

# aaacn ViewPoint

The Official Publication and Voice of the American Academy of Ambulatory Care Nursing

## Safety Corner

# Stick to Procedure When Performing Phlebotomy

Sarah Muegge

Ambulatory care nurses (ACNs) often perform phlebotomy collection when laboratory services are not available. While ACNs are certainly capable of performing phlebotomy, this multi-step procedure is rarely part of formal nursing education. Venipuncture is only one step of the process. I began working as an ACN educator 16 years ago and underappreciated the steps in phlebotomy collection that could either facilitate or hinder accuracy of the results. Unfortunately, knowledgeable personnel who might provide training in proper phlebotomy procedure are not available to some ACN settings. During a busy day, there is little time to search for reference materials. This leaves the ACN in the situation to fend for him or herself, perhaps follow advice from co-workers ("this is how we've always done it"), or simply left to proceed with a 'best guess' approach. We are fortunate that laboratory personnel in our organization recognize the importance of having ACNs trained in phlebotomy collection practices. Our laboratory staff has faithfully presented proper collection techniques during our monthly orientation classes since 2000. This article will review important steps that they cover during that class. Those participating in phlebotomy collection must stick to a procedure that produces accurate results.

Some references estimate that 60-75% of laboratory errors occur before the specimen is analyzed in the lab. Many ACNs may not even be aware that they potentially contribute to this problem. Pre-analytic errors can lead to incorrect test results that can potentially harm patients. The ACN who has not received proper training in phlebotomy procedures can contribute to errors including hemolysis, insufficient sample quantity, wrong tube selection, improperly labeled specimens, and contamination (Proehl, 2016).

Venipuncture site selection and preparation are important things for the ACN to consider. All staff should follow standard precautions when performing venipuncture. Our laboratory staff requests that we utilize the standard phlebotomy needles, vacuum tubes,

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## Call for Submissions: Safety Corner

Please share your evidence-based strategies that can help us provide safer care in the ambulatory care setting. Keep it simple as you address a topic you are passionate about sharing. For our official "Submission Tips," visit [www.aaacn.org/viewpoint](http://www.aaacn.org/viewpoint). Share your questions, ideas, or submissions with Sarah Muegge at [sarah.muegge@coxhealth.com](mailto:sarah.muegge@coxhealth.com).

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## AAACN Members as Owners, Customers, and Workforce

It is with great joy, pride, and resolve that I begin my year as President of AAACN. The joy stems from the fact that I am taking on this leadership role for such an incredible organization, this community of ambulatory care nurses. This community, AAACN, is made up of many members, nurses passionate enough and committed enough to devote their time and expertise to advancing the art and science of ambulatory care nursing. The pride stems from our many resources and accomplishments. I resolve to do everything in my power to serve this community and to enhance efforts to increase the visibility and value of ambulatory care nursing.



Liz Greenberg

It's important for all of us to realize that as members of this nursing association, we are also the owners, the customers, and the workforce (American Society of Association Executives, 2017). As owners, we are invested in the growth and success of the organization. We invest by recognizing and mentoring our leaders and voting in elections to ensure that those in leadership positions are the most qualified. We also invest by paying our dues to keep the organization financially viable, devoting our time and energy to maintaining a productive community, and educating others on the value and resources of AAACN.

As customers, we take advantage of the many services and resources available through our organization – our annual conference, online communication vehicles, telephone conference lines, and our AAACN publications, *ViewPoint* and the “Perspectives in Ambulatory Care Nursing” column in *Nursing Economic\$*. AAACN offers us many ways to share our experiences and practice, and collaborate with nurse experts within and outside of our organization. As customers, we identify the resources, products, and projects needed to meet our practice and professional needs. For example, we identified the need for an updated Role of the RN Position Statement and Paper; a Care Coordination and Transition Management (CCTM) toolkit and certification review questions; Nurse-Sensitive Indicators specific to our practice, population, and settings; an RN residency program; and the *Ambulatory Care Nursing Orientation and Competency Assessment Guide*.

As the workforce of this organization, we are investing our time and energy to come together to create these resources and others, including updating the *Ambulatory Care Nursing Core Curriculum*, ambulatory care nursing and telehealth nursing practice scope and standards, and continued development and review of the Lippincott ambulatory care nursing procedures. As the workforce of the organization, it is obvious that we are deeply and continually committed to the advancement of professional nursing practice in our many ambulatory care settings.

