego.org. In between sessions at AAACN’s Annual Conference, make plans to enjoy San Diego!
Plan to Attend These Pre- and Post-Conference Events!

This year, AAACN will offer 1 pre-conference and 2 post-conference workshops. The pre-conference workshop, “Leadership Essentials: From the Locker Room to the Workplace,” will take place on Thursday, April 7, 2005, from 1:00 p.m. – 4:30 p.m. Diane Michal and AAACN Education Director Sally Russell will present the informative workshop, which will focus on the essential components of leading and managing others. Participants will learn to identify and utilize key sports strategies and coaching skills that can maximize the potential of all employees and guide individuals toward greater teamwork and patient/client outcomes.

Post-conference workshops will be held on Monday, April 11, 2005. “The Ambulatory Care Nursing Certification Review Course” will be presented from 8:00 a.m. – 5:00 p.m., by E. Mary Johnson, Susan M. Paschke, and Kitty Miller Shulman. This course will provide an overview of potential content that may be tested on the ambulatory care nursing certification exam. Course content is based on the Test Content Outline for the ambulatory care nursing certification exam. This course will provide 8.8 contact hours, and participants will receive a course syllabus and a free copy of the AAACN Ambulatory Care Nursing Self-Assessment Manual.

The second post-conference workshop that will be offered on Monday, April 11, is the “AAACN Telehealth Nursing Practice Core Course.” This course is designed to provide a baseline knowledge of concepts for nurses who handle telephone/telehealth inquiries from patients in any practice setting. At the conclusion of this course, you will have the opportunity to take the TNPCC course examination, and upon passing it, you will receive a statement verifying successful completion of the TNPCC. Attendees are encouraged to purchase the 2nd edition of the Telehealth Nursing Practice Core Course (TNPCC) Manual. This book serves as a comprehensive reference of core telehealth information, and is $39 for members and $49 for non-members.

For more information about the pre- and post-conference workshops, and about all the sessions taking place during the AAACN Annual Conference, please visit www.aaacn.org or contact the AAACN National Office at 800-AMB-NURS to request a registration brochure.

New Roommate-Matching System Available for San Diego

Want to share your room at the conference to cut costs? Take advantage of the roommate selection process on our Web site. It is simple: Post your contact information on the discussion board so that others may contact you, while you begin contacting others who are listed to find a roommate. Once you have determined your roommate, remove your post from the discussion board. This is another way we are working to help ensure that you can attend the conference. To post to the conference roommate discussion board, go to the Web site at www.aaacn.org and click on the “Discussions” tab at the top of the home page.

Tri-Military SIG Annual Conference Registration

The AAACN Tri-Military SIG meeting will be held on Wednesday, April 6, from 8:00 a.m. – 5:00 p.m. prior to the opening of the annual conference. All three branches of the service will have their respective Nurse Corp Chiefs or their representatives discuss their vision of where each branch is headed. Topics such as post-partum smoking, nurse-managed emergency department follow up, sexual assault awareness, creating a portable standardized competency assessment for support staff, and establishment of a tri-service integrated trauma system in Iraq for the management of OEF/OIF patients will also be discussed. This year, registration will be $110.00 in advance and $135.00 at the door. The price includes a continental breakfast, refreshment breaks, and lunch. Download the registration form from the AAACN home page or the Tri-Military SIG Special Interest Group page. For more information, contact hfsmith@nmcsd.med.navy.mil.

Air Force Health Care Integrators (HCI) First Conference

Details have been confirmed for the first meeting of the HCl to be held Thursday, April 7, 2005, from 8:00am to 12:00pm in San Diego, prior to AAACN’s annual conference. Lt. Col. Nancy Dezell, Associate Director of Air Force Nursing and Associate Chief, Manpower and Organization Division, will speak on leadership’s vision for health care integration. Fee: $30. Download the registration form from the AAACN Web site home page or contact judy.gavin@brooks.af.mil for more information.

