

aaacn ViewPoint

The Voice of Ambulatory Care Nursing

**Series on
Leadership**

A New Year, A New Career?

E. Mary Johnson

ViewPoint is pleased to present AAACN members with this new series, brought to you by the Leadership SIG. Please share your thoughts, comments, or questions about career planning with E. Mary Johnson by contacting her directly at emjrn@roadrunner.com

Is this your year? As each new year begins, we often pause and reflect on what we'd like to "change" in our lives, including our work life. Our daily lives are often "complicated" or, at a minimum, very busy. It is not uncommon for nurses to say, "I haven't got the time or energy to add another thing to my plate!" Yet, never has the opportunity for ambulatory care nurses been greater, in terms of the changes and challenges existing in health care systems – overall and in your institution in particular. This translates to the reality of actual or potential opportunities that will enhance your career choices and contributions.

AAACN, your professional organization, has always promoted the concept that "every nurse is a leader." This country needs more nursing leadership, whether it is in the small team that you're leading every day or in the Board room – where organizational leaders dialogue and make decisions about how care delivery will take place in their communities. Nurses understand how and what needs to happen in the planning, implementation, and evaluation of patient care. The vision, active participation, and planning of your future goals all start with your willingness to become the CEO of your career. Take charge by reviewing and learning some career-planning basics.

Now is a good time for you to stop, think, and ask yourself where you want to be by year's end. How about five years from now? Professional careers don't just "happen," rather they are often the result of systematic steps that will enhance your career opportunities and job satisfaction. Reflection about your career goals should include your desire to learn more, do more, and be more in the nursing world.

Wondering where to begin? There are three basic steps for you to consider in planning your career goals: *Self-Assessment*, *Goal-Setting*, and *Resume Readiness*.

Self-Assessment

Know thyself! *Self-assessment* is defined as a process of gathering information about you in order to make informed decisions. It's the process of looking at oneself that requires honesty and truthfulness.

Where do you start? It's sometimes hard to know where to begin. It's also important to recognize that our lives are complex and involve many moving parts, consisting of who

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Strength in Numbers: 40 Years of Excellence

As we commence a new year, I thought I might review how far AAACN has come and highlight the multiple benefits of joining and continuing to be a member. Over the years, AAACN has become an influential and recognized organization. This year, AAACN is collaborating with other organizations on several important initiatives.

- American Organization of Nurse Executives (AONE): Dialogue to discuss care coordination and transition management.
- Press Ganey: Develop ambulatory nurse sensitive indicators.
- Medical-Surgical Nursing Certification Board (MSNCB): Develop a certification exam for care coordination and transition management.

Through the efforts of many, AAACN has continued to successfully increase our organization's membership. Those of us who have been members for many years realize how much of a challenge this has been. Most nurses think of joining their "clinical specialty" organization rather than one such as AAACN, which represents the broad spectrum of nurses in ambulatory care. We continue to provide education and support for all nursing leaders in ambulatory care – an unmet need – providing a more clinical focus.

Time and time again, AAACN is lauded for its networking opportunities. Most of us have developed our network of contacts through various Special Interest Group (SIG) email lists, as well as at the yearly conference. These collegial relationships remain strong as the years pass and provide valuable advice and professional support. Additional benefits are the expert advice and information-sharing via the email discussion lists, as well as the practice expertise exemplified by the member-built toolkits on the website.

AAACN began its journey of providing excellent resources with the publication of the *Scope and Standards of Practice for Professional Ambulatory Care Nursing*. Over the years, this document has been updated as standards have changed. The *Core Curriculum for Ambulatory Care Nursing* was another major achievement in educating ambulatory care nurses about their practice in its broadest sense. Other important topics are explored in the *Telehealth Nursing Practice Administration and Practice Standards*, as well as *Telehealth Nursing Practice Essentials* and the *Ambulatory Care Nursing Orientation & Competency Assessment Guide*. Countless other resources and tools help our members become certified. These have been well received and used by many.

Development of the ambulatory care certification pathway was spearheaded by AAACN in collaboration with the American Nurses Credentialing Center (ANCC). AAACN members assisted in creating the test questions and have continued this collaboration. To help our members succeed, we have provided many written resources and review sessions taught by members.

With rapid changes in the ambulatory care practice environment, AAACN developed and disseminated a *Position Paper on the Role of the Registered Nurse in Ambulatory Care*. It is time to update this important piece of work, and we have once again asked for your assistance. Another project was the *White Paper – The Need for an Ambulatory Nurse Residency Program, 2014*. Further information on all the aforementioned publications is available at www.aaacn.org.

In the last year, AAACN has expanded its influence into the care coordination arena with the development of a core curriculum, educational modules, and a certification opportunity that will be available this fall in collaboration with MSNCB, as well as the publication of the scope and standards of practice. AAACN has continued its leadership in the quest to identify ambulatory care nurse-sensitive indicators. In collaboration with Lippincott, Williams & Wilkins (Wolters Kluwer Health), work has begun on identifying ambulatory care nursing procedures.

The growth and influence of AAACN are building. Our organization can remain strong as we attract active members who value those resources and opportunities we provide. I look to you, our current members, to continue the instrumental work you do in expanding our influence.



Marianne Sherman

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The Affordable Care Act and Post-Midterm Elections

Debate and Potential for Change

Now that the midterm elections are over and there is a Republican majority in both the House and the Senate, questions are being asked about the effect this will have on health care reform and the status of the Affordable Care Act (U.S. Department of Health & Human Services, 2010). In the past 2 years, the House voted to repeal the ACA more than 40 times, but there was no support in the Democratic Senate. During the midterm campaigning, much rhetoric focused on the ACA and there were exaggerations, half-truths, and outright misrepresentation of the law. The only way to figure out what could be believed was to go to sites such as FactCheck.org, A Project of the Annenberg Public Policy Center.

