Falls have been identified as one of the most prevalent public health problems facing older adults today. They are the leading cause of injury-related visits to emergency departments in the United States and the primary etiology of accidental deaths in persons over the age of 65 years. Geriatric falls are a source of injury, immobility, psychosocial dysfunction, and premature death (Cornely, 1996). Complications include fractures, injury to soft tissues, increased functional dependence, and fear of falling again (Agostini et al., 2003).

The mortality rate for falls increases dramatically with age in both sexes and in all racial and ethnic groups, and falls account for 70% of accidental deaths in persons 75 years of age and older.

Approximately one-third of individuals 65 years of age or older living in the community and more than half of those living in institutions fall every year. About half of those who fall do so repeatedly (Kannus, Parkkari, Koskinen, Niemi, Palvanen, Jarvinen et al., 1999). In hospitalized patients, 4 to 12 falls occur per 1,000 bed days, ranking them among the 10 most common claims presented to insurance agencies (Kimbell, 2002). Both the incidence of falls and the mortality rate for falls increase dramatically with age in both sexes and in all racial and ethnic groups.
Forging New Partnerships and Championing Change

The theme for AAACN’s 2004 conference, “Forging New Partnerships and Championing Change,” serves to describe the goals and challenges we face today as ambulatory care nurses. Most significantly, it shows how we seek ways to work together on strategies that will inspire much-needed changes in the workplace and in health care.

AAACN’s Board of Directors has always sought change for the better: for the association, nurses, and the system at large. As I leave my role as President, I see our work continuing under the dedicated leadership of Kathleen Krone, MS, RN, our new President. I handed Kathleen the gavel at the March AAACN conference in Phoenix, and I know AAACN members join me in wishing her well. Joining Kathleen on the 2004-2005 Board are Sara Marks, CDR, NC, USN, and Charlene Williams, MBA, BSN, RN, BC. Beth Ann Swan, PhD, CRNP, begins a second term on the Board. Regina Phillips, MSN, RN, President-Elect; and Directors Carole Becker, MS, RN; Karen Griffin, MSN, RN, CNAA; and myself will support them. There will be much for us to do.

Challenges on Tap

The challenges facing all of us in 2004-2005 include the following:

- Continuing to evaluate the effectiveness of professional organizations for nurses in all settings. Change is occurring so rapidly that it becomes ever more critical to find fast and efficient ways to provide the information needed to cope in the evolving universe of health care. Even more important is the need to understand what a professional organization should be in terms of structure and in terms of understanding what its members really want and need.

- Culturally competent care becomes more and more important as the population becomes more diverse. The willingness of patients and families to follow the prescribed course of action is sensitive to their specific culture.

- Continuing to evaluate the effectiveness of professional organizations for nurses in all settings. Change is occurring so rapidly that it becomes ever more critical to find fast and efficient ways to provide the information needed to cope in the evolving universe of health care. Even more important is the need to understand what a professional organization should be in terms of structure and in terms of understanding what its members really want and need.

- Emergency preparedness continues to pose its own unique challenges and there are many complex issues to examine before we can stamp our organization ‘ready’ for a mass disaster. As we develop response plans for potential risks (virulent diseases, biological or chemical warfare, terrorist threats) one thing is clear: each employer organization must be connected to their local/state/national disaster plans.

- Access to health care for the poor and the uninsured or under-insured. The focus will be in two broad areas. First, access to health care for the poor and the uninsured or under-insured. Lots of questions exist to support the sharp rise in risk when practitioners, nursing staff, and others are unable to accurately communicate with those who do not speak or understand the English language. The second challenge comes with the need to provide culturally competent care. Race and ethnicity are key factors in meeting the needs of a diverse population. The willingness of patients and families to follow the prescribed treatment regimen is directly related to the degree to which that treatment regimen is sensitive to their specific culture.

- Emergency preparedness continues to pose its own unique challenges and there are many complex issues to examine before we can stamp our organization ‘ready’ for a mass disaster. As we develop response plans for potential risks (virulent diseases, biological or chemical warfare, terrorist threats) one thing is clear: each employer organization must be connected to their local/state/national disaster plans.

- 2004 is a Presidential election year. There will be much debate about health care: access, level of care, and who will pay for what. The focus will be in two broad areas. First, access to health care for the poor and the uninsured or under-insured. Second, the cost of health care to employers and to individuals. Lots of questions will be raised and lots of promises will be made, but will real and lasting solutions be offered? Stay in touch with political agendas at the local, state, and national level and stay aware of the shifting landscape of health care.

continued on page 19
Elder Abuse and Neglect Assessment

By: Terry Fulmer, PhD, RN, GNP, FAAN

WHY: Elder abuse and neglect is a serious and prevalent problem that is estimated to affect 700,000 to 1.2 million older adults annually in this country. Only one in ten cases of elder abuse and neglect are reported and there is a serious underreporting by clinical professionals, likely due to the lack of appropriate screening instruments. Abuse, neglect, exploitation, and abandonment are actions that can result in elder mistreatment (EM).

BEST TOOLS: The Elder Assessment Instrument (EAI),1-3 is a 44-item Likert scale assessment instrument that has been in the literature since 1984. This instrument is comprised of seven sections that reviews signs, symptoms and subjective complaints of elder abuse, neglect, exploitation and abandonment. There is no “score.” A patient should be referred to social services if the following exists:

1) If there is any evidence (+) without sufficient clinical explanation
2) Whenever there is a subjective complaint by the elder of EM
3) Whenever the clinician deems there is evidence of abuse, neglect, exploitation, abandonment

TARGET POPULATION: The EAI is appropriate in all clinical settings and is completed by clinicians who are responsible for screening for elder mistreatment.

VALIDITY /RELIABILITY: The EAI has been used since the early 1980s. The internal consistency reliability (Cronbach's alpha) is reported at 0.84 in a sample of 501 older adults who presented in an emergency department setting. Test/retest reliability is reported at 0.83 (P<.0001). The instrument is reported to be highly sensitive and less specific.

STRENGTHS AND LIMITATIONS: The major strengths of the EAI are its rapid assessment capacity (the instrument takes approximately 12-15 minutes) and the way that it sensitizes the clinician to screening for elder mistreatment. Limitations include: no scoring system and weak specificity.