Visit www.aaacn.org for the latest information about the 30th Annual Conference!
health. Physicians directed most health-restoring interventions, and nurses followed “doctor’s orders.” Nurses took care of patients while they were hospitalized and rarely had contact with them after discharge. The vast majority of registered nurses (RN) practiced in this paradigm. Some nurses practiced in school, community, or physician office settings. With the advent of Medicare’s prospective payment system based on diagnosis-related groups (DRGs) in 1983 (Litman, 2002), health care began to shift from acute, disease-managed care to proactive health maintenance delivered in ambulatory clinics and other settings. In this primary care ambulatory setting, whether or not it is formally associated with a health maintenance organization (HMO) or managed care, two new expanded roles or functions have emerged for the RN: population health and case management. Schroeder, Trehearne, and Ward (2000) describe the nurse clinician expanded role as “an expert professional RN with a dual role of coordinating care for a population of chronically ill persons and managing care for individual high-resource using enrollees” (p. 14). Another changing phenomenon with this shift is the changing leadership styles and variety of working relationships with other health professionals.

In traditional hospital settings, nurses work with other nurses. Their hierarchical structure is nurses, from the nurse manager to the facility’s director of nursing. They work episodically with doctors, usually seeing them for a few minutes each day. In the primary ambulatory clinic setting, however, the nurse usually works directly with the physician, interacting with him or her throughout each day. A good mentor can help the RN new to this role assimilate successfully to it.

Professional Mentoring

Effective professional mentoring grooms younger members of a profession in the tasks, practices, behaviors, and culture that define the profession, whether it is nursing, law, management, medicine, military, or any defined adult way of life. A mentor is an experienced member of the group who has volunteered or been encouraged to take on the role of wise advisor, teacher, coach, groom, and confidante to ensure that new group members acclimate, grow, prosper, and develop expertise so that eventually they will mentor others. The mentor not only teaches and guides; more importantly, he or she guides by example and maintains professional standards. A mentor must also be compassionate – that is, be willing “to share knowledge and take pleasure in watching others learn and grow” (Truman, 2004, p. 46).

A good mentoring relationship should be trusting, respectful, discrete, and confidential. The protégé should feel comfortable raising a question about any facet or issue, and be confident that the mentor will be open, honest, and non-judgmental in exploring it to the extent necessary for both to be satisfied. They must both be committed to not discussing the issue with others unless both agree or if it becomes a legal issue. Resources on how to improve mentoring techniques appear in Table 1.

Model Application: Advancing Autonomy

In their phenomenological study entitled, Experiences of Pioneer Nurse Practitioners in Establishing Advanced Practice Roles, Brown and Draye (2003) described six themes or stages in advancing autonomy:

Breaking free.
Molding the clay.
Encountering obstacles.
Surviving the proving ground.
Staying committed.
Building the eldership.

This model may be appropriately applied to the mentor-protégé relationship, mentoring RNs toward autonomy in the ambulatory care environment.

Breaking free. The first stage, breaking free, refers to the “process of leaving behind familiar, traditional nursing roles to explore previously unexplored territory” (Brown & Draye, 2003, p. 392). This is certainly true in the transition from inpatient to outpatient nursing. The nurse moves from working in the relatively structured environment of a hospital unit with scheduled tasks (such as medication administration, vital signs, and shift reports) to the semi-structured environment of the ambulatory clinic. While patient appointments are scheduled, telephone calls, walk-in patients, and care coordination are often unscheduled events during the normal workday. The RN is responsible for how he or she plans the day to accommodate these events. The RN new to this role may find this increased responsibility for autonomy somewhat unsettling – a mentor can offer support, guidance, and reassurance.

Molding the clay. The next stage is molding the clay, and it includes three sub-themes: creating new relationships, blending two worlds, and stretching one’s limits (Brown & Draye, 2003). Telehealth, telephone triage, referral management, and
expanded decision-making are multidisciplinary skills honed in the outpatient setting that allow an individual to stretch one’s limits. In addition to being available to guide the RN, the mentor may also introduce the novice nurse to other colleagues in ambulatory care and invite him or her to participate in local and national professional organization activities. In understanding the old and new roles, the mentor discreetly guides the RN in adjusting to and adopting this role.

