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The Voice of Ambulatory Care Nursing

JULY/AUGUST 2005

Inside

FEATURES

NEWS

Susanne A. Quallich, APRN, BC, NP-C, CUNP

Informed consent is the legal doctrine that every adult individual has the right to decide what can and cannot be done to his/her person; this is the issue of autonomy. But the actual concept of informed consent was hundreds of years in the making, and began with the requirement for respect of the individual inherent in the Hippocratic Oath. It was fostered during the Renaissance with the assertion of individual rights. Society began to object to medical experimentation without the prior knowledge of participants in the 1900s, although consent at that time meant simply that the patient agreed to treatment, without a discussion of risks, benefits, or alternatives.

This concept of consent was also the result of historical common-law suits for battery, and conventional practice dictated that participation both in medical treatment and medical research must be voluntary. This belief was furthered by the atrocities in Germany during World War II. The phrase "informed consent" became part of the legal system in the United States in 1957 as the result of a malpractice case in California.

The legal definition of informed consent evolved considerably during the second half of the 20th century, leading to the development of the professional standard and the requirement for detailed discussion of a treatment and its risks and benefits. The decline in society's tolerance for paternalistic medicine, as well as patients who sought specific information about invasive and complex medical treatments, helped to further influence the practice of informed consent today.

Consent Specifics

As the health care environment becomes increasingly litigious, and as patients can obtain information freely via the Internet, understanding the specific components of informed consent becomes vital. In general, consent is not required when the procedure is "simple and com-

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The CE Evaluation Form and Objectives for this article appear on the AAACN Web site (www.aaacn.org). Please complete and submit this form to the AAACN National Office to obtain CE credit.

From the PRESIDENT

Volunteers: *The Key to AAACN's Future*

Regina Phillips

AAACN exists because of its many volunteers who share their expertise and donate countless hours to help you enhance your ambulatory practice and professional career. I have benefited from these efforts over the course of my 10-year membership in AAACN through the use of products such as the standards and the many opportunities to consult with peers in my practice area. Today's volunteerism is about making an impact and seeing the results (Levesque, 2002). Before I became a volunteer leader in AAACN, I never realized how much goes on behind the scenes to provide value to you and your membership. I would like to share some of the activities our volunteer leaders are working on to help us achieve the goals of our strategic plan.

Each year at the annual conference, we hold a Leadership Symposium to recognize and thank our volunteers, and to plan for AAACN's future. At the 2005 symposium, we focused on our strategy for change. We discussed the knowledge-based decision-making process developed by Tecker Consultants that was used to create AAACN's new strategic plan and redefine our core business, which is "nurses as leaders" (AAACN, 2004). Members of the Board of Directors shared our new outcome-oriented goals (knowledge, education, advocacy, and community) with symposium attendees, and I will share some aspects of the goals with you throughout the year in my President's Messages.

Each of these changes were the culmination of several years of member surveys that were conducted to identify the value of membership in AAACN, how to communicate the value, and member expectations. We asked, and you answered. Here is what we have done for you lately. Our volunteer leaders implemented several projects to jump start the strategic plan and address some of the issues you identified, which resulted in several new AAACN products. First, you told us you needed information about staffing ambulatory care settings. The AAACN *Annotated Bibliography* is a product resulting from the work of several volunteers, led by Board Directors Beth Ann Swan and Karen Griffin. These individuals reviewed ambulatory care literature on staffing to bring you this resource of up-to-date staffing research literature.

Second, the Project Management Task Force was charged with developing a process for managing AAACN projects from conception to conclusion. Led by Lt. Col. Vivian C. Harris, USAF, and Board Liaison Capt. Sara Marks, USN, the Task Force completed its project in six months and presented the results during the Leadership Symposium. The Project Management tools developed by the Task Force are frameworks to assist in project management and will be used for future AAACN projects. An added bonus is that the tools can be used by our members to manage workplace and personal projects.

Third, the *TNP Resource Directory* is a 53-page directory that was updated from a previous edition by the TNP SIG Education and Resources Workgroup led by Board Liaison Carole Becker and SIG Chair-elect Rita Svatos, and provides excellent resources on Telehealth nursing practice.

Last but not least, *A Guide to Ambulatory Care Nursing Orientation and Competency Assessment* was developed by the Staff Education Task Force led by Board Liaison Charlene Williams. In addition to Charlene Williams, other contributors to the guide include Carol Brautigam, Linda Brixey, Betty Cody, Lenora Flint, DiAnn Hughes, and Marianne Sherman.

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Reader Services

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Real Nurses. Real Issues. Real Solutions.

FEATURE

Project Management: A Design by the Project Management Task Force

Judy Gavin, Maj., USAF, NC, MA, RNC
Dixie Lyon, Lt. Col. (Ret.), USAF, NC, MPH, RNC

The American Academy of Ambulatory Care Nursing (AAACN) identified the need for a tool to assist in completing short-term and long-term projects, as well as achieving expected outcomes and deliverables. To meet this need, the AAACN Board of Directors established a task force to strategically research and develop a tool for efficient and effective project management. Once completed, this tool would aim to provide a clear guide to assist project teams in identifying essential tasks necessary to accomplish the work, and it would manage time lines, milestones, and deliverables of any project.

In November 2004, a Project Management Task Force of Air Force and Navy nurses was established to research the literature on project management and develop a tool and process for managing all projects from conception to completion. Capt. Sara Marks, NC, USN, was assigned as the Board liaison, and she oversaw the work of the Task Force. Members of the Task Force included Lt. Col. Vivian Harris, USAF, NC; Lt. Col. Dixie Lyon, USAF, NC (Ret); Lt. Cdr. Michael J. Allanson, USN, NC; Maj . Judy Gavin, USAF, NC; Maj. Anna Righero, USAF, NC; and Pat Reichart, AAACN association services manager.

The goals of the Task Force were to:

- Research ways projects can be managed.
- Devise a project management tool for AAACN.
- Brief the completed product at AAACN Leadership Symposium, held during AAACN's 30th Anniversary Conference in April 2005.