In recognizing our successes and appreciating one another as AAACN owners, customers, and workers, it is important to note that our participation and our efforts are strictly voluntary. We are involved because we care, have the passion, expertise, and motivation to identify needs, develop ideas to address them, and then turn those ideas into realities. Indeed, not only do we dedicate time and energy to the ambulatory care nursing community and to AAACN, but we continue to excel at full-time jobs, care for families, and engage in continuing education and professional and personal development. Given the impact of our roles in society and in our profession, it is essential that we also find time to see to our own health.

The American Nurses Association (ANA, 2017) has declared this the year of the Healthy Nurse. ANA defines a healthy nurse as “one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual,

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**FOR SOME NURSES**

**IT'S ALL ABOUT**

**TRAILBLAZING**



Meet Daniel. Nurse. Athlete. Force for good. Nurses at City of Hope do everything full out. To a person, they are passionate, determined and focused. Here, on this extraordinary campus they find a community of physicians, scientists, pharmacists, social workers, and fellow nurses who are, well, as crazy as they are. City of Hope is recognized as an NCI-designated Comprehensive Cancer Center; on the leading edge of new research. What is most interesting is how a place this driven can also be this supportive. As a nurse, Daniel has the resources and the space to practice evidence-based care as he has always wanted to, while moving the world closer to a cure. When he's not being a nurse? That's when you can find Daniel pushing his own limits. We are all in. If you are too, there's a place for you here. Join us. [CityofHopeCareers.com/Viewpoint](https://www.cityofhope.org/careers/viewpoint)

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### Calls by RN Care Managers Post-Hospitalization Improve Transitions of Care

Deadline for Submission:

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AMBJ1703

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#### Learning Outcome

After completing this learning activity, the ambulatory care nurse will have a broad understanding of programs focused on improving transitions of care and the positive impact that follow-up calls by care coordinators have on transitions of care for patients moving from the hospital setting back to the community.

#### Learning Engagement Activity

*Download and review:* Centers for Medicare & Medicaid Services (CMS). (2016). *Community-based care transitions program*. Available at <https://innovation.cms.gov/initiatives/CCTP>

The author(s), editor, editorial board, content reviewers, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

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This article was reviewed and formatted for contact hour credit by Rosemarie Marmion, MSN, RN-BC, NE-BC, AACN Education Director.

# Calls by RN Care Managers Post-Hospitalization Improve Transitions of Care

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Kathryn Boyd-Trull, Corey Lyon,  
and Joanna Sturhahn Stratton

Numerous evidence-based models have been developed to improve transitions of care (TOC) for patients moving from the hospital setting back to the community. These models have resulted in positive outcomes by improving patient care and reducing healthcare costs. The Affordable Care Act (ACA) has highlighted the need to address TOC issues on a national level by creating initiatives to improve the process (U.S. Department of Health & Human Services [HHS], 2017). The ACA, in conjunction with the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) model, demonstrate the commitment on a national level to improve the TOC process for patients. Current TOC initiatives include the development of the Community-Based Care Transitions Program in February 2012 (CMS, 2016a), the Hospital Readmission Reduction Program in October 2012 (CMS, 2016c), and the ability for providers to receive an increased reimbursement rate for Transitional Care Management Services, which started in January 2013 (CMS, 2016b). A press release from the HHS (2014) announced that these programs have had a significant impact on reducing the hospital readmission rates among Medicare beneficiaries from a consistent 19% from 2007–2011 to 17.5% in 2013. In addition to the ACA, the PCMH model has transitions of care as a focus. Providing coordinated care is one of the five key components of the PCMH model, and the 2014 PCMH Standards and Guidelines includes coordinating care transitions. Standard 5C of the Standards and Guidelines states that the PCMH clinic “nurse care manager or care coordi-

nator will be responsible for contacting patients that were admitted and discharged from the hospital within 72 hours to ensure medications and allergies are reconciled in the patient’s chart, schedule follow-up appointments if needed, and obtain additional information as needed” (NCQA, 2014, p. 64).