Encountering obstacles. The third stage is encountering obstacles. As the RN adjusts to the clinic role, there may be resistance resulting from role delineation and confusion, as professional relationships evolve among all staff members from the physician to the front desk clerk. The RN may encounter feelings of being undermined by support staff and may feel a sense of disempowerment. The mentor can explore these feelings with the protégé, eliciting his or her comments and insights (Martin, 2004). The mentor not only teaches and guides; more importantly, he or she guides by example and maintains professional standards.

The mentor works with the protégé, exploring strategies to deal with these feelings and working toward group empowerment that involves the entire clinic staff. The RN may express feeling invisible and undervalued. McWilliam and Wong (1994, as cited in Schroeder, Trehearne, & Ward, 2000) identified three components of hidden work in ambulatory nursing: working with components of bureaucracy, compensating for bureaucracy on behalf of the team (including care coordination and physician’s buffer), providing leadership and information, and acting as an advocate for the patient. In a recent survey, paraprofessional clinic staff identified that roles of the clinic RN included mentor as well as manager/leader (J. King, personal communication, June 23, 2004). The mentor should guide the RN in identifying and celebrating the hidden work, and should feel satisfied and empowered from small successes. Success in this stage leads to the fourth stage in advancing autonomy.

Surviving the proving ground. The fourth stage is surviving the proving ground. Brown and Draye (2003) identified the following survival strategies: establishing credibility, explaining oneself, choosing the battles, fighting for legitimacy, and building networks. RNs establish credibility as they assimilate into the clinic workplace environment with a variety of professional and paraprofessional support personnel. The mentor coaches all these strategies as he or she guides the protégé in gaining experience and expertise in this environment. The mentor acts as a sounding board in helping explore issues and insights, allowing the RN to choose or prioritize “battles.”

Staying committed. The fifth stage is staying committed. There are three sub-themes: making a difference, relishing intimacy, and paying the price (Brown & Draye, 2003). Sometimes the mentor has to help the RN identify how and how often he or she makes a difference, alluding to the “hidden” work mentioned previously. Intimacy stems from getting to know the patients who call and visit the clinic, and realizing that the RN is a valuable link in their continuity of care. It is gratifying and rewarding when patients call for the RN, which reinforces their perception that the RN makes a difference. Paying the price, in this case, refers to the fact that most clinic nurses are salaried and do not have the higher pay generated from overtime and shift differential. Also, because most insurance companies and other third-party payers reimburse only for physician services, RN work is paid for indirectly when billed under the physician or is hidden in the cost of “doing business.” This can be annoying, and the mentor, as a confidante, can listen to the RN’s concerns and offer perspectives and insight.

Building the elderhood. The final stage is building the elderhood. In mentoring the ambulatory care nurse to successful career and role transition, the mentor is “passing the baton” to others and encouraging them to share their wisdom and mentor newer RNs as they make the transition from traditional nursing to ambulatory care nursing. The second sub-theme of building the elderhood is sounding the alarm (Brown & Draye, 2003). This includes identifying and addressing threats to

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**Table 1. Resources for Mentors**

As a mentor, your most valuable resource is yourself. We undervalue ourselves as sources of knowledge and wisdom.

Valuable resources include those to whom we turn for mentoring and guidance. Also, our peers and colleagues (inside and outside the organization) can also offer insight into particular challenges and how they have overcome similar obstacles.

Other resources are those mentors we have never met—our heroes, current leaders in all fields, and historical figures we admire.

Understanding of some change theories help us understand motivation and the process of maturing and growing in a career.

The health belief model (or something similar) helps us understand the impact of perception, benefits, and barriers to action.

Adult learning theories help us understand and appreciate one’s willingness and readiness to change and grow.

Recommended books include *Who Moved My Cheese?* (Johnson & Blanchard, 1998), published by Putnam Books; and *Sacred Cows Make the Best Burgers: Developing Change-Ready People and Organizations* (Kriegel & Brandt, 1997), published by Warner Books. Both books help put change and growth into perspective, offer hope for a better future, and impart a sense of empowerment and success.
quality health care, and encouraging and supporting others to do the same. This theme reinforces the mentor’s characteristic of guiding by example and maintaining professional standards.