The working group met via teleconferences for over three months. They conducted a thorough review of the literature on project management that included tools available to assist with project management. After a comprehensive review, the "Project Management Focus Document," developed by the Air Force Medical Support Agency, Population Health Support Division, Brooks City-Base, San Antonio, Texas, was determined to be the easiest to modify and was selected as the model that would best fit AAACN's needs for managing projects.

Project Management Process Life Cycle Model

Benchmarking from this focus document, the Task Force developed the "Project Management Process Life Cycle Model" as an algorithm for depicting processes and/or activities needed to manage all phases of projects regardless of the size of the project. This model groups tasks into four phases:

- Phase 1: Project Initiation or Assignment (PI).
- Phase 2: Project Planning (PP).
- Phase 3: Project Execution and Control (PEC).
- Phase 4: Project Close-Out (PCO).

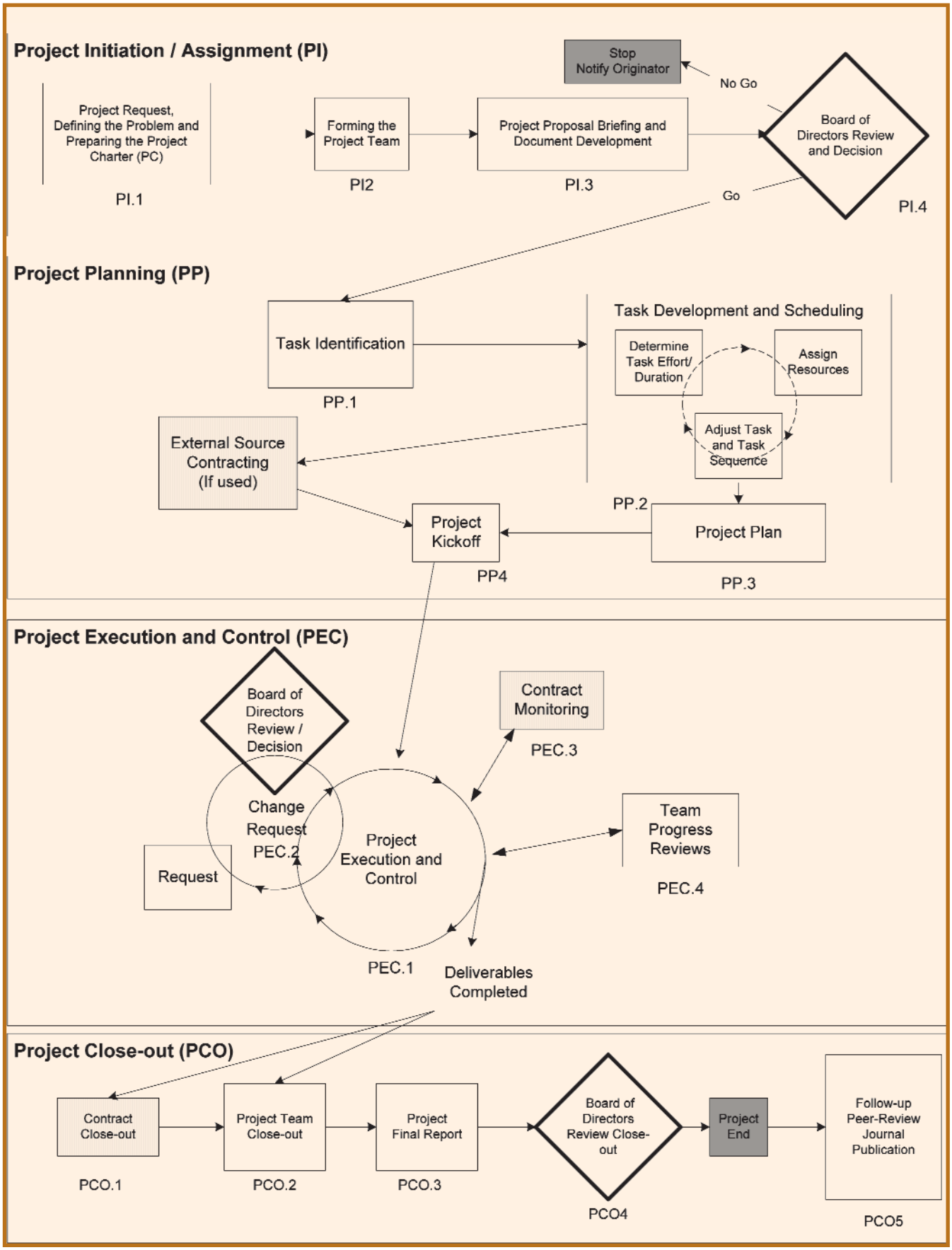
Additionally, the team developed a Project Management Form (working document) that clearly articulates the key elements identified in each phase of the Life Cycle and can be used by the project teams to track and monitor team progress (see Figure 1).

Phase 1: Project Initiation or Assignment (PI)

This phase is critical for the start-up of any project. During this phase, the problem must be clearly identified, stated, and understood to be a true "problem" before a project proposal can be made. The proposal is written and a charter is developed. The charter must clearly state the title and purpose of the project; project team members (to include naming the project manager); parameters of the project; the goals, outcomes, and deliverables of the project team; resources that may be needed to complete the project; and the time frames for completion of the project. In addition, the charter must be approved by the AAACN Board of Directors. The project manager is responsible for determining the number of team members, as well as the experience and expertise needed to work on the project. The manager is also responsible for keeping the board liaison abreast of progress by submitting a project progress report to AAACN Board of Directors' tri-annual meetings. Progress reports should be submitted until the project concludes and is approved by the AAACN Board of Directors.

Figure 1.

Project Management Process Life Cycle



Phase 2: Project Planning (PP)

Once the team is established, project planning begins. In this phase, tasks are identified and scheduling takes place. Tasks are determined and assigned to team members who are responsible for completing the work within a specific time frame. Tasks and timelines should be reasonable with realistic completion dates, and team members should have a clear understanding of the objectives and goals of the project. As a result of this planning, a formal project plan is documented for tracking purposes. Once this is formulated, there should be a project kick-off. This is usually conducted with customers and stakeholders so that they understand the project and it is what they had envisioned. If the project is outsourced, the kick-off should include the hired contractors because they will be responsible for briefing their plan to the group. Occasionally during the kick-off meeting, there will be adjustments made to the plan based on the customers' and stakeholders' needs and expectations.