Registered Nurse Care Managers (RNCMs) can be an instrumental part of a multidisciplinary healthcare team to provide care coordination and transition management (CCTM) in a PCMH practice. The RNCM functions as the hub of the wheel for coordinating care when a patient is discharged from the hospital. As the primary contact who reaches out to recently discharged patients, the RNCM can perform a comprehensive assessment identifying and addressing any issues, needs, or gaps in care. The critical thinking skills that are central to the practice of all RNs guide the conversation with the patient to identify medical issues. These skills also allow RNCMs to recognize other areas of need such as the presence or absence of social support, symptoms of depression, health literacy level, and basic resources such as transportation to appointments. The preparation, unique skill set, and knowledge base of the RNCM allows him or her to address the next steps of the care transition process, which includes coordinating care (home health, referrals to specialists, communication with the primary care provider [PCP] and other members of the care team), leveraging community resources, educating patients and their caregivers about medications and chronic illness, and engaging patients and their caregivers to develop patient-specific goals and care plans. These interventions by the RNCM enhance continu-

ity and quality of care for the patient and ensure a more successful transition from hospital to home.

### Literature Review

Studies have shown the benefits of post-hospital discharge contacts to patients, including higher rates of completed hospital follow up visits, a reduction in hospital readmissions, and the ability to promptly identify issues that could lead to poor outcomes. One study evaluated post-hospital telephone support from a call center for a large population of patients (n=48,538) enrolled in a Medicare Advantage Plan. It showed that the number of patients who were seen by their provider after hospitalization increased from 72.3% to 76.5%, and the number of 30-day hospital readmissions was 9.3% versus 11.5% for the control group (Costantino, Frey, Hall, & Painter, 2013). Tang, Fujimoto, and Karliner (2014) evaluated hospital follow-up calls to 486 patients within 72 hours of discharge by nurses in a primary care practice. The results showed higher rates (60.1%) of completed hospital follow-up visits with a PCP for patients who were contacted versus 38.5% of patients who were not contacted. Furthermore, this study showed that the nurses who conducted the hospital follow-up calls were able to uncover at least one problem in 79% of the patients contacted, which may have led to poor outcomes if not addressed at the time of the call. Another study of 148,020 Medicare patients with atrial fibrillation and other chronic conditions showed a decrease in hospital readmission rates by 11-24% for patients who completed a hospital follow-up visit with a PCP within 7-14 days of discharge versus those who did not have a follow-up visit (Hubbard, Frost, Siu, Quon, & Esposito, 2014). Finally, a study by Farrell and colleagues (2015) described the implementation of a transition management program in a PCMH certified practice where care managers (RNs, social workers, and clergy) contacted 118 patients within 24-72 hours after discharge and ensured a hospital follow-up visit with a PCP was scheduled. Their interven-

tions resulted in a hospital readmission rate decrease from 17.9% to 8% for patients receiving the transition management service. These studies demonstrate that hospital follow-up calls can increase positive outcomes for patients and the healthcare system through higher completion of post-discharge PCP visits, identification of problems that may have led to poor outcomes, and decreases in hospital readmissions.

### Intervention

In September 2015, a PCMH certified, urban family practice residency clinic affiliated with the University of Colorado Hospital (UCH) began contacting patients after discharge from the hospital. This TOC intervention was implemented to improve patient care and to impact the rate of 30-day hospital readmissions. TOC calls were made to patients within 48 hours of discharge, and were made by an RNCM certified in CCTM. Patients included in the TOC intervention had been hospitalized at UCH and received their primary care at the family medicine residency clinic, or were assigned as a new patient to the clinic post-discharge. Patients excluded from the intervention included those who were already seen for their hospital follow-up visit prior to the TOC call, patients with discharge diagnoses who were followed closely by a specialist post-discharge (e.g., transplant or oncology patients), post-partum patients seen for primary care at the residency clinic but who received prenatal care at a different clinic, and patients discharged with hospice or to a skilled nursing facility.