In the victory speeches, Republicans have said that they will vote to repeal the ACA. Republicans may also vote to “repeal the ACA’s individual mandate, a linchpin of the law that spreads risk and makes the insurance market” (Altman, 2014b) work, by requiring that individuals purchase health insurance or pay a fine. Republicans have claimed that this mandate will bust the budget, yet:

The Congressional Budget Office (CBO) officially scored the new law as self-financing, projecting that it would actually *reduce* the deficit over the first 10 years — and beyond. And so, it should surprise nobody that the CBO said January 6 that repealing the new law, as Republicans propose, would increase the deficit. The CBO’s latest figures project that repealing the new law will increase the deficit by a total of \$230 billion over the next 10 years (through fiscal year 2021). So keeping it in place would help the budget, not bust it. (Jackson & Robertson, 2011)

Because the ACA is already law and President Obama’s signature legislation, he is most likely to veto such resolution. But the votes to repeal will be taken to satisfy the Republican conservative base. What hopefully will happen is Republicans and Democrats in both houses will sit down and focus on changing/modifying provisions in the law that need to be fixed. The one area that Republicans are focused on is the tax on medical devices. Senator Mitch McConnell, who became the Senate Majority leader in January, has an interesting conundrum. Voters in the state of Kentucky reelected him. That state has one of the most successfully run state insurance exchanges, so it is not surprising that he is talking about repealing the medical device tax rather than focusing on outright repeal of the ACA. The medical device tax is a very small provision in the ACA and was designed to help finance the law.

John Boehner, Speaker of the House, has stated his desire to repeal the Independent Payment Advisory Board, a not-yet-appointed commission, with the power to trigger a reduction in Medicare payments if spending increases exceed certain levels and Congress does not come up with an alternative approach. Another proposed change might be repealing or altering the requirement that larger employers cover their workers or pay a penalty, likely by changing the definition of *full-time workers* from those working 30 hours per week to 40 (Altman, 2014b; Jackson & Robertson, 2011).

Another area of speculation with regards to the recent midterm elections, specifically the elections of new governors, is the impact that new governors may have on Medicaid expansion. There are 23 states that have not elected to expand Medicaid based on an ACA provision. The ACA has a provision that offers states the opportunity to increase the income level of poor workers so that more of them and their families will have access to health care. The Federal government would cover the cost of this expansion of coverage; the only cost to the state would be costs of administering Medicaid.

In states that do not expand their Medicaid programs, uninsured people with incomes below the poverty level end up in a “coverage gap” where they have no options. They make too much money to qualify for their state’s Medicaid program or don’t fall into their state’s eligibility groups or they don’t earn enough to qualify for insurance tax credits under the ACA. (Altman, 2014a)

Ambulatory care nurses and their patients and families should keep an eye on media releases about changes in the ACA and possibly changes in Medicaid eligibility as the new legislators return to Washington, DC. Families may ask for clarification about health care reform changes as they hear about them. A word of caution, however: don’t believe everything that is said or read. FactCheck.org is a great place to verify whether what is said is truth, half-truth, or a misrepresentation. Another option is to let your current or new legislator know what you think about proposed changes. All it takes is an email to their local or Washington office. They really do read and listen to what constituents have to say.

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Are You Prepared for the Office Emergency?

Deadline for Submission: February 28, 2017
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Objectives

The purpose of this continuing nursing education article is to inform ambulatory care nurses and other health care professionals how simulation-based trainings in ambulatory care can assist with preparing for an office emergency. After studying the information presented in this article, you will be able to:

1. Identify strategies in providing realistic scenarios that challenge staff to think critically and test their knowledge in a safe environment prior to a real emergent event.
2. Discuss how the reflective practice of debriefing after a simulation can be an effective tool toward team communication.
3. Describe the benefits of providing emergency simulations in correcting deficiencies prior to an actual event.

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Are You Prepared for the Office Emergency?

Joanne P. Martin



In 2001, I was a Nursing Administrator of a small family practice clinic in the Seattle area. One Saturday morning, I was working as the only RN due to a sick call. Prior to that Saturday, if you had asked me, "Are you prepared for an office emergency?" I would have answered "of course." After all, I was Advanced Cardiac Life Support and Basic Life Support certified, and I had worked for many years as an Emergency Room nurse. This clinic had a well-stocked crash cart that was securely locked and checked regularly. Our emergency process and policy described providing basic life support and early transport to a higher level of care. Like most facilities, our staff orientation and annual safety training provided a review of the emergency equipment. All staff were trained in providing basic life support to patients of all ages. That day, our preparations were tested when a mother ran through the waiting room screaming that her baby was not breathing. It seemed like it took forever to assess this child, who was wrapped in a queen-sized quilt. It was clear her airway was compromised. As a young mother, I understood this mother's fear and as the first responder and nursing leader, I was now responsible.

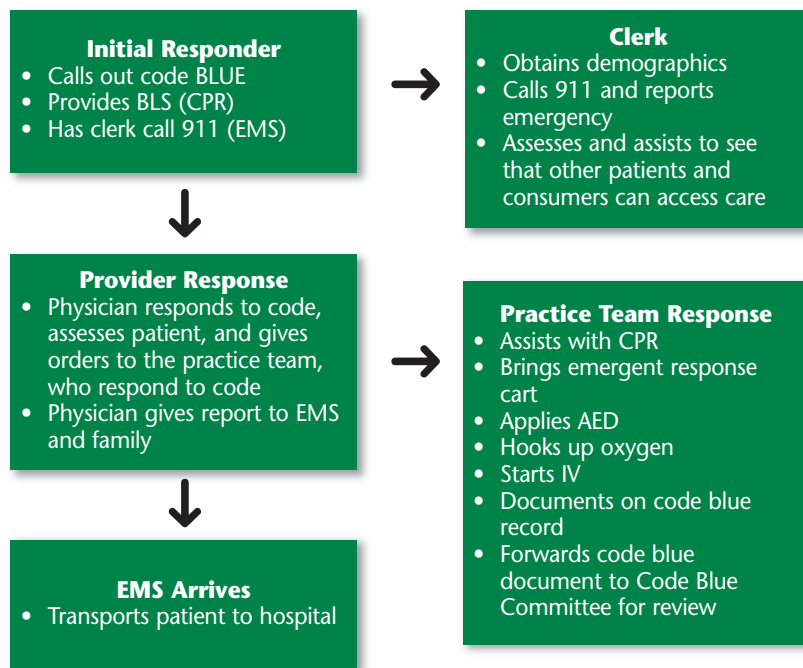
To be able to answer that question – of whether or not I was prepared for an office emergency – there are many more questions to ask. It isn't just about credentials and crash cart supplies, but rather what do your patients expect, what equipment do you need, and do you remember how to use it? You also need to know your setting's policy or procedure in the event of an emergency. The understanding of the role you will play along with all other responders' roles is critical. I was not familiar with where

to find the airway supplies for a pediatric patient. The Medical Assistant I was working with had never turned on an oxygen tank and the physician was not experienced with pediatric emergencies. We had a mother who was extremely anxious and this child's airway was compromised. The ten-minute wait until the medics arrived was the longest ten minutes in my nursing career. This incident is why I have become so passionate about the need for simulating critical events in ambulatory care to prepare for emergencies.