MORE ON THE TOPIC:
## General Assessment
1. Clothing:  
2. Hygiene:  
3. Nutrition:  
4. Skin integrity:  
5. Additional Comments:

## Possible Abuse Indicators
<table>
<thead>
<tr>
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<th>Definite Evidence</th>
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<tbody>
<tr>
<td>12. Additional Comments:</td>
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<tr>
<td>26. Additional Comments:</td>
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## Possible Exploitation Indicators
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<th>Probable Evidence</th>
<th>Definite Evidence</th>
<th>Unable to Assess</th>
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</thead>
<tbody>
<tr>
<td>32. Additional Comments:</td>
<td></td>
<td></td>
<td></td>
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## Possible Abandonment Indicators
<table>
<thead>
<tr>
<th>No Evidence</th>
<th>Possible Evidence</th>
<th>Probable Evidence</th>
<th>Definite Evidence</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Evidence that a caretaker has withdrawn care precipitously without alternate arrangements</td>
<td>34. Evidence that elder is left alone in an unsafe environment for extended periods adequate support</td>
<td>35. Statement by elder re: abandonment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Additional Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Summary
<table>
<thead>
<tr>
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<th>Probable Evidence</th>
<th>Definite Evidence</th>
<th>Unable to Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Additional Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Comments and Follow-up

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**try this:** Best Practices in Nursing Care to Older Adults

A series provided by The Hartford Institute for Geriatric Nursing  
hartford.ign@nyu.edu  
www.hartfordign.org

Falls in Older Adults

continued from page 1

severity of complications increase with age and increased disability and functional impairment. About 5% of falls result in a fracture. Other serious injuries occur in 5 to 11% of falls. In 1999, about 10,000 or 31% of all unintentional-injury deaths were caused by falls (Centers for Disease Control and Prevention [CDC], 2002).

Hip fractures are the most feared complication of falls. Up to 20% of people sustaining a hip fracture become nonambulatory, and only 14 to 21% recover their ability to carry out instrumental activities of daily living (IADLS) (Zuckerman, 1996). Older adult patients admitted to hospitals for hip fractures often develop delirium, which is associated with increased risk of being discharged to institutional care (Bloom, 2003). Twenty-five percent of older adults who sustain a hip fracture from a fall will die within 6 months of the injury. More than 50% of older patients who survive hip fracture are discharged to nursing homes. Hip fracture survivors experience a 10 to 15% decrease in life expectancy and a meaningful decline in overall quality of life (Fuller, 2000).

Older adults fear reporting falls because falling is negatively associated with getting old, feeble, and dependent. Most falls do not end in death or result in significant injury; however, a fall or a near-fall often has a negative psychological effect on the older adult, who may self-impose physical and/or social limitations because he/she fears falling again. With decreased mobility comes decreased strength; decreased endurance, increased joint limitations, social isolation, and depression. Falls can be a major life-changing event that robs the older adult of his/her independence. The fear of future falls and subsequent institutionalization often leads to dependence and increasing immobility, followed by functional deficits and a greater risk of falling (Fuller, 2000).

The cost of falls among older adults is immense because of disabling conditions, recovery in hospitals and rehabilitation institutions, and the high death toll. The U.S. spends an estimated $20.2 billion annually for the treatment of fall injuries in older adults, with the majority spent on hip fracture care. More than 250,000 older adults are hospitalized each year for fractured hips at a cost in excess of $10 billion. More than 90% of hip fractures are associated with falls, and most of these fractures occur in persons over the age of 70. Projections for incidence of hip fractures in the future show that they will double by the middle of the 21st century (Fuller, 2000).

Falls Risk Factor Assessment

A single fall is not always a sign of a major medical problem or an increased risk of subsequent falls. The fall may simply be an isolated event. However, recurrent falls, defined as more than two falls in a 6-month period, should be evaluated for treatable causes. A fall might indicate an underlying medical problem or a problem with balance or gait, or decreasing strength.

Preventing falls is an integral part of the nursing assessment. An accepted definition of a fall is “unintentionally coming to rest on the ground, floor, or other lower level” (Agostini, 2003). Nursing assessments used in the hospital setting, such as the Morse Fall Scale and the Hendrich Fall Risk Model, identify who is likely to fall based on intrinsic, or specific patient-related, fall risk factors. The patient is usually assessed upon admission to the facility and then periodically updated per facility policy. The recommended period for reassessments include per shift, daily, weekly, change in patient condition (such as post-operative or post-procedural), or change/addition to medication regimen. Poor scores on these tools trigger either further assessment or nursing interventions aimed at preventing a fall during the hospital stay.

The risk of sustaining an injury from a fall depends on the individual patient’s susceptibility and environmental hazards. The frequency of falling is related to the accumulated effect of multiple disorders superimposed on age-related changes (Fuller, 2000).

The risk factors responsible for a fall can be intrinsic (for example, age-related physiologic changes, diseases, and medications) or extrinsic (such as environmental hazards). Some intrinsic changes occur naturally with aging. Others are the result of disease processes. Each body system can be affected by these changes, which can lead to falls (McElhinney, 1998).

A critical element of the targeted history is a review of medications, including prescription, over-the-counter, herbal, and illicit drugs. Polypharmacy (four or more prescription medications), the initiation of a new drug therapy in the previous 2 weeks, and a variety of medications (such as diuretics, major tranquilizers, cardiac medications, hypoglycemic agents, and any medication that is likely to affect balance) have been associated with an increased risk of falling in elderly patients.

Extrinsic causes of falls in older adults are the easiest to prevent. A variety of extrinsic factors, such as poor lighting, unsafe stairways, and irregular floor surfaces are involved in falls among older adults in the community. Frail older adults tend to fall and injure themselves in the home during the course of routine activities.