**Use in Practice**

As a mentor, this model is very useful in identifying where a protégé is, guiding interactions with him or her, and moving toward the next stage. This model was used to mentor RNs as they contemplated changing positions within the organization or nurses assimilating and maturing in outpatient health roles. For those considering lateral position changes and/or advancing on the career ladder, the mentor considers the first two stages – breaking free and molding the clay. The mentor and protégé discuss moving away from the familiar, exploring new territory, creating new relationships, and stretching one’s limits. When used for RNs as they develop and mature in new roles, this model helps the mentor guide them in managing and understanding their journey from novice to expert/elder. As the protégé develops expertise, he or she may add this model as a tool to mentor others. Also, it is quite helpful to the protégé to know that the “growing pains” being felt are a normal part of the development process.

**Nursing Implications**

The nursing implications for mentoring are that it is critical in shaping the future of professional nursing through other nurses. Other health disciplines – notably health administration – consider mentoring critical and a “primary link to the profession” (Walsh, Borkowski, & Reuben, 1999, p. 273). They noted that individuals with mentors “receive more promotions within their current organization than those who did not have a mentoring relationship” (p. 277). Also, a good professional mentoring culture could go a long way in eliminating nursing’s traditional “feeding frenzy” – the phenomenon of “nurses eating their young” rather than nurturing their growth and development. Mentors serve as positive and professional role models, upholding standards of professional integrity and lifelong learning necessary for the continuity and advancement of the nursing profession.

**Summary**

The changing health care delivery paradigm has been described as a shift from inpatient to outpatient care. The new roles for RNs are in population health and case management. Assimilation and success in these new roles can be facilitated by a good mentoring relationship. The stages of advancing autonomy were used as a basis for a mentoring model. Nursing implications include the affect mentoring has in shaping the future of professional nursing as well as nurturing the growth and development of future mentors. Mentors serve as powerful and positive role models.

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**References**


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**Objectives**

This educational activity is designed for nurses and other health professionals who are in or preparing for a mentor-mentee relationship. For those wishing to obtain CE credit, an evaluation form is available on the AAACN Web site. After studying the information presented in this activity, you will be able to:

1. Relate shifts in health care and leadership practices to changes in ambulatory care nursing.
2. Outline the transition that a nurse goes through when moving from inpatient to outpatient nursing.
3. Summarize the importance of mentoring the nurse making the transition from an inpatient to an outpatient area of practice.

This article, co-provided by AAACN and Anthony J. Jannetti, Inc., provides 1.0 contact hour. Anthony J. Jannetti, Inc. (AJJ) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation (ANCC-COA). AAACN is a provider approved by the California Board of Registered Nursing Provider Number CEP 5336, for 1.0 contact hour. Licensees in the state of CA must retain this certificate for four years after the CE activity is completed.

This article was reviewed and formatted for contact hour credit by Sally S. Russell, MN, CMSRN, AAACN Education Director, and Rebecca Linn Pyle, MS, RN, Editor.

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**Ann M. Burns, MSN, RN, CEN,** is a Major, United States Air Force Nurse Corps, Health Care Integrator, 52d Medical Group, Spangdahlem Air Base, Germany. She may be contacted at ann.burns@spangdahlem.af.mil

**Note:** The views and opinions expressed or implied in this article are those of the author and should not be construed as carrying the official sanction of the Department of Defense, Air Force, or other agencies or departments of the U.S. government.
Call for AAACN Advisory Team Members

The AAACN Board of Directors invites you to assist in setting the direction for the future of our organization. We are seeking ambulatory care nursing experts to serve as members of four advisory teams that will provide the board with recommendations for action steps for the AAACN strategic plan. The teams will be organized according to the four goals of the plan:

1. **Knowledge:** AAACN will be the recognized source for knowledge in ambulatory care nursing.
2. **Education:** Nurses will have the leadership skills and capabilities to articulate, promote, and practice nursing successfully in an ambulatory care setting.
3. **Advocacy:** Nurses, employers, and third-party payers will recognize and value ambulatory care nursing.
4. **Community:** Ambulatory care nurses will have a supportive and collaborative community in which to share professional interests, experience, and practice.