Each morning, the clinic's certified RNCM pulled a report from the electronic medical record, which listed patients discharged from UCH. The discharge summaries of patients eligible for TOC calls were reviewed prior to the call to identify specific areas needing more attention during the telephone encounter. For example, specific areas included reinforcing daily weights for a patient with a discharge diagnosis of congestive heart failure or ensuring home health infusion services were initiated for a patient discharged on IV antibiotics. In

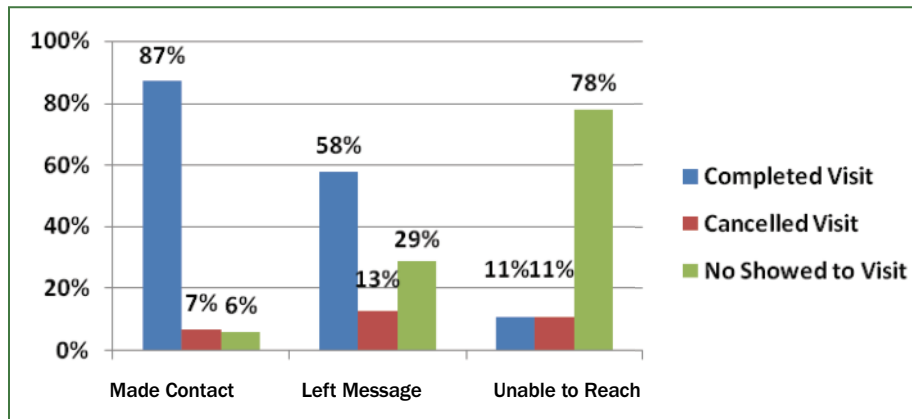
addition, the certified RNCM reviewed the after visit summary (AVS), which was a discharge report given to patients prior to leaving the hospital. The AVS provided additional information for the certified RNCM to review with the patient, further ensuring a patient-centered experience.

A scripted list of questions was asked during the TOC call. Questions addressed symptoms (new and/or "red flags"), medications, home health services, durable medical equipment, follow-up appointments, needed follow-up tests or procedures, transportation, social support, and behavioral health. In addition to these questions, an open-ended question was added to provide patients with the opportunity to identify their individual needs. The patient was asked, "What do you need most right now?" Asking this type of question has shown that patients' concerns are more likely to be addressed. For example, Heritage, Robinson, Elliott, Beckett, and Wilkes (2007) implemented a study with 20 family physicians and a total of 224 patients. The physicians' interview with the patient included asking, "Is there something else you want to address in the visit today?" A comparison of pre-visit surveys completed by the patients was compared to concerns brought up by the patients during the visit that were not listed on the pre-visit survey. Their intervention resulted in addressing 78% of patients' unmet needs. Nursing practice includes using open-ended questions as a foundation to provide holistic assessments of patients' needs. Although this study was focused on physicians, it clearly demonstrated that this specific type of

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**Figure 1.**  
Comparison of Visits with Contact vs. Message vs. No Contact



open-ended question is an effective way to identify and address patients' immediate concerns, which is particularly important when a patient is discharged from the hospital. During each call, the patient was reminded of their hospital follow-up visit (usually scheduled by the inpatient staff prior to discharge) or a visit was scheduled, if needed. For patients who could not be reached, a message was left indicating the reason for the call, the date and time of their scheduled hospital follow-up visit (if already scheduled), and the direct contact information of the RNCM. Three attempts by telephone were made to patients who could not immediately be reached.

Once the TOC call was completed, the RNCM addressed any immediate patient needs. For example, the RNCM might have consulted with a provider if a patient was experiencing symptoms and a same-day appointment was necessary; ordered home health care, if needed; ensured medications were obtained; or arranged for transportation to hospital follow-up visits. For identified issues requiring further support, referrals were sent to other members of the multidisciplinary team. For example, a clinical pharmacist received referrals for patients diagnosed with insulin-dependent diabetes, a social worker received referrals for patients needing community resources, patients with symptoms of depression or other behavioral health issues were linked to the psychologist, and patients discharged on an anti-coagulant therapy

were referred to the anti-coagulation RN. Once the TOC call was documented in the electronic medical record, the note was routed to the PCP and other members of the multidisciplinary care team who would be involved in the patient's care.

#### Outcome Measures

The data gathered and analyzed for this intervention included percentages of completed post-hospital follow-up visits, 30-day all-cause hospital readmissions rates with the average LACE+ scores and length of stay of hospitalized patients, and the types and percentages of near misses. Near misses were defined as issues that, if not addressed, may have led to poor outcomes such as emergency department visits or re-hospitalizations. Baseline (pre-intervention) data was collected over an eight-month period (January 2015–August 2015) and post-intervention data was collected over a six-month period (September 2015–February 2016).