Prior to discharge, a home safety checklist can be given to the patient, significant other, and/or caregiver to

continued on page 7
Table 1.
Home Safety Checklist

<table>
<thead>
<tr>
<th>HAZARDS</th>
<th>MODIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lighting</strong></td>
<td></td>
</tr>
<tr>
<td>• Poor access to switches or lamps</td>
<td>• Provide ample lighting in rooms and hallways.</td>
</tr>
<tr>
<td>• Low lighting</td>
<td>• Provide extra lighting along path from bedroom to bathroom by one- and two-</td>
</tr>
<tr>
<td>• Lack of night lights</td>
<td>step elevations, and by top and bottom of stairway landings. Use 100 to 200</td>
</tr>
<tr>
<td></td>
<td>watt bulbs and three-way light bulbs to increase lighting levels.</td>
</tr>
<tr>
<td><strong>Floors and Hallway Problems</strong></td>
<td></td>
</tr>
<tr>
<td>• Clutter</td>
<td>• Use night lights. Keep flashlight at bedside table in case of power failure.</td>
</tr>
<tr>
<td>• Limited walking space</td>
<td>• Arrange furnishings so that pathways are unobstructed.</td>
</tr>
<tr>
<td>• Waxed/wet floors</td>
<td>• Provide stable furnishings along pathways for balance support.</td>
</tr>
<tr>
<td>• Sliding throw rugs</td>
<td>• Use non-skid rugs and carpet runners on slippery floors. Use non-skid floor</td>
</tr>
<tr>
<td>• Worn carpets</td>
<td>wax; wipe up spills.</td>
</tr>
<tr>
<td>• Curled carpet edges</td>
<td>• Replace sliding area rugs with non-skid rugs or place non-skid tape or pads</td>
</tr>
<tr>
<td>• Patterned carpet or floor covering</td>
<td>underneath existing rugs.</td>
</tr>
<tr>
<td><strong>Bathroom Problems</strong></td>
<td></td>
</tr>
<tr>
<td>• Low toilet seat</td>
<td>• Repair or replace worn, loose, wrinkled, or tow carpets.</td>
</tr>
<tr>
<td>• Inaccessible tub or shower stall</td>
<td>• Tape down all carpet edges.</td>
</tr>
<tr>
<td>• Slippery floor tile</td>
<td>• Avoid floor coverings with complex patterns.</td>
</tr>
<tr>
<td>• Slippery tub or shower floor</td>
<td></td>
</tr>
<tr>
<td>• Unstable towel or shower rods</td>
<td></td>
</tr>
<tr>
<td>• Lack of telephone or alarm</td>
<td></td>
</tr>
<tr>
<td><strong>Stairway Problems</strong></td>
<td></td>
</tr>
<tr>
<td>• Lack of handrails</td>
<td>• Use elevated toilet seat or install toilet safety frame.</td>
</tr>
<tr>
<td>• Slippery steps</td>
<td>• Install wall-mounted or tub-attached grab bar or shower chair.</td>
</tr>
<tr>
<td>• Steps in poor repair</td>
<td>• Use non-skid strips or decals to tiled floors.</td>
</tr>
<tr>
<td>• Lack of step visibility</td>
<td>• Use non-skid rubber mat on floor.</td>
</tr>
<tr>
<td><strong>Furniture Problems</strong></td>
<td>• Replace with grab rails that can be bolted to wall studs.</td>
</tr>
<tr>
<td>• Low chair seats</td>
<td>• Take cellular/portable phone into bathroom. Do not lock bathroom door.</td>
</tr>
<tr>
<td>• Unstable table</td>
<td></td>
</tr>
<tr>
<td><strong>Storage Problems</strong></td>
<td></td>
</tr>
<tr>
<td>• Shelves too high or too low</td>
<td>• Keep frequently used items at waist level; use reacher device to get objects.</td>
</tr>
<tr>
<td>• Unstable chairs or step stools</td>
<td>• Get stable step stool with handrail.</td>
</tr>
<tr>
<td>• Lack of adequate storage space</td>
<td>• Install shelves and cupboards at accessible height.</td>
</tr>
</tbody>
</table>
guide them in what should be evaluated in the home setting (see Table 1 on previous page). It is particularly important to assess caregiver and housing arrangements, environmental hazards, alcohol use, and compliance with medications (Fuller, 2000). Successful prevention of falls, fall-related injuries, and fear of falling is complicated by the multi-factorial nature of the problem. Patient information should be provided to the patient and/or significant other in the attempt to prevent falls and fall-related injuries in the home setting after discharge. Every patient should be told to see his/her primary care provider if a fall occurs so that adequate follow-up is ensured.

References


Additional Reading


Legal and Ethical Issues at the End of Life

Sally Russell, MN, CMSRN

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

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

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

End-of-life care has always been a complex, multidimensional aspect of nursing care, but with increasing technology, changes in family structures, managed care, and health care choices that seem never ending, it is even more complex than in the past.

Key issues that affect nursing practice in this arena include the following:

- Lack of family available to care for the dying person
- Increasing fears of being sued
- Aging of the population
- Access to hospice services
- Palliative care and the obstacles to its use
- Reimbursement concerns.

Ethical dilemmas, which are everywhere, are even more clear in nursing care at the end of life, as decisions about supporting – or life-ending – interventions are made every day. Decisions are affected by the culture, values, and religion of those who have to make those decisions, and this becomes even more difficult when a clash exists between those giving the care and those receiving it.

This installment of Viewpoint’s end-of-life series will focus on some of the ethical issues and dilemmas surrounding care. While this is not a complete list (one article cannot address all the permutations that occur in individual situations), it is imperative that nurses recognize their role as a member of the health care team responsible for assuring that patients/significant others have the ability to make well-informed decisions with full knowledge of the options and consequences.

The Difficult Decisions

Issues of decision making and communication require thought about who can, or should be, making the decisions and communicating those decisions to others.

To take part in the informed consent process, people must have the ability to understand what they are being told, to think about the options presented, to evaluate the benefits and risks, and to let others know of their decisions.

Unless proven otherwise, adults are presumed to have the capacity and authority to make decisions for themselves. Capacity means the ability to do these things, while competence is a legal term determining how well the person understands the decisions he/she is making. When a person does not have the capacity to choose, living wills, health care proxy, or power of attorney for health care decisions are mechanisms that may be used.

The main elements involved in consent are that it is voluntary and not coerced, and that the person has the capacity to make the decision along with all the information necessary.

Confidentiality is a critical ethical issue, as nurses are involved in very intimate, private relationships with people at the end of life. A trusting relationship is essential for the work to be done during this time, requiring the nurse to be diligent about keeping any shared confidences. Disclosure, the revealing of information about the patient’s illness, has created some concerns for nurses as families sometimes ask that a patient not be told the nature of his/her illness or prognosis. Research and clinical practice has shown that open and honest communication is preferable, as energy is spent with everyone hiding what they know from everyone else, decreasing the ability of the person dying to share thoughts and feelings with those around them. There is, however, the right for the patient to decline information, but that should be dictated by the patient.
**Advance Care Planning**

Advance care planning is a process of making decisions and then communicating those decisions between the patient, family, friends, and health care team. This assures that patients’ choices are known even when they are not able to participate in discussions about how, where, and with whom they want to live the end of their lives. This also involves patients in deciding and designating whom they would like to make decisions on their behalf when they are no longer able to do so.