Because emergencies are infrequent in an ambulatory care setting, it may be more challenging to stay prepared for critical events. Donaldson's (2008) overview of The Institute of Medicine's report, *To Err is Human: Building a Safer Health Care System*, outlines the role of simulation training as a strategy within the concept of patient safety providing circumstances where staff can practice standardized processes and tasks to plan for the prevention of errors. A critical contribution to this child's survival was due to the early activation of Emergency Medical Services (EMS) by our receptionist. Recognition and first response in any emergency is critical to patient safety. This real event demonstrated the importance of the whole team being prepared for an emergency. According to Aggarwal and colleagues (2010), preparation is about more than just individual skills and knowledge, but also about how teams communicate and interact in an emergency as these occasions in ambulatory care settings are rare and it is more challenging to stay prepared.

How frequent are office emergencies? A review of the literature did not reveal recent surveys on this topic. The surveys cited took place many

Figure 1.
Lahaina Code Blue Process



years ago. Tolbeck (2007) cited a survey of rural Australian general practitioners, which indicated a median of eight emergencies per year, and 95% of those surveyed had at least one emergency a year. Another survey cited found the average family practice office had 3.8 childhood emergencies each year. Sempowski and Brison (2002) looked at classifying risk of an emergency in an office. The authors listed many factors that placed a practice at low, moderate, or high risk. Whether a practice was considered moderate or high risk was based on differences in volume, distance from an Emergency Room, procedures performed, and whether or not walk-in services were provided.

At the Kaiser clinics on the Island of Maui in Hawaii, there are variations in the volume of patients served, distance from the only community hospital, and services provided. While providing scenarios in 2009 for training purposes in required basic and advanced life support, we learned the equipment and clinic emergency processes varied and lacked standardization. In order to begin the process of rolling out the standardizing of

equipment and processes and training staff, our organization used a hands-on approach. The staff embraced this method and feedback was positive. The staff provided input to help us focus training on the most common life-threatening emergencies encountered. These were chest pain, anaphylaxis, and pediatric respiratory distress. Simulating common emergency situations, followed by a team-focused debriefing, developed into an ongoing improvement project. The initial goal of educating staff and standardizing equipment using simulated events was realized with an added benefit of communication and team performance.

As outlined by Durham and Alden (2008), the term *simulation* is a technique or device that attempts to create characteristics of the real world. There is a range of simulation devices and equipment that can be used from the very complex (high fidelity) and highly technical to the very “low tech” (low fidelity). The training devices of today can replicate almost all physical characteristics used to simulate an actual event. High fidelity mannequins can be programmed and controlled

from another computer to replicate vital signs and even change skin color. The high fidelity mannequins are expensive and their use may be more appropriate in a trauma training situation. Our organization’s plan was to use the portable infant-, child-, and adult-sized low fidelity mannequins we had available, along with a rhythm generator and Automatic External Defibrillator trainer. Relevant scenarios with the use of low fidelity equipment have provided our teams with opportunities that simulate emergent events in a non-testing environment. Our focus was to prepare staff to be able to recognize and understand their response plan to an actual emergency using the appropriate equipment and supplies.

Initial Response

As a result of the simulations, many participants were found to be unfamiliar with their clinic’s processes. Activating EMS and identifying which staff responds to a call for help were some of the questions addressed in our simulations. Some of the clinics did not have an overhead paging system, while others had a specific number to call. When debriefing a simulation, we reviewed the relevant clinic or department’s written emergency process or policy. This allowed us to clarify and update the process/policy to ensure all questions were answered and the front line staff understood it. As part of a review process, it was found that the initial response differed at each clinic. With this data in mind and knowing that the initial response to a life-threatening event is critical, our clinics chose to focus on the initial response. The response process visual workflow was invaluable in helping us debrief and review our process during a simulated event. An example of a response process developed by one of the clinics is described in Figure 1. The response processes were shared and developed to assist clinics with a more realistic and detailed response plan the staff could follow and understand.

Staff input was crucial in making helpful improvements such as ensuring each phone had a sticker on it with the important information on calling for help in an emergency. The

Figure 2.
Crash Cart Contents



application of a sticker on a phone may seem a simple thing to do, yet it helps to do the right thing in an emergency, which can save time. Identifying the staff who will respond and the primary roles they will play was critical.

Equipment and Supplies

After opening the crash cart and using the equipment and supplies, the following opportunities for improvements were found.

Required medications. The carts initially mirrored a hospital or emergency room crash cart. Many of those drugs were not familiar to staff and were more advanced than would be needed in the clinic setting. With our goal to provide support and early transport to a higher level of care, the decision was made to work with pharmacy to ensure the right drugs were available that might be needed until EMS arrived. The simulated events incorporated the actual administration of medications, which also offered learning opportunities to the nursing staff. Anaphylaxis scenarios offered the opportunity to calculate Epinephrine medication dosages for pediatric patients and the proper administration technique for Epinephrine Auto Injector Pens.

Equipment use. As a result of the simulations, our organization encountered clinical areas that needed clarification of response level and/or correc-

tions in crash cart equipment. Clinics were defined at two different levels of response: Basic Life Support and Advanced Life Support. Basic Life Support Clinics were defined as those clinics that would be providing effective bag mask ventilation until transport to a higher level of care rather than having advanced airway equipment in the crash cart. Advanced Life Support Clinics were clarified as those areas where surgical services or conscious sedation were being performed; therefore, an advanced level of airway equipment was required over and above the Basic Life Support Clinic crash cart equipment. In the Basic Life Support Clinics, crash cart supply levels were reduced appropriately, which made it much easier to locate items. Figure 2 is a comparison photo of before and after improvements in stocking the crash cart. The simulations also assisted staff in making decisions regarding inventory as well as in proper equipment use. In addition, some of the monitor defibrillators used in the simulations required updated software to meet the new American Heart Association guidelines of two-minute shock intervals.

Staff Training

In 2008, LaVelle and McLaughlin identified wide disparities in approaches, unfamiliarity with equipment, and lack of skills and confidence in handling office emergencies, and

they implemented team-based simulation to improve emergent care responses in the ambulatory setting. They focused on the two most common, high-risk events: patients with chest pain and patients with anaphylaxis responses. Both of these events require excellent assessment skills, psychomotor skills, critical thinking, and teamwork. Similarly, our clinics also recognized the staffs' discomfort in assessing and managing patients with emergent needs and thereby initiated simulation sessions called "Mock Code Crash Cart Reviews."