The pre- and post-intervention percentages of completed post-hospitalization follow-up visits, canceled visits, and visits not completed (no-shows) were compared. In addition, to determine the effect of the RNCM's personal contact on the patient, post-intervention percentages of hospital follow-up visits (completed, canceled, and not completed) were compared with whether the patient was contacted, only received a message, or was not able to be reached. This comparison was done to determine if there was a correlation

between completed hospital follow-up visits and whether patients could be reached.

The pre- and post-intervention 30-day all-cause readmission rates were compared. In addition to the readmission rates, the average length of stay and the average LACE+ scores were compared to determine if there were similar levels of acuity with the pre-hospitalization patient population. The LACE+ tool assists in predicting risk of early death or urgent readmissions and is automatically calculated within the electronic medical record and displayed on each patient's discharge report. Our clinic used the LACE+ Index Score, which is more comprehensive than the original LACE score because it adds values such as patient age, sex, acute diagnoses, procedures performed, and level of care while inpatient (van Walraven, Wong, & Forster, 2012). The LACE+ Index Scores are stratified as follows: 0-28 is low risk, 29-58 is medium risk, and 59-90 is high risk for adverse outcomes.

The third outcome measure for which data was collected were those findings that our clinic called "near misses." The purpose of collecting and collating this information was to share those areas where there could be improvement in the discharge process with both the inpatient and clinic clinicians.

#### Results

A total of 529 clinic patients were discharged during the six-month collection period and 351 were eligible for a TOC call. Of the 351 patients eligible for a TOC call, 304 were directly contacted (87%). The majority (251) of the patients confirmed hospital follow-up visits and 53 declined a hospital follow-up visit. Fifty-eight patients (11%) received up to three messages; nine (2%) were not able to be reached. The most frequent stated cause for declining a visit with the PCP was that the patient already had a follow-up appointment with a specialist.

Post-intervention results revealed that 87% of patients who were personally contacted by the certified RNCM had a completed follow-up visit, whereas only 58% who received

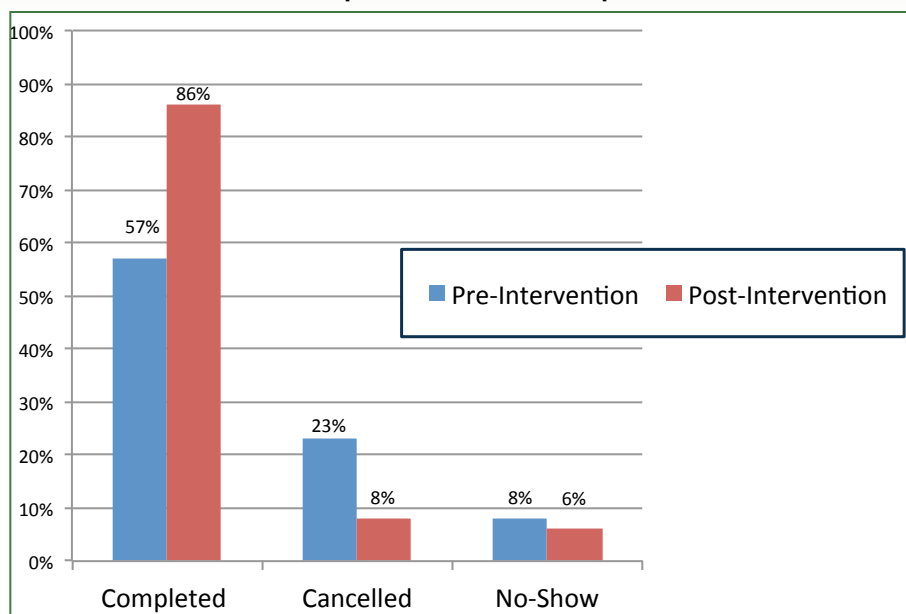
a message completed a follow-up visit; 11% who could not be reached came for a visit. Cancelled visit rates were 7% for patients contacted, 13% for patients who received a message, and 11% for patients not able to be reached. The no-show rates were 6% for contacted patients, 29% for patients who received a message, and 78% for patients not able to be reached (see Figure 1).

Pre- and post-intervention follow-up visits were compared. The percentage of hospital follow-up visits completed pre-intervention was 57% compared to 86% post-intervention. The rate of cancelled visits pre-intervention was 23% compared to 8% post-intervention, and the no-show rate was 8% pre-intervention compared to 6% post-intervention (see Figure 2).