Phase 3: Project Execution and Control (PEC)

Execution and control of the project is a dynamic process. It includes delineating the roles and responsibilities of team members, frequency or group meetings, and how the group will meet (such as monthly and/or bimonthly teleconferences or face-face meetings). The project manager is critical to this phase. He or she is responsible for reviewing the work of the team to ensure that milestones and goals are being met and tracked. Project barriers or challenges are appropriately addressed to keep the project on target. Any and all changes proposed will be briefed by the project manager to the Board liaison for review, discussion, and approval. The execution and control phase can be considered the lynch-pin of the project and continues throughout the life of the project.

Phase 4: Project Close-Out (PCO)

As the project nears completion or close out, the project outcomes and deliverables may need to be reviewed by an internal review board established by the Board of Directors. This review board should be the "objective" audience for the project briefing to ensure that the outcomes and/or deliverables are met and that the briefing is concise and succinct. The final product should be presented to the AAACN Board of Directors for approval and a final report should be submitted to AAACN in a package that includes an executive summary, table of contents, the actual report, glossary of terms, and a bibliography of all references cited. Once the board has reviewed the final product, any recommendations for changes will be completed and the final package approved.

Conclusion

In April 2005, Lt. Col. Vivian Harris, team leader for the Task Force; Maj. Judy Gavin; and Lt. Cdr. Michael Allanson presented their completed project to the AAACN Board of Directors at the AAACN National Conference in San Diego, CA. The Project Management Focus Document was approved by the Board of Directors and was adopted as the working document and tool for all AAACN projects.

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Additional Readings

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Leading in a Culture of Change

March 23-27, 2006
Sheraton Atlanta Hotel, Atlanta, GA

AAACN's 2006 31st Annual Conference

The AAACN 2006 Conference Planning Committee is hard at work lining up speakers for the 31st Annual Conference, "Leading in a Culture of Change," being held in Atlanta next March. Specialty session and concurrent session speakers are still being confirmed, but pre-convention workshops and general session speakers have been slated. Here's a peek at what to expect for 2006!

This year, the pre-convention workshop will present a JCAHO Update. AAACN Past President Shirley Kedrowski will share her vast knowledge and expertise with us, bringing us up to date on the JCAHO visits and how they work, the Tracer methodology being used in the visits, and the national patient safety goals included in the survey. Ms. Kedrowski has the ability to make the preparation necessary to be in compliance with JCAHO seem obtainable, and she will keep you interested for the entire afternoon. Bring your questions and your concerns, and gain valuable information from the expert!

Shirley Kedrowski

Anne Ryder

Don't miss one minute of the general session featuring *Eyewitness News* Anchor and Emmy Award Winner Anne Ryder. Anne has earned numerous national, regional, and state honors for her reporting, including the prestigious Gabriel and Wilbur awards, two Edward R. Murrow awards, and more than a half-dozen Emmys. She created and produces *Hope to Tell*, an ongoing series of reports about hope, faith, and the resilience of the human spirit. Her reporting has taken her all over the world, from Bosnia and Kosovo during the wars, to Northern Ireland during the historic Good Friday peace accord, to Calcutta, India. Anne was the only American reporter in more than a decade to be granted a sit-down interview with Mother Teresa. It was the last interview the nun gave before her death. Anne's documentary, *In the Arms of Mother Teresa,* sold more than 7,000 copies, with proceeds benefitting the Missionaries of Charity. Anne will share stories and show video clips of her talks with Mother Teresa, with patients whom she met while there, and inspire a feeling of awe and pride in our profession.

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AAACN Announces 2006 Slate of Candidates

The AAACN Nominating Committee is pleased to present the 2006 slate of candidates for the upcoming election by the membership. These candidates are from varied and prestigious backgrounds and have agreed to devote their expertise to serving AAACN.

President-Elect (1 position)
Karen Griffin, MSN, RN, CNAA
Charlene Williams, BSN, RN,C

Board of Directors (2 positions)
Linda Brixey, RN
Belinda Doherty, MBA, BSN
Cynthia Pacek, MBA, RN, CNA
Marianne Sherman, MS, RN,C

Nominating Committee (1 position)
Ruth Ann Obregon, MSN, MBA, RN
Linda Schneider, BSN, RN

A ballot will be mailed to all AAACN members in November 2005. I ask that you take the time to review the candidate information and cast your vote for the colleagues who will best represent your voice as an ambulatory nurse and a member of AAACN.

Kathleen P. Krone, MS, RN
Nominating Committee Chair
kkrone@cch.org

AAACN Endorses a Healthful Work Environment

The AAACN Board of Directors has agreed to endorse the Nursing Organizations Alliance "Principles & Elements of a Healthful Work Environment." This statement addresses nine principles of a healthful work environment. To read the complete statement go to **www.aaacn.org/news/o5na_statement.pdf**

Summer Board Meeting held at National Office

2005-2006 AAACN Board of Directors

The 2005-2006 AAACN Board of Directors met for the first time at the National Office in Pitman, NJ, on June 17-18. This meeting is held at the National Office annually so that new Board members and Board members assuming new roles can be oriented to their new position as well as understand the workings of the National Office. Everyone who works on the AAACN account introduced themselves to the AAACN Board and explained his or her role in AAACN's success. Both AAACN's financial advisor and accountant gave presentations to the Board to explain their involvement in managing AAACN's assets and ensuring accurate record keeping.

Preceding a duration of team-building exercises, the Board accomplished the following agenda items:

- Made decisions on recommendations from the Public Relations and Marketing Task Force.
- Received the final draft for review of *A Guide to Ambulatory Care Nursing Orientation and Competency Assessment.*
- Approved the 2006 slate of candidates.
- Discussed an alliance with a patient education materials vendor.
- Reviewed the final figures from the San Diego conference and the first quarter financial report.
- Discussed ways to use technology to enhance communication and education of members.
- Endorsed the Nursing Organization's Alliance "healthful work environment" statement.
- Completed the full two-year review of the *AAACN Policy and Procedures Manual.*

After working diligently for two days, Board members and staff took a quick trip to Ocean City, New Jersey, for some not-so-low calorie dinner items and cool ocean breezes.