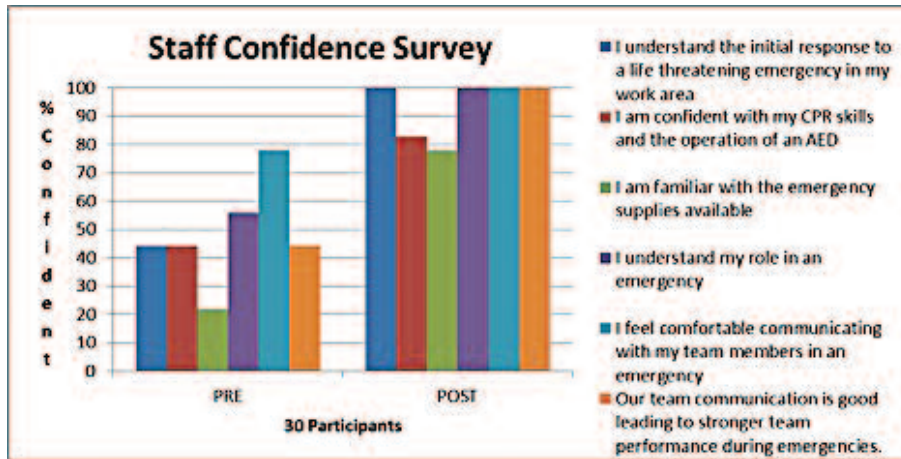
The objectives of these reviews were: to demonstrate early recognition and knowledge of the site-specific policy or process in an emergency, assemble needed equipment and supplies and demonstrate its proper use, demonstrate teamwork and communication by designating a leader and distributing the workload, and practice SBAR communication techniques. Prior to the simulation, we reviewed these objectives and focused our debriefing on the objectives rather than individual performance.

At the beginning of each session, the stage was set for learning by creating a non-threatening environment, described as the pre-scenario briefing. These sessions began with a review of the crash cart contents and equipment – which reinforced the opportunity to practice using all the appropriate and available supplies – followed by a brief discussion of the objectives. A typical scenario was given to allow staff to practice the initial responses. A site-specific policy (or workflow) was applied to the scenario's initial response, cart supplies, and team roles. As Mort and Donahue (2004) discussed, much of the learning occurs during the debriefing stage of simulation. Guided by our review objectives during the debriefing held after simulation, a common finding was how important team communication was to our success. An example was how important it was to call out roles and to identify a team leader and recorder early in the response.

Evaluation and Results

The evaluations of the sessions were very positive. Initially, the out-

Figure 3.
Pre- and Post-Simulation Survey Results



comes were measured by reviewing staff surveys, considering recommendations, and identifying safety concerns. Specific objective measurements were developed using a tool for observers to complete during the simulation. The measurement tool included recognizing emergencies, calling for help early, identifying a leader, and team communication.

The simulations and scenarios have been further developed and are more specific for each setting. For example, a scenario in our ambulatory surgery center could be a patient with Malignant Hyperthermia in the operating room, while the outpatient pediatric department scenario might be a 24-month-old child with a fever who suddenly begins having a seizure. The goal of developing more measurable tools is to allow us to show improvements in safe patient care.

The pre- and post-simulation survey results in Figure 3 illustrate an improved understanding of and confidence in the clinic's process during the initial response and that of the staff member's role. The level of comfort with the supplies and equipment improved after the simulations and remains a need for the staff.

Conclusion

Preparing for the most common office emergencies requires proper training, correct medications, and appropriate and functional equipment for the level of care you are providing. Consistent written procedures and

workflows using simulation-based training have been demonstrated to be effective. Finally a supportive, non-threatening learning environment where specific objectives are emphasized is crucial to success. Team communication and role clarification can be improved by debriefing simulated events. Providing staff with the opportunity for hands-on learning with correct but infrequently used equipment and supplies improves staff confidence levels. When providing an opportunity to test our processes and policies, staff understanding and patient care improvements can be realized. Being prepared for an office emergency requires a team-based approach and simulation-based improvements can be beneficial in all health care settings.

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Anatomy of a Lawsuit

The U.S. health care system is undergoing a tumultuous transition that promises sweeping changes in professional nursing practice, by requiring expansion of old roles and the creation of new ones. The Affordable Care Act will accelerate changes in ambulatory care nursing practice by reorganizing how care is delivered, such as enhanced care coordination, resulting in improved patient transitions across the care delivery continuum. Many organizations have initiated changes in how and where health care is delivered, often without writing the necessary new policies to guide employees, and implementing changes without seeking legal advice or inquiring whether the proposed transition falls within nursing practice standards. In so doing, the nurse and his or her professional license may be placed at risk.

Patients and families look to nurses to provide care and comfort as well as to keep them safe during their health care experience. When patient and family expectations are not met or adverse events occur, nurses are increasingly finding themselves individually named in professional liability suits. There are five main reasons that individuals or families sue (Iyer, 2012).

1. What Happened?

The reality is that people want answers to what caused a poor outcome. They may have received minimal or misleading information, so frank and up-front conversations may avert a lawsuit. However, not all physicians are gifted in discussing why something went wrong. Case #1 describes how families seek help through attorneys to find out why an outcome occurred.

2. Fix the Error

People desire to correct the error so that other patients won't be affected. Lawsuits are limited to dollar (\$\$) compensation and do not result in changes in the health care system. However, organizations that have developed a method to discuss errors and lessons-learned may reduce the reoccurrence of these errors in their organization.

3. An Apology is Desired

The benefits of apologizing to patients and families are small, and the risks are huge to providers. The apology given to a patient may not prevent a lawsuit and in fact, it may pave the way for that process. In Yasgur (2013), 36 states had "apology" laws that bar patients from using an apology against physicians in court. While some states have passed "sorry laws," most states only protect the expressions of sympathy or empathy. By contrast, there are eight states that have explicitly made a distinction between expression of sympathy and admissions of fault and have elected to exclude both types of statements from admission into evidence (Myers, 2012). Location is therefore very important,

as in one state a physician may apologize and not be sued, but in other states would never risk apologizing.

4. Personality and Cultural Differences

Personality and cultural differences may result in different patient expectations. Patients may feel they are not getting the attention they want or need in the chaotic health care environment that currently exists. Suggestions for doctor visits might include having a spouse or patient advocate accompany one to a clinic visit or carry a notebook in which one lists the issues or questions one desires the provider to address. I have used the second suggestion successfully for a number of years and now my doctor always asks, "So what's on your list for today?"