The work will be conducted primarily by conference call, with the option of meeting at the 2005 annual conference in San Diego. If you would like to participate on one of these teams, please contact reichartp@ajj.com

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Audio Conferences Provide Convenient Education

AAACN’s first four audio conferences have been a terrific success! AAACN has had 46 sites registered for one conference, with one site having 30 people on the call. Topics included *Linking Performance and Staffing, The JCAHO Survey, Leadership,* and *The Ambulatory Nurses Role in Heart Failure.* Ambulatory nurses from Hawaii to Canada have listened and learned via these convenient new offerings. For one low fee of $59 for members/$69 non-members (slightly more for International connections), as many nurses as are interested can participate via a speaker phone at your facility. Handouts are sent by e-mail to a leader prior to the call. CE forms are returned following the call to earn 1.5 contact hours. CDs of past audio conferences and handouts used during the conference are for sale on our Web site.

Look for upcoming Audio Conferences on the AAACN Web site or call 800-262-6877 for more information.

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Ambulatory Nurse Delegation to China

AAACN President Kathy Krone will lead a delegation of ambulatory nurses to China, October 30-November 11, 2005. Organized through the People-to-People Ambassador Programs, participants on this trip will be able to bridge political and cultural differences and gain an understanding of each other’s countries and perspectives. Some of the topics for discussion will include ambulatory care delivery systems (primary and specialty care), tele-health nursing practice, evidence-based practice, health beliefs and cultural aspects of care, disease management, nursing competency, continuing education programs, and more. Professional and cultural programs are planned in Beijing, Xian, and Kunming. Spouses and guests are invited. A cultural and educational program will be arranged for guests while you attend the professional sessions. Estimated cost is $4,995 per delegate. Watch for an invitational letter from Kathy in February.

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Ambulatory Certification Dates Set for 2005

The American Nurses Credentialing Center (ANCC) has announced the dates for the ambulatory care nursing certification exam in 2005. They are:

**Date**
- May 14, 2005
- October 15, 2005

**Application deadline**
- March 4, 2005
- August 5, 2005

Go to [www.nursecredentialing.org](http://www.nursecredentialing.org) for more information or call 800-284-2378

Go to [www.aaacn.org](http://www.aaacn.org) for more information on test preparation resources.
AAACN Staff Education SIG Project

The Staff Education SIG is currently constructing a well-formatted document of the Ambulatory Care Nursing Orientation Competencies, which had been identified as a priority need during the 2004 Leadership Pre-conference Workshop and at several focus group sessions during the conference. In addition, the project is aligned with one of the goals of AAACN’s Strategic Plan, which is to “increase recognition of AAACN as a source of ambulatory care nursing information.”

The Ambulatory Care Nursing Orientation Competencies will be aimed at newly hired nursing staff in an ambulatory care setting. Priority competencies will include clinical knowledge, communication, customer service, critical thinking, assessment, and technology skills. The publication should be available by the 2005 Annual Conference in San Diego.

The content will include:
1. A list and definition of orientation competencies for ambulatory nurses in their various practice settings.
2. A description of attributes for the environment, patient’s requirements for care, and specific role dimensions.
3. Provide examples of competencies in action, as well as those being used in other facilities and/or organizations.
4. Provide resources and literature review.

You may contact any of the following members of the staff education SIG to share your organization’s resources or for more information.

Carol Brautigam (carol.brautigam@kp.org)
Linda Brixey (lbrrixey@kelsey-seybold.com)
Lenora Flint (lenora.j.flint@kp.org)
DiAnn Hughes (diann.e.hughes@kp.org)
Marianne Sherman (marianne.sherman@uch.edu)
Charlene Williams (williac7@ccf.org)

TNPCC Course
On the Road in Hawaii

AAACN provided an “on the road” Telehealth Nursing Practice Core Course (TNPCC) in Hawaii on November 29-30, 2004. Approximately 45 nurses attended the course, which was held over 2 days at the Tripler Army Medical Center, and was sponsored by the Army and Navy for their ambulatory care nurses. For more information on offering “on the road” courses from AAACN, contact the National Office at 800-AMB-NURS. Pictured here left to right are Penny S. Meeker, MS, RNC; Capt. Peggy Anne McNulty, NC, USN, DrPH; Col. Vicki Odegaard, U.S. Army; and Traci Haynes.