Work on 2nd Edition of the *Core Curriculum for Ambulatory Care Nursing* has Begun

AAACN has obtained the copyright to produce the 2nd edition of the *Core Curriculum for Ambulatory Care Nursing.* Candia Baker Laughlin has been appointed editor, and Anthony J. Jannetti, Inc. has been selected as the publisher. Candy is currently seeking chapter authors and reviewers to help complete this massive project. Watch for AAACN e-news announcements for a call for writers and reviewers. Let us know if you believe you have the expertise to contribute to this important publication.

Candia Baker Laughlin

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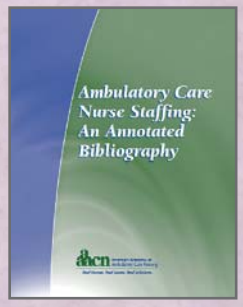

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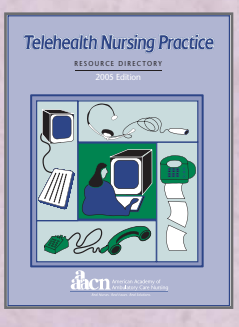
Are you looking for great ideas for nurse staffing?

AAACN has developed an excellent spring-board for you to find the best staffing model for your ambulatory setting.
Ambulatory Care Nurse Staffing: Annotated Bibliography

Do you need help starting or improving your telehealth services?

Our revised guide provides resources to assist you with professional standards, decision/practice support tools, textbooks, articles, Web sites, newsletters, continuing education, consultants, etc.
Telehealth Nursing Practice Resource Directory



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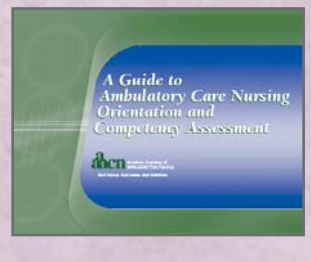

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Orienting your staff has just become easier!

AAACN's new guide helps you develop a customized orientation process for new employees based on specific competencies.
Guide to Ambulatory Care Nursing Orientation and Competency Assessment

Ambulatory nurses are everywhere caring for you

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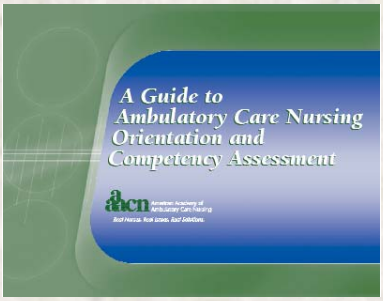
The Wait is Over!

A Guide to Ambulatory Care Nursing Orientation and Competency Assessment has been completed. Many members pre-ordered the publication at the San Diego conference, and we appreciate your patience as we refined the last draft of the document. This 200-page guide presents fundamental competencies to direct the orientation process for new ambulatory care staff. The information can also be used to evaluate existing staff. We know you will feel the competencies were worth the wait!



Chapters include:

- Chapter 1: *Putting it All Together*
- Chapter 2: *Organizational/Systems Role of the Ambulatory Care Nurse*
- Chapter 3: *The Clinical Nurse Role in Ambulatory Care*
- Chapter 4: *The Professional Nurse Role in Ambulatory Care*
- Chapter 5: *Telehealth Nursing Practice Competencies*

Appendices: Over 60 pages with sample tools on Delegation of Tasks and Procedures; Environmental Management and Safety; Ethics, Informatics, and HIPAA; Patient Care Review; Clinical Nursing Competency; Initial and New Competency Assessment Form; Medical Record Review Tool; Charge Nurse Orientation Plan; Telehealth Orientation; Orientation of RN, LVN, MA, and OA; Competency-Based Check-Off; and more!

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AAACN is Spreading its Wings to find Members

The Board of Directors has approved funding to support AAACN exhibiting at two specialty nursing conferences where attendees could benefit from membership in AAACN or our educational products. The conferences AAACN will attend are:

Pediatric Nursing Conference
September 16-18, 2005
Philadelphia, PA

American Association of Nurse Executives
April 20-22, 2006
Orlando, FL

Member-get-a-Member Campaign Underway – Get in on the Action!

We have found that most members join AAACN because a colleague has recommended AAACN to them. You probably do this frequently, maybe without even realizing you are officially "recruiting." We encourage everyone to remember to ask anyone you recruit to write your name in the "referred by" section of the membership application. We ask that you consider having your own "mini-campaign" to recruit members. If you recruit the most members (6 or more) by December 31, 2005, you could win an expense-paid trip to AAACN's 31st Annual Conference in Atlanta, including free registration. Members who recruit 3 or more members will receive a $100 certificate good towards any of AAACN's products and/or education offerings. Download a membership application from the Web site or contact the National Office at 800-262-6877 for a supply of applications or to request an electronic copy. Start recruiting today!

Have a Safe and Relaxing Summer

We know our members are busy year round juggling work and family responsibilities. Summer is a time to sip a cool lemonade, relax in a pool or on the beach, read a good book, barbecue, or get to explore that one thing you have really wanted to do. We hope you will spoil yourself a little over the next few months. As an ambulatory care nurse, you most likely spoil and take care of your patients and family before yourself. We hope you will take our advice and take some "summer" time for yourself. You deserve it. *Have a happy and safe summer from AAACN!*

Needlestick Injuries:
Is There a Need for More Effective Safety Devices?

According to a study published in a recent edition of *Current Medical Research and Opinion,* nearly 80% of nurses caring for patients with diabetes reported experiencing at least one needlestick injury (NI). The study, "Needlestick injury in acute care nurses caring for patients with diabetes mellitus: A retrospective study," is the first to quantify NIs in nurses caring for patients with diabetes.

Needlestick injuries continue to be an important public health concern because they can expose health care workers to bloodborne viruses such as human immunodeficiency virus (HIV) and hepatitis. The findings are of concern in light of recent measures by government regulators and the medical community aimed at reducing needlestick injuries.

Government regulators such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Occupational Safety and Health Administration (OSHA) are working together to provide a safe environment for health care workers. JCAHO issued an "alert" geared toward improving health care facility compliance with provisions of the Needlestick Safety and Prevention Act. OSHA's Office of Occupational Health Nursing and the Office of Occupational Medicine share technical information and best practices to control bloodborne pathogen and needlestick hazards in the workplace, while identifying important issues and potential methods to address these issues.