5. Desire for \$\$

Some patients have a big desire for money and they file a claim against an organization to help pay their medical bills. In this situation, out of court settlements are frequent because it prevents bad press for the health care organization.

The Pre-Discovery Stage of a Lawsuit

There are three stages that occur during a lawsuit: pre-discovery, discovery, and post-discovery. The pre-discovery period is very important as it allows the attorney to determine whether the lawsuit has merit and is worth pursuing. The first steps in a lawsuit (pre-discovery stage) include:

1. An individual identifies a plaintiff attorney (one who files the lawsuit). The yellow pages in the telephone directory are a good place to find an attorney or by obtaining a recommendation from friends or family.
2. Once an attorney is selected, the person contacts the attorney's office and will be interviewed by a paralegal/legal secretary to gather pertinent information. The legal team often uses an intake form with specified criteria to gather information such as, the "who, what, when, where, or the why" of an injury or mistake that may have occurred. Less than 5% of calls taken/month are investigated further, because the potential case may not demonstrate sufficient injuries (physical or psychological) (Iyer, 2012). Figure 1 provides a list of elements required to determine whether a case has merit.
3. The attorney then reviews the data collected, looking for potential damages (physical or psychological) to the person. Following the attorney's review of the facts, he/she meets with the potential client to discuss the facts of the case. At that time, a decision is made as to whether the attorney will investigate further. If so, a copy of the medical record is requested (with HIPPA release), and a retainer is paid to the attorney.
4. Good attorneys write an affidavit (sworn statement) on all initial interviews with a client. This is an important step as the affidavit outlines the content of the initial interview and may become admissible to the case should the client die or becomes incompetent later.

Figure 1. Determining if a Case Has Merit

Does this case have merit?

- Is the case still within the statute of limitations? Some types of injuries, such as birth injuries, have a period of time in which a case must be filed.
- Was there a departure from the standards of care? (Requires an expert opinion.) An expert opinion source varies from state to state. Some states permit MDs to provide an opinion on nursing practice.
- Is there a link (causation) between the alleged negligence and the injuries that occurred? If there is a link, it makes the case stronger.
- How is the plaintiff (client who sustained the injury) likely to be perceived by the jury? (Attorney judgment.) If the plaintiff is likeable, a good outcome is possible. The plaintiff attorney may conduct a mock trial to determine how a jury would perceive his client.
- Are the damages (injuries) sufficient to offset the cost of litigation? (Attorney judgment.) The case must be worth at least \$50K for attorneys to prosecute. Clients must pay attorney costs as they occur plus 33% of damages (\$\$) to attorney.
- Do the strengths outweigh the weakness of the case? (Expert opinion will provide this information.)

Source: M.B. Butler, personal communication, January 15, 2014.

Case 1 – What went wrong?

An 88-year-old veteran was admitted to a veterans hospital for treatment of a subdural hematoma after a fall at home. He died three days after admission, and the family wanted answers to “what went wrong.” In reviewing the medical record, there was no nursing negligence, but RN documentation was poor. The family was given a copy of my review and they appreciated the frank and honest discussion regarding their father’s care. The case was dropped (Paté, 2014).

Case 2 – Who caused the injury?

A 40-year-old man visited a clinic for treatment of nausea, vomiting, and diarrhea. After he was placed in an examination room, he went to the restroom and fell, striking his head on the sink. When the medical assistant found him, he was lying on the floor moaning. The physician was notified, vital signs were taken, and 911 was called. When EMS arrived, the patient was placed on a long backboard and was transported to the hospital. The ER physician diagnosed the patient with quadriplegia because he had no voluntary movement of his extremities. There was no nursing negligence found in this case because there were no *licensed* nurses working in this clinic. However, there may have been physician negligence because there was no neurological assessment conducted at the clinic, and the patient had been moved without maintaining spinal cord alignment. The case did not go forward (Paté, 2014).

Note: The cases cited above are nursing negligence cases that have been settled and closed.

5. The attorney, paralegal, and nurse consultant review all the medical records, files, and organizational policies to determine the exact nature of the injury and whether there was a breach in the standard of care. Often attorneys retain a Registered Nurse to provide him or her with an expert nursing opinion as to whether there were negligent acts committed and what nursing standard of care was breached. In an ambulatory clinic/outpatient setting, the American Academy of Ambulatory Care Nursing Practice Standards would apply. These are national nursing practice standards that any reasonably prudent RN, with same or similar skills and knowledge, in the same or similar setting (such as a clinic) in the United States, must follow (Paté, 2010). Generally, the RN expert provides the attorney with a verbal report initially, because any written documents are subject to discovery (the second stage of the lawsuit process) by the opposing counsel. Depending on the verbal report, the attorney may request a written report or affidavit if there are sufficient damages, or the attorney may record the information for the record (M.B. Butler, personal communication, January 15, 2014). In Case #2, an attorney requested a review of a medical record involving a man who fell in an outpatient clinic and asked, “Which nurse was negligent?”
6. The final step in the pre-discovery stage is to file the complaint with the appropriate court (District, Appeals) and jurisdiction (state or federal). When the attorney files affidavits (client or expert witness), along with the complaint, it decreases the likelihood that a judge or a state medical board will dismiss the case. Some states require an attorney to first present the case to the state medical board before filing the case with the court. The state medical board’s responsibility is to determine whether there is sufficient merit for a trial to take place. Thirty days after

filing the complaint, the discovery process (second stage of the lawsuit) begins (M.B. Butler, personal communication, January 15, 2014).

The Discovery Stage of a Lawsuit

The “discovery” stage of a lawsuit is a fact-finding period in which the attorney searches for the truth in what happened to the client. A number of legal procedures are used to gather this evidence, but the deposition of experts is a critical tool in the successful outcome of the case. A deposition of experts is a “pre-trial, sworn testimony of one whose special knowledge of a subject enables him/her to express opinions and draw conclusions in his/her testimony at trial” (Gilberts Law Dictionary, 1997, p. 82). In a case where nursing negligence is alleged, a plaintiff attorney will retain a registered nurse, who works in the same specialty as the nurse involved in the case to review the medical records/files and provides an opinion on the facts of the case at deposition. Often cases are settled after the deposition of experts because the information and facts obtained through the deposition are sufficient for settlement.