Patients with dementia have been assumed to be unable to participate in decision making but current research indicates this is an inaccurate assumption (Mezey, 2000). An assessment tool, “Guidelines for Determining Capacity to Execute a Health Care Proxy” is being tested to give people with dementia a voice in their end-of-life care. Early unpublished findings of people with mental illnesses suggest that people with severe mental illness can participate in end-of-life decisions and that their concerns are no different than anyone else’s (Midwest Bioethics Center, 2001). Adults with developmental disabilities can also make sound end-of-life treatment decisions when given help to do so (Midwest Bioethics Center, 2001).

Ethical decisions encountered frequently at the end of life are ones dealing with prolonging life, withholding treatment, “Do Not Attempt Resuscitation” orders, assisted suicide, nurse-provided palliative care, euthanasia, medical futility, and pain control. While these issues do not occur in a vacuum, with more than one being a concern at any given time, the scope of this article does not lend itself to as deep a discussion as care givers need to have. These issues should be an ongoing topic among those working with patients at the end of life and should be discussed by the individual and their significant others to determine that everyone is aware of the issues, decisions, and ramifications.

Prolonging life actually involves more than keeping someone alive with curative treatments. For example, an issue may arise about providing antibiotics for a secondary infection, as it may clear up the infection but prolong the life of the suffering person. Life-sustaining measures may be appropriate to relieve symptoms but may be seen as prolonging the suffering of the one who is dying. Other aspects of this, though, are the psychological benefits, if using the measures allows family members to become prepared and to say their good-byes. Resuscitation may be seen as a different aspect of these same life-saving measures and patients or their surrogate should be able to either accept or refuse it. Access to end-of-life care should never be dependent on the patient’s “Code Status.”

Withholding treatment may be a choice when the patient or surrogate decides the treatment is worse than the disease. It should be seen as an action that allows the disease to progress on its natural course, not one intended to cause death. Health care professionals often find the decision to withhold treatment difficult as it is antithetical to supporting life, however it is a choice that should be made by the patient and/or surrogate.

The “Do Not Attempt Resuscitation” order confirms and expresses that if cardiopulmonary arrest occurs, no measures are initiated. This is the only intervention that requires a prohibitive order.

In the practice of assisted suicide, a person knowingly provides a patient with the means to commit suicide. It is important to note that the person doesn’t actually administer the treatment but simply provides the means. The United States Supreme Court has ruled that an individual does not have a Constitutional right to assistance with dying, nor do physicians have the obligation to provide it (Vacco v. Quill, 117 S. Ct. 2293, 1997), but a movement to protect those who do assist has begun. In contrast is the right to palliative care, which is widely accepted. In fact, the same Supreme Court decision supported the right of all Americans to receive quality palliative care.

Euthanasia has been defined as an act by which the cause of death is administered by someone other than the patient. A patient requesting euthanasia is asking the other person to take an active role by intentionally hastening the patient’s death. This essentially creates a different pathological state than the one caused by the disease process, as the agent (usually a drug) causes the patient’s death. Serious legal ramifications occur with this practice, even when done with the patient’s involvement. There are other cases which blur the acceptance of euthanasia, for exam-
ple when health care givers take it upon themselves to deliver lethal doses of drugs to “put patients out of their misery” without the patient’s request to do so.

In cases of medical futility, ethics committees are often called to consult. Conflict often results in these situations when there has been a failure in communication over prognosis or benefit vs. burden of treatment options. Some institutions have developed policies in which the prognostic data is used to help determine when treatment is futile. This by itself doesn’t solve the disagreement about quality of life, but it at least may start the necessary discussions among the parties involved.

Pain control enters the ethical dilemma arena when caregivers hesitate to give full and effective doses of pain medication for fear of hastening death. A Catholic theological principle has been used as justification for this treatment at end of life and is known as the principle of double effect. When an action is taken for its intended good effect but has known harmful effects, the principle asserts that the act is not wrong and that the good is sufficiently desirable to compensate for allowing the harmful effect.

Nursing Implications

Nurses have an obligation to be knowledgeable about the ethical and legal dilemmas of professional practice and to understand that these issues are inevitable in end-of-life care.

When conflicts occur during the end-of-life experience, resolution can often be achieved through a foundation of ethical practice and thought. Standards of practice help guide nurses by establishing an ethical benchmark for the profession. Nurse Practice Acts provide essential information from the legal standpoint of nursing practice. Organizational ethics are increasingly being seen as methods for making decisions related to pain management issues, advance care planning, treatment cessation, and resource allocation. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has intensified its monitoring of evidence of organizational commitment and involvement in addressing the ethical dimensions of care.

When an ethical dilemma occurs, it is the nurse’s responsibility to:
- Assure that the patient and family understand the options available
- Clarify the patient and family’s wishes and desires to others on the health care team
- Ensure that communication among all those involved occurs

If the dilemma cannot be resolved through care planning, using a formal case analysis or involving an organization’s ethics committee may be helpful. By keeping all avenues of communication open and searching for answers in the most thorough manner possible, the nurse has helped ensure the treatment of patients at the end-of-life has been as complete and honest as possible.

References


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NCLEX-RN® Exam Passing Standard Revised for Public Safety

The National Council of State Boards of Nursing, Inc. (NCSBN) voted at its December 2003 meeting to raise the passing standard for the NCLEX-RN® examination, the National Council Licensure Examination for Registered Nurses. The new passing standard is -0.2800 logits on the NCLEX-RN logistic scale, 0.070 logits higher than the previous standard of -0.3500. The new passing standard will take effect on April 1, 2004, in conjunction with the new 2004 NCLEX-RN Test Plan.

NCSBN increased the passing standard in response to changes in U.S. health care delivery and nursing practice that have resulted in the increased acuity of clients seen by entry-level RNS. After considering all available information, the Board of Directors determined that safe and effective entry-level RN practice requires a greater level of knowledge, skills, and abilities than was required in 1998, when NCSBN established the current standard.

The NCSBN Board of Directors used multiple sources of information to guide its evaluation and discussion regarding the change in passing standard. As part of this process, NCSBN convened an expert panel of nine nurses to perform a criterion-referenced standard setting procedure. The panel’s findings supported the creation of a higher passing standard. NCSBN also considered the results of a national survey of nursing professionals including nursing educators, directors of nursing in acute care settings, and administrators of long-term care facilities.