Study and Findings

The study was based on responses to an Internet-based survey from nurses caring for patients with diabetes in 281 hospitals throughout the United States. Of 400 nurses who responded, 313 (78.3%) reported experiencing at least one NI, 110 (27.5%) reported at least one NI within the last 12 months, and 44 of these (40% of 110) reported multiple NIs. Nearly two-thirds of these injuries (73/110; 66.4%) were punctures that drew blood, resulting in one case of hepatitis C. NIs occurred most commonly when the nurses were injecting insulin (33/110; 30%).

Of the 110 NIs reported over the past year, disposable syringes were involved in 88 (80%), and half (55) involved a needle device equipped with a safety feature that was ineffective, mostly because it was not fully activated (47/55; 85.5%), or it malfunctioned (2 to 5; 3.6 to 9.1%). Nurses reported the injuries in accordance with current regulations and policies only 21.8% of the time.

In the two weeks following their NI, 60.1% of nurses said they were more afraid of needle devices than before the injury, and 41.8% said they felt anxious, depressed, or stressed. As a direct result of the NIs, nurses surveyed missed 77 days of work.

About Needlestick Safety

According to the American Nurses Association (ANA), health care workers suffer between 600,000 and one million injuries from conventional needles and sharps annually. These exposures can lead to hepatitis B, hepatitis C, and HIV. At least 1,000 health care workers are estimated to contract serious infections annually from needlestick and sharps injuries. Over 80% of NIs could be prevented with the use of safer needle devices. Less than 15% of U.S. hospitals use safer needle devices and systems.

According to the American Hospital Association, one case of serious infection by bloodborne pathogens can soon add up to $1 million or more in expenditures for testing follow-up, lost time, and disability payments. The cost of follow-up for a high-risk exposure is almost $3,000 per NI even when no infection occurs.

AAACN 2004 Financial Profile: *July 2004 to December 2004*

In anticipation of the AAACN annual budget converting from its former Fiscal Year (July to June) to a Calendar Year (January to December) in January 2005, the Board of Directors needed to develop a 6-month budget for the last half of 2004. This financial profile summarizes the revenues and expenses for the period July 1, 2004, through December 31, 2004.

The AAACN Board of Directors entered this 6-month budget period with a projected $27,100 deficit knowing that AAACN would realize less than half of its revenues from membership dues and product sales and no revenues from the annual conference during this period.

There were projected revenues of $153,700 versus actual revenues of $143,625. There were projected expenses of $180,800 versus actual expenses of $180,683.73 for a negative variance of $9,958.35. Total expenses exceeded revenues by $37,058.

Discussion and efforts by the AAACN Executive Director and Board were focused on increasing revenue sources, as well as decreasing expenses during this 6-month change period, guided by strategic planning initiatives. Expenses were managed; however, projected revenues were not realized.

Beth Ann Swan, PhD, CRNP
AAACN Treasurer

Cynthia R. Nowicki, EdD, RN, CAE
AAACN Executive Director

JCAHO Announces 2006 Patient Safety Goals For Ambulatory Care Facilities

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has announced the 2006 National Patient Safety Goals and related Requirements that will apply specifically to accredited ambulatory care facilities and offices in which surgery is performed.

Major additions to the fourth annual issuance of National Patient Safety Goals, which were approved by the Joint Commission's Board of Commissioners, include a new requirement stating that "hand-offs" of patients between caregivers be standardized, with particular attention to assuring the opportunity for asking and responding to questions. This requirement is part of the goal: "Improve the effectiveness of communication among caregivers." An additional new Requirement for ambulatory care facilities and offices providing surgical or other invasive services specifies that all medications, medication containers, and other solutions used in perioperative settings are to be labeled. This requirement is part of the goal: "Improve the safety of using medications."

"The 2006 National Patient Safety Goals extend the Joint Commission's commitment to focusing attention on the greatest opportunities for improving patient safety," says Dennis S. O'Leary, M.D., president, Joint Commission. "We are confident that accredited facilities will integrate these requirements into their efforts to redesign internal systems to avoid unnecessary patient disabilities and loss of life."

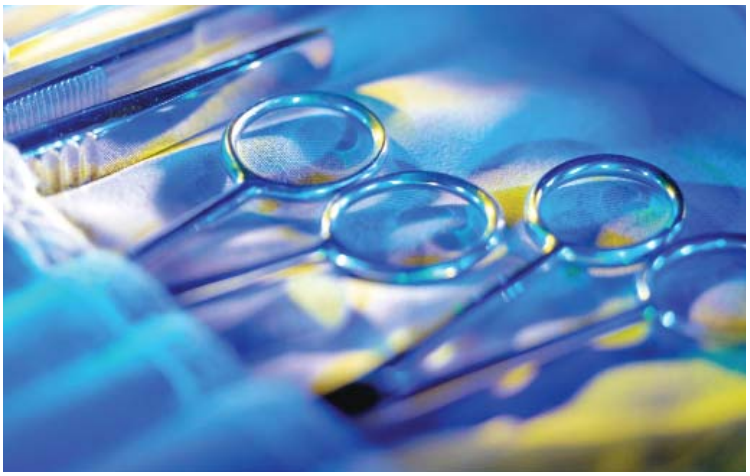
The development and annual updating of the National Patient Safety Goals and Requirements continue to be overseen by an expert panel that includes widely-recognized patient safety experts, as well as nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, the Sentinel Event Advisory Group works with the Joint Commission to undertake a systematic review of the literature and available databases to identify new goals and requirements. Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other parties of interest, the Advisory Group determines the highest priority goals and requirements, and makes its recommendations to the Joint Commission.

In order to maintain the focus of ambulatory care organizations and office-based surgery centers on the most critical patient safety issues, the Sentinel Event Advisory Group also recommends the retirement of selected goals and requirements each year. The following requirements will be retired in 2006:

- Elimination of the requirement to remove concentrated electrolytes (including but not limited to potassium chloride, potassium phosphate, sodium chloride greater than 0.9 percent) from patient care units. This requirement will continue to exist in relevant accreditation manuals.
- Retirement of a requirement to ensure free-flow protection on all general-use and patient-controlled analgesia intravenous infusion pumps used in an organization. Compliance with this requirement has been greater than 99%, and equipment manufacturing and availability issues for all health care settings have been satisfactorily resolved.