Understanding the process of conducting a deposition, evaluating the credibility, skill, and opinions of the nurse witness through the observation of an actual discovery deposition will expose nurses to this tool used by attorneys in preparation for a trial of a lawsuit. Advanced coaching of a nurse witness is a key element in preparing nurses to successfully testify at deposition and trial.

Learn More

Please join your colleagues at the 2015 AACN Annual Conference in Lake Buena Vista, FL, for a pre-conference session entitled “*Taking the Terror Out of Testifying & Survive the Deposition*” to observe a mock deposition and discuss the preparation a nurse must undergo in anticipation of testifying at deposition and trial.

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TIMES

Keeping the Child with Autism Spectrum Disorder Safe

Children with Autism Spectrum Disorder (ASD) present special challenges to keeping them safe in the clinic setting, at home, and in the community. ASD affects children in all racial, ethnic, and socioeconomic groups. According to the Centers for Disease Control and Prevention (CDC, 2014a), approximately 1 in 68 children is diagnosed with ASD, the prevalence being almost five times greater in boys than in girls. Nurses working in a variety of clinical settings are likely to come in contact with a child who has ASD. Williams and Minshew (2010) described ASD as a neurodevelopmental disorder, in which the brain of the child with ASD processes information differently than the child with the normally developing brain; this affects how children react to their environment and their ability to learn, think, and problem-solve. ASD can cause lifelong disability in social, communication, and behavioral areas, although the range of abilities and symptoms is wide and symptoms may change with age (CDC, 2014b, 2014c).

Safety in the Clinic

A visit to the clinic may cause the child with Autism Spectrum Disorder to become very anxious due to a change in their routine and the variety of stimuli encountered in this possibly unfamiliar environment (Inglese, 2009). There are several things that the nurse can do that may help reduce anxiety, facilitate a safe and successful visit, and pave the way for greater success at future visits. Prior to a visit for a test or procedure, call parents to ask about their child's unique characteristics and needs (Byrne-Barta & Anderson, 2013). Ask about nicknames, developmental level, communication abilities, sensitivities, fears, phobias, behaviors, and relaxation techniques that have helped in the past (Golnik & Maccabee-Ryaboy, 2010; Scarpinato et al., 2010). Some children with ASD are hypersensitive to tactile, olfactory, auditory, and visual stimuli and may be hyposensitive to pain (CDC, 2014c). Scarpinato and colleagues (2010) suggested a pre-visit to increase familiarity with the environment and opportunity to manipulate instruments and materials. Request that parents bring a favorite toy, tokens, or rewards used at home. Ask parents to prepare the child at home with books, doctor kits, etc. These children are usually visual learners. Application of analgesic cream at home (if anticipating a blood draw or injection) may be helpful (Scarpinato et al., 2010; Souders, Freeman, DePaul, & Levy, 2002; Thorne, 2007).

On the procedure day, educate staff of patient's unique needs; utilize staff with whom the child is familiar, and have extra staff on hand who are trained to handle

behaviors. Remove extra equipment/clutter and minimize sensory stimuli in the environment (Inglese, 2009; Scarpinato et al., 2010; Thorne, 2007). Ensure that any doors to stairwells or rooms with hazards are closed due to short attention span and impulsivity (Byrne-Barta & Anderson, 2013; CDC, 2014c).

Keeping in mind that the disorder is a spectrum and each child is unique, the following general rules for safety, communication, and approach may prove helpful for any type of visit. Approach the child in a calm and gentle manner, and be aware of his or her non-verbal communication. Minimize distractions, give directions one at a time and wait patiently; the child may have difficulty following directions (Browne, 2006; Inglese, 2009; Williams & Minshew, 2010). Speak directly to the child and use clear, concrete words (Browne, 2006; Scarpinato et al., 2010). When performing your assessment, use family assistance, encourage the child to touch, feel, and hold items. Use techniques such as modeling and imitation and take into account any sensitivity to sound or touch (Inglese, 2009; Souders et al., 2002). Utilize relaxation techniques and use distraction techniques such as counting, watching numbers on machines, or singing. Using positive reinforcement and rewards at regular intervals is often helpful (Golnik & Maccabee-Ryaboy, 2010; Thorne, 2007). Taking these steps may mean fewer behaviors and increased chance of success and safety.

If the child exhibits undesirable behaviors, recognize that this may be a way of communicating. The nurse may be able to offset behavior such as tantrums by using the word "stop" instead of "no." In addition, try telling the child to *do* something (as opposed to asking the child to *stop* doing something) (Browne, 2006). If the child is safe, ignore inappropriate behaviors. Say only what is essential and redirect as appropriate; remember to praise acceptable behaviors (Browne, 2006; Souders et al., 2002; Thorne, 2007). Behaviors such as head banging, biting self, pulling hair, or hitting may be expressions of pain; teach parents to seek medical attention if these occur at home. Problems such as hyperactivity, tantrums, aggression to self and others, and depression may worsen in adolescence, along with development of other psychiatric disorders. Comorbidities such as gastrointestinal issues and sleep disturbances can exacerbate problems and behaviors (Golnik & Maccabee-Ryaboy, 2010; Scarpinato et al., 2010).

Medications used to treat symptoms and lessen behaviors (see Table 1), as well as complementary and alternative medicine sought by parents (see Table 2), can pose additional safety concerns. Knowing side effects and monitoring parameters and precautions can help ensure a safe course (Elder & D'Alessandro, 2009; Golnik & Maccabee-Ryaboy, 2010).

Safety in the Home and Community

Parents of children with Autism Spectrum Disorder face many challenges in keeping them safe in the home and community. Unlike other children, safety precautions are often necessary throughout the lifespan for those with ASD (Autism Society of America, 2014). Teach parents that

Table 1.**Medications Used to Treat Behavioral Symptoms and Routine Monitoring Parameters**

Medication Class	Routine Monitoring Parameters
Select Serotonin Reuptake Inhibitors (SSRIs)	<ul style="list-style-type: none"> ➤ Monitor for increased self-injurious behaviors, suicidal ideations
Atypical Antipsychotics/ Neuroleptics	<ul style="list-style-type: none"> ➤ Blood pressure, height, and weight each visit ➤ Labs: lipids, glucose, liver function, electrolytes, blood count ➤ Extrapyramidal symptoms ➤ EKG
Stimulants	<ul style="list-style-type: none"> ➤ Blood pressure, height, and weight each visit ➤ Blood count and liver function annually
Alpha Agonists	<ul style="list-style-type: none"> ➤ Blood pressure and heart rate

Source: Adapted from Elder & D'Alessandro, 2009.