The NCSBN Board of Directors evaluates the passing standard for the NCLEX-RN examination every 3 years to protect the public by ensuring minimal competence for entry-level RNs. General information regarding NCSBN and the NCLEX examination program is available at www.ncsbn.org.

For many seniors, taking medication is part of their daily routine, and the last thing they need to worry about is a medication error. Unfortunately, errors do occur, but they can be prevented through special attention and careful monitoring, according to the United States Pharmacopeia (USP).

USP sets standards for prescription and over-the-counter drugs and dietary supplements in the United States. USP also operates two voluntary patient safety reporting programs, the Medication Errors Reporting (MER) Program, which allows health professionals to report actual or potential errors confidentially and anonymously; and the MedMARxsm Program, an interactive, anonymous, Internet-based medication error reporting program. MedMARx compiles medication error reports from participating hospitals in order to analyze patient safety trends, develop best practices, and disseminate this information to participating hospitals.

The information collected from these two programs is used to develop standards and help USP promote safe medication use at the national, state, and local levels.

Share Tips With Your Patients

As part of USP’s work in patient safety, the organization has created a list of tips for seniors and their caregivers on how to better manage the medication they use and decrease the risk of medication errors (see below). Feel free to use this information as a patient handout.

1. Check the label when you get a prescription to verify that you’re receiving the proper medication. If possible, read back the prescription to your pharmacist or health care provider.
2. When possible, keep all medications in original containers.
3. Know what to do if you miss a dosage, and always remember to contact your health care provider or pharmacist if you have any doubts.
4. Try to fill all prescriptions at the same pharmacy.
5. Read the patient information sheet that accompanies your medication. If you are not given one, ask your pharmacist for the printed information about your prescription.
6. Should there be a change in the color, size, shape, or smell of your medication, notify your pharmacist immediately.
7. Do not share or take another person’s medications.
8. When in doubt about a medication you are taking, always consult your pharmacist and/or health care provider! And remember to ask about any side effects that you might experience or expect.
9. When in the hospital:
   - State your name before taking any medications and always offer your wrist bracelet for identification. Ask the nurse to identify each medication by name before you take it.
   - If your medication has not been given at its regular time during your hospital stay, inquire from the nurse as to why.
   - Remind your health care provider if you have any allergies to certain medications and food, or if you also have a health condition that could affect the use of certain medications.
10. Remember to tell your health care provider if you are taking any dietary supplements or over-the-counter medications.
11. Finally, create a list of all the medications you’re taking. The list should include the following information:
   - Your full name and date of birth
   - Drug name (the drugs being taken, both generic and brand, over-the-counter as well as dietary supplements)
   - Strength (dosage)
   - Directions for using the medication, including how many times a day and when the medication should be taken
   - What liquids or foods are being used to take or should be used to take with medications, for example, water, juice, apple sauce etc.
   - Allergies to certain medicines and foods
   - Pharmacy and health care providers’ names, addresses, telephone numbers
   - Family emergency contact information.

This list should be updated on a monthly basis and seniors should keep a copy with them at all times. Also keep copies at home and share it with family members and friends who need to know where a senior’s personal medication list is located. Seniors should take the list with them when they go for health care appointments, hospital stays, or emergency room visits and show it to all health care providers so that they are aware of the medications a senior is taking.

USP has created a Personal Medication Organizer for use in listing and accounting for the medications seniors are taking. To obtain this organizer, please visit www.usp.org/pdf/patientSafety/personalMedOrg.pdf. The organizer can be downloaded from the Web.

Source: United States Pharmacopeia (USP) press release. (2004, January 6). USP Provides Tips to Seniors to Help Reduce Medication Errors. (USP is a nonprofit, non-governmental, standard-setting organization that advances public health by ensuring the quality and consistency of medicines, promoting the safe and proper use of medications, and verifying ingredients in dietary supplements. For more information about USP and its four public health programs, visit www.usp.org/newscenter.)
Study Suggests Rapid Rise in Alzheimer’s

Scientists project that approximately 13.2 million older Americans will have Alzheimer’s disease (AD) by 2050 unless new ways are found to prevent or treat the disease.

According to the latest estimates of the current and future prevalence of AD, reported by Denis A. Evans, MD, and colleagues of Rush-Presbyterian-St. Luke’s Medical Center in Chicago, IL, the numbers of older people with AD – now at 4.5 million – will grow dramatically as the population ages. The most notable increases will be among people 85 and older, when by mid-century, 8 million people in that age group may have the disease. The projections appeared in the August 2003 issue of the Archives of Neurology.

“These updated estimates from Evans and his group underscore the challenge that we face in the fight against AD,” says Marcelle Morrison-Bogorad, PhD, National Institute on Aging (NIA) associate director for the Neuroscience and Neuropsychology of Aging Program, which funded the research. “But I am also optimistic that current research will lead to strategies for intervention early in the disease so that we can keep these projections from becoming a reality.”

The estimates were derived from a study of the incidence (number of new cases of AD per year) over 4 years among 3,913 people, 65 and older in Chicago. The researchers then calculated the national prevalence of AD (the number of people at any particular time who have the disease) using population projections from the Census and death rates from the National Center for Health Statistics. Their estimates, based on Census Bureau “middle series” population projections, are shown in Table 1.

In 2000, 7% of those with AD were 65-74 years old; 53% were 75-84, and 40% were 85 and older. By 2050, it is projected that 60% of people with AD will be 85 and older.

In 2000, among people ages 65-74, 17% of AD cases were classified as severe, compared with 20% severe among people 75-84 and 28% severe at age 85 or older.

“Declines in death rates after age 65 mean that more people will survive to the oldest ages, where risk of AD is greatest,” Evans said. “These numbers validate the current thinking that we must do what we can as early as possible in the disease process, prior to advanced age, if we are to head off these very high rates of AD in the future.”

Over a decade ago, Evans and colleagues estimated the national prevalence of AD, based on an East Boston, MA, population study. The new estimates are similar to those earlier findings.

The updated findings were reported by Evans, Liesi E. Hebert, Julia L. Bienias, and David A. Bennett of Rush, and by Paul A. Scherr of the Centers for Disease Control and Prevention. The NIA, along with funding this study, also supports the Rush Alzheimer’s Disease Center. The Alzheimer’s Association also provided funding for the prevalence study.