The net effect of these changes is that the total number of goal-related requirements for each accreditation program will remain unchanged, as has been true since 2004.

The Board of Commissioners also affirmed the six existing "do not use" abbreviations that constitute a single requirement under the Goal, "Improve the effectiveness of communications among caregivers," but acted to delete a related stipulation that each organization also identify an additional three organization-specific "do not use" abbreviations that have been integral to this requirement as well. Failure to substantially eliminate the utilization of "do not use" abbreviations in medication orders remains one of the most frequent non-compliance findings during Joint Commission surveys.



The 2006 Ambulatory Care and Office-Based Surgery National Patient Safety Goals are:

1. *Improve the accuracy of patient identification.*
   - Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.
2. *Improve the effectiveness of communication among caregivers.*
   - For verbal or telephone orders, or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the

order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.
- Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.

3. *Improve the safety of using medications.*
   - Standardize and limit the number of drug concentrations available in the organization.
   - Identify, and at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization and take action to prevent errors involving the interchange of these drugs.
   - Label all medications, medication containers (such as syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.
4. *Reduce the risk of health care-associated infections.*
   - Comply with current U.S. Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
   - Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with health care associated infection.
5. *Accurately and completely reconcile medications across the continuum of care.*
   - Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
   - A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner, or level of care within or outside the organization.
6. *Reduce the risk of surgical fires.*
   - Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes.

The full text of the 2006 Goals and Requirements is also posted on the JCHAO Web site. Compliance with the Requirements or alternatives judged to be acceptable is a condition of continuing accreditation for Joint Commission-accredited ambulatory care organizations and office-based surgery facilities.

President's Message

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To continue to address the immediate needs of our members, several new task force teams are in various stages of planning. They include:

- Source of Knowledge Task Force (Chair – Lyn Gehring; Board Liaison – Beth Ann Swan).
- Public Relations/Marketing Task Force (Board Liaison – Karen Griffin)
- AAACN Standards Review Task Force (Co-Chairs – Peg Mastal and Sherri Smith; Board Liaisons – Karen Griffin and Carole Becker).

To move AAACN forward, project advisory teams were developed to define longer range action steps for each goal of our strategic plan. These teams exist to generate and prioritize ideas and state them in the form of recommendations to the Board of Directors. The aim is to provide the Board with membership input as it defines future actions and planning. The advisory teams, chairs, and board liaisons are:

- Knowledge – Janie McKenzie (chair) and Carole Becker (liaison).
- Education – Joanne Appleyard (chair) and Charlene Williams (liaison).
- Advocacy – Tom Reed (chair) and Karen Griffin (liaison).
- Community – Anne Hopkins (chair) and Kitty Shulman (liaison).

Prior to the annual conference, we had a tremendously positive response from members to our call for volunteers to participate on the advisory team projects. In the very near future, the advisory team chairs will be in contact with those of you who volunteered to take advantage of your enthusiasm and build on the momentum generated from the valuable feedback received during the Leadership Symposium. We appreciate your commitment to AAACN and look forward to your input. Each ongoing project needs your continued support, ideas, and suggestions for planning the next steps.

AAACN's mission to advance the art and science of ambulatory care nursing has not changed. The leadership provided by nurses in ambulatory care settings will be essential to quality health care. An important strategy for organizations is to give others an opportunity to succeed. It can be very rewarding when a task force is successful in its assignment (Blech, 2005).

I hope you have a clear understanding of our need for you – our leaders and members – to volunteer and take active roles in planning, participating, and implementing strategies for the successful future of AAACN.

Regina C. Phillips, MSN, RN, *is AAACN President and Delegation Compliance Process Manager, Humana, Inc., Chicago, IL. She can be reached at rphillips1@humana.com*

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BOOK REVIEW

Optimal Aging Manual: Your Guide from Experts in Medicine, Law, and Finance

Edited by Kevin W. O'Neil, MD, FACP and Renno L. Peterson, JD

Optimal Aging is a reference book that is not intended for professionals but rather for those who are experiencing the effects of aging and have more questions than answers. According to the publishers and editors Kevin O'Neil and Renno Peterson, it is "a long book, but not designed to be read from cover to cover" (p. 1). It has been designed to allow readers to easily find information they need at the moment they need it.

The book is divided into three sections, with Part I providing information about health issues. Each chapter addresses a specific body system, describing how that system works, and the assessments about which health care professionals may ask. Following the normal function of each specific body system, a compilation of common disorders of each system is found. Excellent pictures are included to illustrate how each disorder may appear by the person or family members. When appropriate, self care and assessment techniques are highlighted. For instance, in the chapter on "Skin," a highlighted box entitled "How To Do a Skin Self-Exam" takes a half page teaching when these self-exams should be done, how to do them, and what to look for. At the end of each chapter is a list of associations and agencies that could provide more information, with the Web addresses, phone numbers, and mailing addresses included.

Part II, "Special Health Issues," addresses issues and health conditions that affect the quality of life. Chapters include "Mental Health," "Memory," "Falls," "Pain," "Cosmetic Surgery," "Spirituality and Health," and "Elder Abuse." In each chapter, information is presented about the varied aspects of that subject; at the end of every chapter is a summary with a compilation of "What You Should Know." Each of these chapters contains stories from patients detailing their experiences and problems, after which the author of that chapter gives factual information about how prevalent these problems are and ways to address these concerns. Another feature of these chapters is the "Then and Now" section, which addresses how our ancestors handled these issues and the changes that have occurred in society and health care that have changed those practices. Agencies and associations that can provide additional information are listed at the end of each chapter.

Part III is entitled "Legal and Financial Issues." Included in this section are chapters on "Estate Planning," "Life Insurance," "Personal Annuities Du Jour," and "Handling Legal Aspects of Disability and Death." These chapters are easy to read, give complete and understandable information about complex subjects, and are designed to provide information that is necessary to protect one's future. These chapters should be mandatory reading for everyone because this section contains complete and reader-friendly information regarding legal and financial issues . Also included is information that will assist those who are retiring or considering retirement, as well as information for families working with estates following a death. A "What You Need to Know" section is presented at the end of each chapter, followed by a listing of agencies or associations that could provide additional specialized information.