What I Like Best About AAACN...

The networking opportunities at the conference. Not only do I learn new and exciting things, but it allows me to reaffirm the great things we are doing in our own facilities. I enjoy the articles in Viewpoint. Our project for the year is asthma, and the recent article in Viewpoint was very helpful.
– Deborah Johnson, Binghamton, NY

AAACN is new for me, but I love it! I have learned a lot on many topics and networked with many nurses. The best thing has been the information coming from similar areas of operation. I’m in a hospital setting and so much is geared for in-patients. Thank you!
– Margie Winfield, Darien, IL

The opportunity to re-energize myself about nursing! Sharing our knowledge and experiences enhances the probability that someone at the AAACN conference may have the perfect solution or may generate a thought or idea that enables us to dive into our dilemma with gusto! I challenge all ambulatory care nurses to seriously think about certification. Go for the gusto!
– Christine R. Lowery, U.S. Airforce, Dayton, OH

I get a level of support and understanding for ambulatory that you just don’t get anywhere else.
– Eileen Esposito, Jericho, NY

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Meeting and interacting with all the different nurses from around the country. Educational and informative meetings are very inspirational and motivating. I want to get back to work and begin all the new ideas I have learned.
– Patricia Menendez, Parma, OH
7. Professional Practice and Continued Growth/Development Is Encouraged
   - Continuing education/certification
   - Participation in professional association
   - An information rich environment

8. Nurses Have Meaningful Contribution
   - Pride in work

9. Shared Decision-Making at All Levels
   - Participation in system, organizational, and process decisions
   - Formal structure to support shared decision-making
   - Control over practice

   The Alliance provided a unique forum for this important work. At the 2004 Fall Summit, member organizations accepted the work of the task force and agreed to continue this effort by further defining the elements of each principle that are appropriate to their respective organizations. Imagine how powerful it would be if the representatives of thousands of nurses collaborate on a common understanding of what is important in a healthful work environment for nurses! We can then speak with a unified voice as advocates for our nurse members.

   As president of AAACN, I am proud to be a part of this initiative and will involve our Board of Directors in incorporating this work into our strategic plan. I invite you to provide comments about the principles as they relate to you as an ambulatory nurse. Please send your comments to reichartp@ajj.com

Kathleen Krone, MS, RN, is AAACN President and Nurse Director, Behavioral Health Service, Chelsea Community Hospital, Chelsea, MI. She may be contacted at kkrone@cch.org

Use of AEDs


AAACN is the association of professional nurses and associates who identify ambulatory care practice as essential to the continuum of accessible, high quality, and cost-effective health care. Its mission is to advance the art and science of ambulatory care nursing.

2nd Annual Viewpoint Writer’s Award

Call for Manuscripts

Viewpoint, the official publication of the American Academy of Ambulatory Care Nursing, announces a call for manuscripts for the 2nd Annual Viewpoint Writer’s Awards.

The purpose of this annual award is to encourage and recognize excellence in ambulatory care nursing. Manuscripts published in the newsletter on topics in ambulatory care nursing practice, clinical research, and professional development and leadership are eligible for consideration. Articles published in 2005 are eligible for consideration. An awards committee will select the winning manuscripts. The awards, consisting of a plaque and one complimentary registration to the 2006 AAACN Convention, will be presented at the 31st Annual AAACN Convention. The winners will be notified by mail and announced in Viewpoint.

Please contact the AAACN National Office for author guidelines and more information:

Carol Ford, Managing Editor
Viewpoint
East Holly Avenue Box 56
Pitman, NJ 08071-0056
(856) 256-2433 • FAX (856) 589-7463
e-mail: fordc@ajj.com