<table>
<thead>
<tr>
<th>Year</th>
<th>Age 65-74</th>
<th>Age 75-84</th>
<th>Age 85+</th>
<th>Total</th>
</tr>
</thead>
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<td>2.4</td>
<td>1.8</td>
<td>4.5</td>
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<tr>
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<td>0.3</td>
<td>2.6</td>
<td>2.8</td>
<td>5.7</td>
</tr>
<tr>
<td>2030</td>
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<tr>
<td>2040</td>
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<td>5.0</td>
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<tr>
<td>2050</td>
<td>0.4</td>
<td>4.8</td>
<td>8.0</td>
<td>13.2</td>
</tr>
</tbody>
</table>

Table 1. Number of People with AD, by Age Group (In millions)

AD is an irreversible disorder of the brain, robbing those who have it of memory, and eventually, overall mental and physical function, leading to death. For more information on such research, as well as on biological, epidemiological, clinical, and social and behavioral research on AD, two new publications are available from the NIA: 2001-2002 Alzheimer’s Disease Progress Report and Alzheimer’s Disease: Unraveling the Mystery, which includes a CD-ROM animation of what happens to the brain in AD. These publications may be viewed at NIA’s AD-dedicated Web site, www.alzheimers.org, the Institute’s Alzheimer’s Disease Education and Referral (ADEAR) Center, or by calling ADEAR at 1-800-438-4380.


For general information about aging and health, including materials on exercise specifically aimed at people 50 and older, visit the NIA Web site at www.nia.nih.gov or ask for a publications list by calling 1-800-222-2225.
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Exemplified by the contributions of dedicated nurses such as Debbie Knopf, Kaiser Permanente is committed to making a difference every day.

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Email: nursingcareers.ga@kp.org

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Success of AAACN Education Event Heard ‘Round the Country

First audioconference links experts with participants at 48 sites

AAACN hosted its first audioconference on Wednesday, January 28. For an inaugural foray into this new education venue, there was a very strong response with 48 sites registered across the country. The topic, presented by Karen Griffin, MSN, RN, CNAA, and Suzette Alexander, MSN, RN, was “Linking Performance and Staffing (How to Prove Your Intuition is Right!).”

The AAACN Board of Directors constantly seeks ways to promote and grow the association. In one such effort, the Board charged AAACN Education Director Sally Russell, MN, CMSRN, to look for new and effective ways of providing education of value to our members and ambulatory care colleagues. It was determined that an audioconference would be a convenient and valuable format, and the Board decided to test the format with this staffing presentation from the 2003 AAACN Annual Conference, which had received high marks from attendees.

To produce the audioconference, AAACN partnered with Intercall, an audio, Web, and event conferencing company. Intercall’s technology and expertise helped ensure that the event went smoothly. Participants registered through the AAACN National Office, and conference handouts were collated and e-mailed to registrants. On the day of the conference, the registrants called in to the event’s assigned number, then accessed another line that allowed them to listen yet not be heard. They were then given instructions on how to answer several polling questions as well as how to ask questions during the Q & A session at the end.

After the event, the registrants were sent an e-mail asking them how many people participated at their site. Although not all sites responded, those that did said they had over 130 participants. Each participant will be eligible to receive continuing nursing education contact hours after submitting an evaluation form to the AAACN National Office.

The number of questions and queries at the end of the conference indicated that the session was very well received, and we look forward to receiving the evaluation forms. The most difficult part for speakers in doing this kind of presentation is the lack of nonverbal feedback during the presentation itself. Not having people to look at makes it difficult to gauge whether the content is being understood or enjoyed, and that can create challenges for some speakers, however Ms. Griffin and Ms. Alexander gave an information-packed dynamic 75-minute presentation.

Given the success of this first audioconference, AAACN plans to provide several per year on various topics. Look for information in upcoming issues of Viewpoint and plan on joining in on these valuable and convenient education events.

Sally Russell, MN, CMSRN
AAACN Education Director
russells@ajj.com

More for Members on the Web!

Now Available: On-Line Continuing Education Article

Earn 2.1 FREE contact hours

AAACN is responding to members’ needs by adding another membership benefit. This introductory offer gives members the opportunity to earn 2.1 free contact hours by reading the article “Nursing Leadership Oxymoron or Powerful Force?” on the AAACN Web site, www.aaacn.org.

Log in as a member, then click on the link in the announcement paragraph on the home page to access the article. Print and submit the downloadable form to receive your contact hour certificate. Watch for future continuing education opportunities on our Web site.

Write for Us!

Go to www.aaacn.org for author guidelines and more information.
AAACN Media Report

In the last few years, AAACN has intensified its public relations and association marketing efforts and is now involved in an ongoing program to gain media exposure. Media coverage increases awareness about AAACN and ambulatory care nursing while at the same time attracting new members and promoting the specialty. Such articles also increase understanding of the varied roles of ambulatory care nurses and demonstrate the excitement, passion, and innovative work of nurses in this field.

To achieve media exposure, AAACN sends press releases to nursing, health care, and lay media about the association’s news, events, education programs, and products. The PR Department also pitches stories to nursing press and disseminates a list of ambulatory care nursing areas of expertise.

The following is a list of some of the media coverage for AAACN in 2003-2004.