"Medical and Legal Glossaries" can be found at the end of this book, which are very thorough and give easy-to-understand definitions for a large number of difficult terms. Along with these are three appendices: "Weights and Measures," "Prescription Drugs and Medicaid," and an alphabetical listing of drugs mentioned throughout the book. This last appendix gives both generic and a brand names and uses for each drug.

Optimal Aging is approximately 1,200 pages in length and is an excellent resource for those who are aging or those caring for an aging person. Health care providers may find the information in Part I to be simple and somewhat superficial, but could easily use Part II and III on a daily basis if caring for elderly patients in their personal or professional lives. It can be purchased on-line at www.optimalaging.com for $59.95.

A monthly update to this manual is provided, entitled *Optimal Aging Report,* and can be subscribed to for $49.95 a year. A box on the first page of the first newsletter describes the purpose of the newsletter as "dedicated to helping baby boomers and their families navigate through the emotionally charged issues associated with aging" (vol. 1, issue 1, p. 1).

This book is copyrighted by Optimal Aging, LLC, and published by the editors. Optimal Aging, LLC can be contacted at the following:

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AAACN Public Relations/Marketing Task Force Update

The AAACN Public Relations (PR) and Marketing Task Force recently completed their charter. The task force was charged by the AAACN Board of Directors to develop a public relations and marketing plan, and prioritize the action items in order of their importance. The chair of the task group was Cindy Patterson. The members included Traci Haynes, Kari Hite, Marian Laroche, Mirian Vasquez, Mona Mathewson, Pam Del Monte, Susan Paschke, and Pat Reichart and Janet D'Alesandro from the national office. The Board liaison was Karen Griffin. The first meeting was held at the Leadership Symposium at the national conference in April for those who were able to attend. They had three additional follow-up conference calls in April, May, and June. The task force submitted their completed PR and Marketing Plan to the Board for the June Board of Directors Summer Meeting. The chair and all the members of this task force are to be commended for their hard work and the excellent plan that was submitted! The Board is very appreciative.

To implement the first recommendations from this plan, a new PR and Marketing Task Group is being formed to develop a powerful, four-color AAACN membership brochure, poster, and vendor fact sheet. If you are interested in volunteering for this project, please contact Karen Griffin at kfgriffin@hotmail.com.

Informed Consent

continued from page 1

mon, and for which the risks are commonly understood" (Cady, 2000, p. 106). Much of routine nursing care would seem to fall into this category.

Any provider who recommends treatment to a patient must obtain informed consent, particularly if the planned treatment is invasive. Informed consent regarding medical or surgical treatment has five distinct components that must be included when in discussion with a patient:

1. The diagnosis or nature of the specific condition that requires treatment.
2. The purpose and distinct nature of the treatment.
3. Risks and potential complications associated with the proposed treatment(s).
4. All reasonable alternative treatments or procedures, and a discussion of their relative risks and benefits, including the option of taking no action.
5. The probability of success of the proposed treatment(s).

The obvious exceptions to these rules are in the cases of emergencies, or when the window for intervention is short and there is no legal representative for a patient to provide consent within that window (Fish, 2004). Documentation of the consent discussion is vitally important, as is documenting the emergent nature of the situation.

Implied consent. This is the concept that if the possibility for more extensive treatment is necessary the treating provider can proceed, as long as this potential for additional treatment was discussed as part of the original consent. An example of this would be the need for a diverting colostomy as the result of a rectal injury during a radical prostatectomy.

But implied consent can also be seen as failure to refuse treatment or intervention, such as in the case of an inpatient allowing daily blood draws. Much of routine nursing care would also fall under the concept of implied consent, such as dressing changes, as long as there is a minimal explanation provided as to the rationale and need for the action.

Patient waivers. A patient who is competent can waive his/her right to be informed (Coulson, Glasser, & Liang, 2002), saying that he/she defers to the provider's judgement and recommendation. However, the patient should be as fully informed as possible regarding the information being waived, in order to provide him/her the opportunity to reconsider. Despite the fact that a patient may waive the right to be informed, there is the continued responsibility of the provider to present opportunities to discuss the ongoing treatment. The waiver must also be clearly documented. An example of this is the patient who states she relies on the expertise of the provider to guide treatment, due to the length of their provider-patient relationship and the trust she has placed therein.

Refusal to consent. As stated earlier, all competent adult patients have the right to determine what happens to them, even if their choice is likely to result in death. The difficulty comes in documenting that the patient is competent, and that a clear discussion has taken place. The patient must be provided with all of the information a "reasonable person" would need to proceed before she can be said to have been informed and refuse the recommended course of care. A clear example of this would be the patient who chooses to enter hospice care rather than consent to an experimental cancer treatment.

Factors Influencing Informed Consent

Informed consent requires comprehension, often at a time when the sheer volume of information being related can be frightening. This can be particularly true if the discussion centers around several treatment options. It also requires that the provider relaying the information be as objective as possible so as not to influence the choice of the patient. However, there are few standards as to which invasive procedures require a patient's consent (Manthous, 2003), and some facilities employ a generalized "consent to treatment" form that is signed when a patient is admitted, which then provides implied consent for basic treatments, including all aspects of nursing care.

Many individual states have laws that specifically detail how much information must be discussed in order for the patient to be considered "informed." Michigan, for instance, is subject to a "physician-based" standard (Coulson et al., 2002), meaning that the physician or provider has the expert knowledge with a duty to disclose what another reasonable physician would disclose. This is generally an objective standard, as there are guidelines particular to individual specialties that can be referenced.

On the other hand, some states will subscribe to a "patient-based" standard, meaning that the informed consent process must include all the information that a "reasonable" patient might need to make a decision (Coulson et al., 2002). This is also considered objective, as any information, such as a surgeon's experience with a particular type of case, would be considered as reasonable to include in the consent discussion. This standard provides less guidance for the provider, in that an informed consent discussion that includes every possible option and all the consequences of choosing or not choosing an option can get quite lengthy.

Lastly, there are states that incorporate a "hybrid" standard that includes aspects from both of these standards. In this case the discussion must include the components of both the "physician-based" and "patient-based" standards.