Table 2.**Precautions Regarding Complementary and Alternative Medicines**

Alternative Therapy	Precaution
Any	<ul style="list-style-type: none"> ➤ Advise parents to talk with doctor; many are controversial
Biological treatment protocols	<ul style="list-style-type: none"> ➤ May complicate management of infections, allergies, and illnesses
Gluten-free and casein-free diets	<ul style="list-style-type: none"> ➤ Insufficient vitamin D, calcium, iron, and protein; supplementation is necessary
Vitamin and mineral supplements	<ul style="list-style-type: none"> ➤ Vitamin D and calcium supplements should be given 2 hours apart from Depakote® or Keppra®
Omega-3 fatty acids	<ul style="list-style-type: none"> ➤ Hold prior to surgical procedures ➤ Toxin contamination ➤ Excess vitamin A

Sources: CDC, 2014d; Golnik & Maccabee-Ryaboy, 2010; Inglese, 2009.

symptoms such as speech delays, inattention, aggression, or antisocial behavior could be the result of lead poisoning due to pica and mouthing objects (Golnik & Maccabee-Ryaboy, 2010). Teach parents seizure precautions because, according to the National Institute of Mental Health (2014), 1 in 4 children with ASD develops seizures; preschoolers and young adolescents are at highest risk (Scarpinato et al., 2010). Due to impulsivity and lack of awareness of danger, they are at greater risk than other children of running away, wandering, getting lost, and trusting strangers (Stull & Ladew, 2010). Teach parents the

importance of having their child carry/wear identification; recall safety information such as name, phone number, and address; know how to make a request; and follow directions such as “stop,” “come here,” and “wait.” Parents should teach their children not to share personal information with everyone. Children should be taught that if they get lost, they should approach someone in a uniform. Some families find personal tracking devices or service dogs helpful (Autism Society of America, 2014; Stull & Ladew, 2010). Children with ASD may also be at high risk for sexual assault, abuse, victimization, and bullying (Autism Speaks, 2014; Golnik & Maccabee-Ryaboy, 2010). Drowning is a risk, especially due to wandering off, because these children are attracted to water. Ensure that pools in the neighborhood are fenced, with locked gates and toys put away when not in use. Close supervision, as well as providing the child with swim lessons (last lesson with clothing on), is essential (Autism Society of America, 2014; National Autism Association, 2014).

Some ways to modify the home environment include making expectations and limits clear with visual clues, placing toys and other items on low shelves in see-through bins, covering outlets and knobs, hiding wires, and locking/alarming cabinets, windows, and doors. Prevention of poisoning can include using pump dispensers for shampoo and soaps. Fire safety can include reading stories about fire safety, making a STOP sign with a picture of a burner or fire, and putting a “Tot Finder” sticker in the bedroom window. If the child is apt to pound windows, use of Plexiglas or boards over windows may be the safest measure. If the child throws things, secure eating utensils and place settings, and use plastic dishes. Corner seating with wrap-around arms may help to reduce behaviors. Other behavioral modification techniques can include modeling and using activity schedules or charts. Positive reinforcement for good behaviors and consistent consequences for unsafe behaviors are key (Autism Society of America, 2014). Finally, provide parents with support and resources.

Conclusion

Nurses are in a unique position to provide safe care as well as education to parents about safety precautions they can use to safeguard their child in the clinic setting, home, and community. We hope that you have learned a few tips that will facilitate a safe and successful visit and help improve the lives of your patients and their families.

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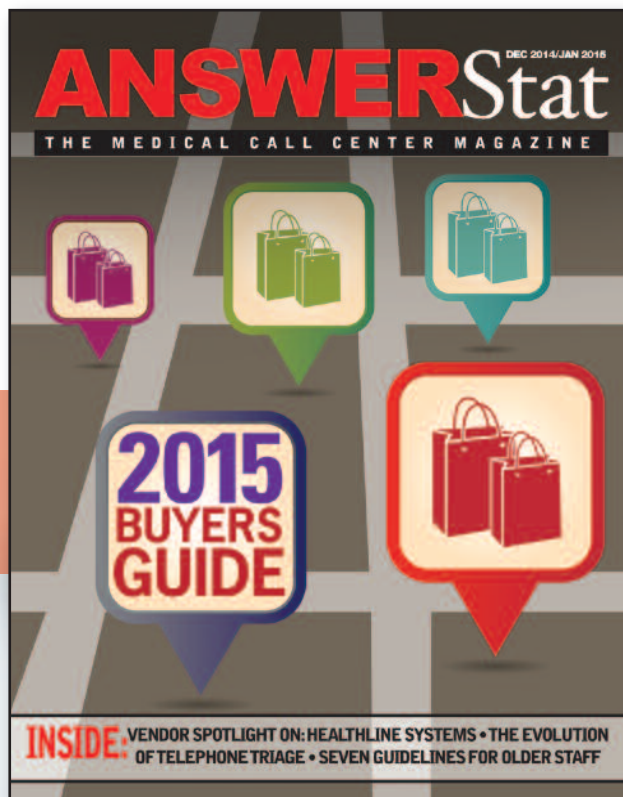
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member spotlight

Deanna Blanchard, MSN, RN-BC, a 1980 diploma graduate, has been an RN for 34 years. After her initial degree, she spent the next 20 years periodically continuing her education to complete her BSN, then MSN, while working mostly full-time and raising three daughters. Her career began in the inpatient setting in general internal medicine, then on to cardiothoracic surgery ICU, and she proudly worked with the very first heart transplant patients at University of Wisconsin Hospital and Clinics (UW).



Deanna Blanchard

After six years of providing care in the inpatient setting, Deanna moved to ambulatory care. She has served in roles in family practice, urgent care, home health care nursing, and as assistant manager, population health management, parish nursing, and EMR education.

It was just three years ago that Deanna came back to UW as a nursing education specialist for about 1,100 ambulatory care clinic staff at nine locations – what a huge job! She spends the majority of her time coordinating ambulatory orientation, and annual review for all staff. She also plans educational inservices for all staff to include contact hours. Deanna frequently presents on various topics during preceptor, advanced preceptor, and mentoring workshops held for non-RN staff who train others. She is active in the ambulatory care nursing council and other system-wide committees such as fall prevention, policy, and protocol. In addition, she works with staff to complete required competencies and to learn about new procedures and equipment. Of course, she performs other duties as assigned.