- Maureen Espensen, co-coordinator of AAACN’s Telehealth Nursing Practice Core Course (TNPPC), was interviewed for an article entitled “Calling All Nurses! The 411 About Telehealth Nursing” published April 2003 in Vital Signs, a health care supplement to the Florida Sun Sentinel (circulation 80,000 nurses and health care professionals.) The article presented information on the TNPPC session to be presented at the AAACN 2003 conference in Tampa, FL.
- E. Mary Johnson, AAACN 2002 president, was interviewed for an article entitled “Patient Safety: Perform Pre-Op Assessments and Safety Teaching in All Offices” published in May 2003 issue of Medical Office Nurse, a magazine for health care providers in Florida.
- Catherine Futch, AAACN’s current president, was interviewed for an article entitled “Ready for Anything” published in the Summer 2003 issue of Minority Nurse, a magazine that goes to 40,000 nurses, 1,800 nursing programs, and 4,500 hospitals in the United States. The article discusses the need for nurses to be prepared for a bioterror event and also covers the nurse’s role in providing culturally competent care during a crisis.
- An article entitled “Telenursing Ed” was published by Medical Meetings on the MeetingsNet Web site (www.meetingsnet.com), and in their print magazine and e-newsletter on July 1, 2003. The article presented information on the TNPPC, telehealth nursing trends, and the TNPPC course taught at the 2003 conference. AAACN contact information was included.
- AAACN sent a press release on November 10, 2003 entitled “Requirements Changed for Ambulatory Care Nursing Certification.” Candia Laughlin, AAACN’s president in 2003, and AAACN Executive Director Cynthia Nowicki are quoted; information on the exam, test dates, and Web sites are included. This release was picked up by the following publications: Gulf Coast Nursing Times (circulation 10,500, Texas to Florida panhandle); Advance for Nurses, Greater Philadelphia Region (75,000 nurses); and Nurse Manager Weekly, published by HCPro, Inc., in “Nurse Manager News” section (e-mail newsletter). 
- Candia Laughlin was interviewed for an article entitled “The Nurse Physician Relationship” published December 10, 2003 in Health Care Leader, a newsletter and Web-based publication.
- Maureen Espensen, MBA, BSN, RNC, and Penny Meeker, BS, RNC, co-coordinators of AAACN’s Telehealth Nursing Practice Core Course (TNPPC), were interviewed for an article entitled “New Edition of the AAACN Telehealth Nursing Practice Core Course Released” published in the February 2003 issue of Physician Referral & Telephone Triage Times. Maureen and Penny describe AAACN’s pioneering work in the TNPPC and discuss the updated content of the new edition.

Editor’s Note: If you see an article that includes information on AAACN or its members and officers, please e-mail PR Director Janet D’Alesandro at janetd@aij.com and let her know. Please also e-mail Janet if you are contacted by a member of the media -she will provide media training services - or if you have an idea for an article that she can pitch to the press. Thank you!
Dear Editor,

I have enjoyed the excellent Viewpoint series, “Nurses & Legislation,” written by Regina C. Phillips, MSN, RN. Part Two, “How a Bill Becomes Law” (July/August 2003, pp. 6-7) was especially helpful in understanding the process of national legislation.

I have recently completed a course in health policy and became acutely aware how important we as nurses are in influencing policy both on the state and national levels. I think many of us have a tendency to overlook and discount our power and think “I’m only one person,” but legislation is often initiated through the efforts of an individual or small group. I hope that nurses will make it a top priority this year to take an active part in the process.

Sincerely,

Janet P. Moye, MS, RN
Director of Nursing Practice, Brody School of Medicine
East Carolina University, Greenville, NC
(252) 744-1882 • moyej@mail.ecu.edu

Nurses & Legislation Series Available on AAACN Web Site

AAACN has received excellent feedback regarding the four-part Nurses & Legislation series by Regina C. Phillips. Because we wanted to share these valuable articles with a larger audience, we have posted them on the Web site for public access and free download. Please feel free to print out a copy of the series and share it with your colleagues, or simply direct them to AAACN’s home page, www.aaacn.org.
General Information

Interested speakers for the 2005 Annual Conference, April 7-11, 2005 are encouraged to submit an abstract following the guidelines described under “Required Information” on the reverse side. Speakers are encouraged to submit topics that reflect the theme of the conference and program objectives.

Abstracts reflecting innovative, research-based, or new practice information within the identified tracks have the highest possibility for selection as a presentation at the 2005 conference.

Program Objectives

1. Describe the positive impact that Ambulatory Care Nurses can have in charting the future of ambulatory care.
2. Promote ambulatory care best practices through networking and sharing of expertise.
3. Develop strategies for professional practice in Ambulatory Care.

Participants

Nursing staff, administrators, educators, clinical nurse specialists, advanced practice nurses and researchers who are involved in the delivery of nursing care in the ambulatory care arena.

Tracks

**Clinical Practice:** Topics include those that present cutting-edge information about the clinical aspect of ambulatory care practice to include clinical practice trends and new treatments.

**Education:** Topics in this track include those that provide information related to patient and staff education, especially those with measures of positive outcomes or those that meet regulatory requirements or accreditation guidelines.

**Research:** Research-based studies relevant to ambulatory care nursing are encouraged.

**Communications/Technology:** Topics might include new ways of communicating and delivering care as well as discussion of new technology related to ambulatory patient care.

**Health Care Administration:** Emerging models of leadership, ways to influence outcomes and quality, and experiences integrating new models of care within the fiscally-challenged environment are topics to consider.

**Pediatrics:** Information relative to the care of this specialized group of patients is encouraged.

**Professional Development:** Topics relative to personal development in the profession of nursing such as belonging to professional organizations or career innovations.

**Telehealth Nursing Practice:** Information about innovative practices, new/emerging roles, clinical issues, and challenges associated with this practice setting are important.

Types of Presentations

**Concurrent Session:** Formal presentation in a lecture-style format lasting 75 minutes. Some freedom exists in terms of formality, but a course size of 75+ participants should be expected.

**In Brief Sessions:** Presentation of 20 minutes on an innovative or exciting concept related to creating a preferred future, ambulatory victories experienced, effective strategies to use, or technological advances. Presentation must include goals and desired outcomes of the presentation, overview of innovation/concept/experience, and either a plan for evaluation or results of experience being reported. Presentation must reflect creativity and vision. Three presenters will be scheduled for each 75-minute session which allows for a 15 minute Q & A activity following all three presentations. Course size of 75+ should be expected.

**Poster Session:** Display of information using a hanging or freestanding poster. Developers of the poster should expect to be present for two sessions, totaling 2.5 hours. Presenters should be prepared to interactively discuss their poster with individuals who arrive randomly during the open sessions. Poster development expenses are not reimbursable.

Honorariums

Concurrent session speakers will receive an honorarium of $200. In Brief speakers and poster presenters receive no honorarium. All speakers receive a $100 discount off the normal 3-day registration fee. No travel or other expenses are provided. An honorarium, if offered, and speaker registration discount are provided only to the primary presenter.

Submission Deadlines

All abstracts being submitted as a hard copy must be postmarked no later than April 19, 2004 and be received at the AAACN National Office no later than April 30, 2004. If the abstract is being submitted electronically, the deadline is May 14, 2004.

Review and Acceptance

Abstracts are selected on blind review by members of the Annual Program Committee. Notice of abstract review results will be mailed by early September, 2004.