The difficulty with any of these standards, particularly in this era of evidence-based medicine, becomes when and how to draw the line during a consent discussion. Evidence-based medicine would seem to support an expansion of the consent process to include a discussion of each and every possibility in detail (Kapp, 2002). This becomes particularly murky in the states that support the patient-based standard, the argument being that any and all information could influence a patient's decision to consent to a proposed treatment. Does providing all-inclusive information run the risk of paralyzing the individual patient into indecision? Or would it lead to a more refined self-determination? And how can this be incorporated when there can be such profound time constraints on an individual appointment?

Literacy. One way to address the need to provide information can be through printed materials. But this is not the quick fix that it may seem; the printed material must be accessible to a wide range of educational backgrounds.

Illiteracy in the United States continues to present a challenge to providing all aspects of health care, particularly as it relates to the ability to recognize and understand words that are commonly used in the discussion and description of medical procedures (Andrus & Roth, 2002). This extends to the consent form itself, which is often standardized within an institution. In order to make it as broad-reaching as possible, it may include portions that use very sophisticated language that can encourage a signature without discussion of its actual meaning when the patient has a lower literacy level.

Mental status. If there is any question as to the mental competence of an individual, it is prudent to have a formal evaluation prior to proceeding with the consent discussion. The specifics can vary from state to state, but it is not uncommon for a spouse or other designated party to provide permission for treatment.

Internet savvy. Patients with Internet access and the time to perform extensive research present a consent challenge in the opposite direction; they often have data from competing facilities or have used resources such as Medline to query a topic or procedure. This can present the provider with the challenge of answering exceedingly specific questions in areas in which the provider may not be as well-versed. This can serve to undermine the authority of the consenting provider and create a clinic encounter that is adversarial.

On the other hand, patients who have taken the time to research a procedure can make the consent process much less time consuming, as they have spent time to ensure they understand the risks and benefits inherent in the procedure. Informed consent for them is simply an affirmation of the information they have previously gathered, along with the provider-specific details (length of time for the procedure, days until discharge, post-procedure pain medication, etc.).

Complementary and alternative medicine (CAM). This presents a particular gray area regarding informed consent for patient and provider alike; there is far less published data on the specific risks and benefits with CAM. In the case of traditional medical therapies, failure to disclose the risks can result in claims of negligence. CAM provides special challenges: there have been fewer standardized methods for treatment; there is a diminished ability to adequately represent risk in a particular circumstance; and there is uncertainty in determining which risks are important when making a treatment decision. The informed consent discussion regarding CAM should nonetheless incorporate the five components of consent as completely as possible, even if that necessitates a statement that indicates that the benefits and risks may be unclear.

The Role of the Nurse

Busy inpatient and clinic settings can create situations in which the medical provider (be it a physician, nurse practitioner, or physician assistant) may not be immediately available to address the ongoing questions a patient may have. The educator role of the nurse becomes even more vital in this circumstance, as the patient seeks additional information on which to base his decision. This also highlights the role of the nurse as patient advocate, as he or she should raise concerns if the patient has multiple questions or the nature of the questions indicate that the information given by the provider was not well-understood. In fact, the American Nurses Association (ANA) Code of Ethics supports a patient's right to self-determination and states "the nurse preserves, protects and supports (the right to self determination) by assessing the patient's comprehension of both the information presented and the implications of decisions" (ANA, 2001). A signed consent form does not necessarily indicate comprehension, and it becomes the responsibility of all those on the "team" who are treating a patient to insure that the patient both understands and is comfortable with the choices he or she has made.

In the end, the issue of informed consent is one of respect for the individual, his or her personal autonomy, and wish to direct his or her own life. What originally started as protection from battery has evolved with time to encourage respect for the individual and support beneficence, as patient and provider enter into a partnership regarding treatment.

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Objectives

This educational activity is designed for nurses and other health professionals who wish to implement quality-improvement measures in ambulatory care. 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. Define the following: informed consent, implied consent, patient waivers, and refusal to consent.
2. Analyze factors that influence informed consent.
3. Summarize the role of the professional nurse in the issue of informed consent.

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.

American Academy of Ambulatory Care Nursing

Real Nurses. Real Issues. Real Solutions.

Volume 27 Number 3

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

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.

Testimonials from AAACN's 30th Anniversary Conference

"What I like about AAACN…"

I will be attending the post-conference to review for ambulatory care certification. I am looking forward to using the books to study for the exam. I have also completed the telephone triage CD/book for training in telehealth and found it very helpful, especially in emergency management.
– Lisa Madison, RN, BSN, Beale AFB, CA

The access and variety of information, including the Web site, [which is] attractive and user-friendly. Love *Viewpoint*.
– Kathleen J. Soper, RN, Scottsdale, AZ

The telephone triage book for CEs is excellent.
– Anna Doremus, RN, BSN, MSA, Jacobstown, NJ

[AAACN products] are fun and reasonably priced. It makes me proud to be in ambulatory care nursing.
- Shirley Gay, RN, Ottawa, Ontario

I am a consultant for the Air Force and use some of the products while I am out teaching.
– Sandra J. Witthauer, BSN, CNAA, BC, USAF, Brooks City Base, TX

I enjoy the articles, information, and collaborating with other nurses, [especially via] e-mail.
– Janet Durden, RN, Islip, NY

The information and products are very helpful in meeting and/or setting goals for my organization.
– Jacqueline Williams, RN, BSN, Washington, DC

The Core Curriculum is an outstanding book. It was invaluable to me as I prepared for the certification exam. It educates and inspires my fellow nurses. It give us a body of knowledge from which to practice.
– Catherine Williams, BSN, RN, RN-C, Scottsdale, AZ

[The products are] very informative and practical. I would like to see articles on how to get published and poster presentations.
– Amie Purnell-Davis, Collinsville, IL

The articles are timely and informative. I gave my colleagues my copies to justify a need to review their position. I love *Nursing Economic$*.
– Margaritia Gore, RN, MBA/HCM, Chandler, AZ

The Air Force has adopted *AAACN Ambulatory Care Standards* as their standard for ambulatory care. So I like the mere fact that they *are* the standard.
– Carol B. Andrews, RN, CNA, BC, San Antonio, TX