As an educator with an Ambulatory Care Nursing Certification, Deanna decided to join AACN in 2011 to promote professional development among ambulatory care staff. Certification and membership were a way for her to model that behavior as well as link to so many great resources. Her volunteer activities include serving as a manuscript reviewer for *ViewPoint* and participating in a workgroup focused on preparing a preceptor training toolkit. The aspect of the organization she likes most is the support and promotion of professional ambulatory care nursing.

According to Deanna, the one AACN conference she was able to attend was “excellent and very motivating.” She says, “Ambulatory care is growing, and keeping professional nursing involved in decision-making and leadership is very important.”

Deanna uses the *Core Curriculum for Ambulatory Care Nursing* and the *Review Questions* book when helping nurses prepare for the ambulatory care certification exam. She has also used the DVD of the review course in the past. Over the past three years, Deanna has conducted review workshops with 49 RNs, and so far, 100% of those who have taken the exam have passed. Hooray for Deanna’s expertise and extra efforts!

To Deanna, the best part of working in an ambulatory care setting is the long-term, deeper relationships formed with patients and their families over the years. That is the message she gives RNs who are considering ambulatory care – they will really enjoy and value those relationships. Because her current position is not so closely aligned with patient contact, she finds it most rewarding to work with ambulatory care RNs who are motivated to be life-long learners and to collaborate with colleagues on projects that improve the quality of patient care. Her greatest sources of job satisfaction have been when nurses created and presented posters of their projects, when nurses become certified, or when nurses develop creative ways to help other staff members learn. All of these outcomes are very rewarding for Deanna.

The biggest challenge for Deanna over her long nursing career has been to avoid becoming cynical about health care. There are so many things that do not function very efficiently or places where resources seem to not reach the right groups of patients. For Deanna, it has become difficult to watch co-workers who are affected by the stress of caring for others, which in turn may cause them to be indifferent to patient needs.

“Sometimes it is difficult to feel like we can make a difference as an individual RN,” stated Deanna. She tries to remember that each patient and each family member is doing the best they can at that moment. She encourages her staff to treat each patient as they would want to be treated; frequently reminding herself of these basic philosophies is what has kept her involved and striving to make nursing care delivery the best it can be.

The pet project that Deanna would like to complete over the next five years is to get an ambulatory care nurse residency program in place. UW has a well-respected and thriving inpatient nurse residency program, so she is focusing on opportunities to expand that service to ambulatory care or perhaps create a track with an inpatient and outpatient component.

Future goals are to finish her nursing career at UW, and then perhaps do some writing for educational publications or online education.

Deborah A. Smith, DNP, RN, is an Associate Professor, Georgia Regents University, College of Nursing, Augusta, GA, and Editor of the “Member Spotlight” column. She can be contacted at dsmith5@gru.edu

It’s Your Time To Shine!

If you would like to be featured in the “member spotlight” in a future issue, please contact Deborah Smith at dsmith5@gru.edu to receive a brief set of introductory questions. These questions can also be found on the AACN website (www.aacn.org/viewpoint). Please include a high-resolution photo with your submission.

A New Year, A New Career?

continued from page 1

we are and what we currently are responsible for in our lives. For that reason, I suggest beginning with an exercise that recognizes all the different areas that reflect your everyday life. In other words, consider the big picture view of your life!

A Road Map for Setting Goals

Step 1. Make a list of the following categories: Family, Friends, Personal Love Life, Spiritual, Career, and Money.

Step 2. In each category, determine and record your greatest pain, weakness, or challenge.

Step 3. In each category, determine the best solution and course of action that will honor you in overcoming each challenge.

Step 4. Break down each course of action into manageable “baby” steps, and reward yourself when you reach your goals. (Have some fun!)

Step 5. Post your goals within plain sight as a daily reminder.

Step 6. Share your goals with someone you trust; choose someone who will support your efforts to attain these goals.

Step 7. ACT!

Another favorite self-assessment tool that I often recommend focuses on the better understanding of your strengths and abilities. A book by Buckingham and Clifton (2001) called *Now, Discover Your Strengths* provides an assessment that assists in identifying your skills, talents, and knowledge strengths in order to focus and develop yourself into a more effective and engaged performer. Your answers to the descriptive questions identify your individual top five strengths. The advantage of doing this assessment of self is that it “coaches” you based on your results and suggests strategies on how to apply those skill sets in working with others. I often refer to this particular tool as “The best-ever \$ 20.00 investment in self!”

Get Your Resume Ready

If I’ve heard this statement once, I’ve heard it (what seems like) a thousand times, “My resume isn’t quite up to date – I need to add something(s).” In my experience, there are three key missing links that will continually show up when I’m doing resume reviews.

Missing link 1: Failure to frequently review your resume. You should be doing this every six months! This small habit can yield great results. When your resume is always updated and accessible, it does two things: it helps create a positive professional image and it’s an affirmation of your accomplishments. The ability to quickly email your resume to a prospective recruiter/HR manager is the primary purpose of this exercise. Most job opportunities are found through NETWORKING. Some data suggests 70% of new jobs are found in this manner (Cornell University, 2015). An accessible, current resume allows you to take advantage of opportunities as you become aware of them – often through networking.

Missing link 2: Not having an appropriate email address. It needs to be *professional* in tone and not catchy

or cute. This means you should use your name and/or initials – not phrases that reflect your passions or interests. I’m amazed at what nurses list as their point of contact (e.g., *krazykats@*, *PB&jx5@*, *serialthriller@*, etc.). (Yes, these are actual email addresses that I’ve seen and advised be changed immediately.) The lesson learned here is that no one reviewing your online resume is impressed or thinks these email names are clever or cute.

Missing link 3: Forgetting to differentiate yourself from the crowd. Remove the objective statements from your resume. They add no value in describing you. Basically, all objective statements on resumes say the same thing! They reference that every nurse wants “to work as part of a highly effective team that provides excellent patient care.” Who doesn’t want to work in that kind of environment? Instead, add a “Summary of Qualifications” section. This bulleted section helps to differentiate you as a candidate for a position. An example of this section:

Summary of Qualifications

- Demonstrated effective team leader
- Strong initiative and follow-through
- Extensive clinical/operational knowledge
- Ability to communicate and collaborate with various disciplines
- Quality care and research experience

These are some beginning steps to consider while moving forward with your career. The health care world needs nursing leadership to affect change. This all begins with you – the individual nurse – and your willingness to assess, plan, and evaluate your career.

2015 has already begun. Maybe, just maybe, it’s your year of new beginnings!

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