Abstract Consultation

For assistance with the abstract development process, contact AAACN Education Director Sally Russell, russells@ajj.com, (800) 262-6877.
**Required Information**

Abstracts should be submitted using the format below. Those submitting are encouraged to provide complete information and follow the space guidelines. Abstracts MUST BE TYPED if being faxed or sent via U.S. mail. Use 1-inch margins and a font size no smaller than 10 point. Those in smaller font will not be reviewed related to scanning and fax transmission difficulties. Abstracts being submitted electronically are not restricted to font size, but must still have 1 inch margins.

**Pages One and Two**
- 1 inch margins
- Font size 10 point or larger

I. **Page One – Speaker Demographics**
   A. Primary presenter’s name and credentials (e.g., Sue E. Smith, MSN, RN,C)
      1. Preferred mailing address
      2. Preferred telephone number
      3. E-mail address, if available
   B. Secondary presenter’s name and credentials (limited to only one Secondary Presenter)
   C. Attach a CV or resume for each presenter to the abstract. Include educational and professional qualifications related to the proposed topic.

II. **Add the Following Statements**
   Indicate your preference with your signature
   - “If selected, I am/am not (select one) willing to submit a brief article to Viewpoint” followed by your signature.
   - “If selected, I agree/do not agree (select one) to provide handouts to support my presentation.”

III. **Page Two**
   Do not use your name(s) on page two – Presentation History of Primary Presenter
   A. List up to three significant presentations within the last 5 years
      1. Title
      2. Location/year
      3. Level (e.g., local, state, regional, national)
      4. Size of audience
   B. List all past presentations at AAACN’s Annual Conference within the last 3 years
      1. Title
      2. Year

IV. **Page Three**
   Do not use your name on page three
   Use 1-inch margins, font size 10 point or larger
   A. Title of abstract
   B. Desired track
      (Choose one: Clinical, Education, Research, Communications/Technology, Health Care Administration, Telehealth Nursing Practice)
   C. Level of Presentation: Basic, Intermediate, Advanced
      • Basic level appropriate for review, or new information for the beginning ambulatory care nurse or caregiver
      • Intermediate appropriate for the ambulatory care nurse or caregiver with experience
      • Advanced appropriate for the advanced practice nurse
   D. Desired Type of Session
      (Indicate your first and second choice: Concurrent session, Poster Session, or In Brief Session)
   E. Objectives
      • No more than three
      • Behaviorally stated (e.g., words such as define, describe, list, identify, demonstrate)
      • Reflective of content
   F. Description
      Provide not greater than a half-page, single-spaced description of your proposed presentation, detailing the content of the presentation.

**Abstract Submission Address**

**Preferred:** E-mail to reichartp@ajj.com
(If e-mailing, use Word or WordPerfect, please.)
FAX: (856) 589-7463
U.S. mail address:
AAACN National Office
East Holly Ave, Box 56
Pitman, NJ 08071-0056
Phone: 800-262-6877
level. Don’t assume you aren’t touched in some way by the decisions being made, because you will be. Don’t assume you don’t need to be involved in or informed about decisions affecting health care payment and delivery because your voice and actions are crucial.

- Managing chronic illness will continue to take a front-row seat for all of us. Acute illness and injury are usually quickly addressed and resolved. The real challenge comes with handling chronic illness (congestive heart failure, diabetes, hypertension, to name a few). Healthy life styles, individual ownership for health and well being, treatment protocols, and guidelines to help lessen variability in approaches to care will continue to take center stage as we look for ways to improve care, extend life expectancy and reduce cost.

- Redesigning the workplace is one of our most significant challenges. So many factors play a role in helping to create and sustain an environment that is attractive to professional nurses, support staff, patients, and families. These include:
  1. Support by senior leadership
  2. Well-prepared leaders and managers
  3. Sufficient staffing and resources
  4. Pay and benefits
  5. Meaningful mentoring and support
  6. The ability to thrive without the need to leave the profession
  7. Retention

This last item – retention – is perhaps our greatest challenge. To attract and retain nurses who are engaged in the profession and in the care that must be provided to their patient population, we must focus on the workplace and on what it is like to be part of that workplace.

As is usually the case, we won’t be bored and we won’t be free of challenge. However, we will have ample opportunities to help shape the face of health care as it adjusts to the challenges that come with rapidly advancing technology, diverse patient populations, overburdened employers, escalating health care costs, declining access to health care, and the potential for man-made or natural disasters. There is great comfort in knowing that we, as nurses, are more than ready and capable of rising to the challenges we face.

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

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Thank You to Members
Finally, thank you for allowing me to serve as your President. The Board of Directors and I have worked throughout the year to continue the work of those who came before us, to make our own unique contributions, and to pave the way for those who will come after us.

We have been a great team and you have been wonderful partners as you have provided input and offered your time and energy to help us with a variety of initiatives. Together we have made a difference. We will continue to do so as we move into another year.

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

AAACN Corporate Members
Celebrate National Nurses Week
May 6-12, 2004

The work of America’s 2.7 million registered nurses to save lives and to maintain the health of millions of individuals is the focus of this year’s National Nurses Week, celebrated annually May 6-12 throughout the United States.

“Nurses: Your Voice, Your Health, Your Life” is the theme for 2004. National Nurses Week opens on May 6, the traditional National Nurses Day. This year the American Nurses Association (ANA), in conjunction with its Constituent State Nurses Associations, will be recognizing nurses by drawing special attention to nurse staffing issues.

Annually, National Nurses Week begins on May 6, marked as RN Recognition Day, and ends on May 12, the birthday of Florence Nightingale, founder of nursing as a modern profession. During this week, registered nurses nationwide will be honored at rallies, community health screenings, childhood immunization efforts, dinners, receptions, and hospital events.

In addition to this celebration, nurses are encouraged to observe and participate in Cover the Uninsured Week, May 10-16, 2004. Nurses see firsthand the consequences that stem from a lack of health insurance coverage: sicker patients who have postponed needed health care. More than 1,000 events will take place during Cover the Uninsured Week, involving nurses, doctors, union members, business owners, hospitals, members of religious groups, students, grandparents and people from all walks of life and every point of view. For more information, go to www.CovertheUninsuredWeek.org.

Traditionally, National Nurses Week is devoted to highlighting the diverse ways in which registered nurses, the largest health care profession, are working to improve health care. From bedside nursing in hospitals and long-term care facilities to the halls of research institutions, state legislatures, and Congress, the depth and breadth of the nursing profession is meeting the expanding health care needs of American society.