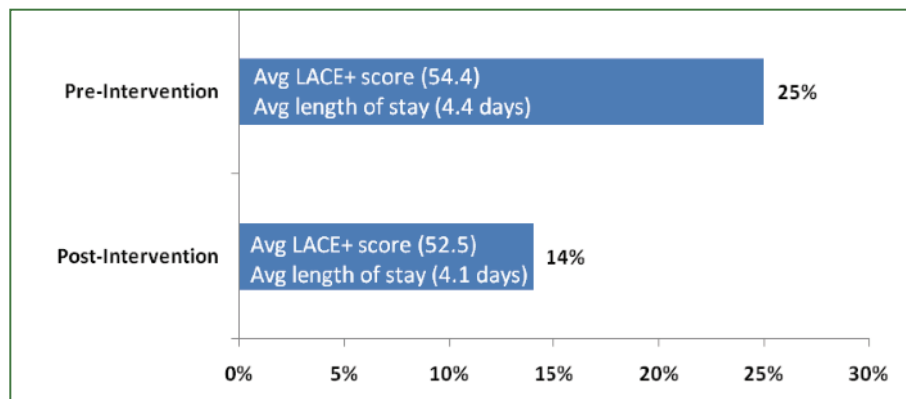
The pre- and post-intervention 30-day, all-cause hospital readmission rates were compared, as well as the LACE+ Index Scores and length of stay in days, to determine if either group had a higher risk of readmission than the other. The readmission rates decreased from 25% pre-intervention to 14% post-intervention. The average LACE+ Index Scores and average length of stay in days was 54.4 and 4.4 pre-intervention and 52.5 and 4.1 post-intervention, respectively, showing that the population of patients' pre- and post-intervention had similar risks of readmissions (see Figure 3).

The "near miss" categories were identified and categorized during the TOC calls (see Table 1). Of the 304 patients contacted, 73 near misses were identified (24%). The identified categories of "near misses" included issues surrounding medications, symptoms, home health, transportation, follow-up appointments, health literacy, and behavioral health. One frequent example was that some patients couldn't get one of their medications because their prescription insurance did not cover the drug. In this situation, the RNCM either worked with the insurance company to get an authorization to cover the medication or consulted with the pharmacist about other drug options.

**Figure 2.**  
Post-Hospitalization Follow-Up Visits



**Figure 3.**  
30-Day All Cause Readmission Rates



**Conclusions**

Post-hospitalization follow-up calls to recently discharged patients is an intervention common to most evidence-based transitional care models. While it is just one step in many models, studies have shown that follow-up calls have a positive impact on completed PCP follow-up visits and reduce hospital readmissions, especially when performed by an RNCM. The personal intervention of a follow-up call by the RNCM showed favorable results, which included an increase in completed hospital follow-up visits, decreased cancelled follow-up appointments, and a decrease in the no-show rate. Patients receiving direct contact by the RNCM were much

more likely to complete hospital follow-up visits. The UCH 30-day hospital readmission rate was also reduced. Finally, near misses were identified and addressed, which may have prevented hospital readmissions or visits to the emergency department. The results of this study's intervention support the value of TOC calls and the personal contact by the clinic's certified RNCM.

The family medicine residency clinic offers an integrated, multidisciplinary team including clinical pharmacists, psychologists, and a social worker. The RN certified in CCTM has the critical thinking skills and the necessary knowledge of resources that makes him or her a valuable member

**Table 1.**  
**Near Misses Found During Calls**

Near Miss Type	Near Miss Count
Medication Issue	27
Symptomatic	21
Home Health Issue	8
Transportation Issue	8
Follow-Up Appointment Issue	6
Health Literacy Issue	2
Behavioral Health Issue	1
<b>Total</b>	<b>73</b>
<b>Total Patients Contacted</b>	<b>304</b>
Near Miss Rate	24%

of the multidisciplinary care team who can provide TOC calls and other care coordination functions. The clinic's multidisciplinary care team creates a true PCMH, which ensures better outcomes with regard to transitions of care and improved overall quality of patient care.

The certified RNCM has since oriented RNCMs at two other UCH-affiliated clinics who are preparing to become certified in CCTM. They, too, have started implementing TOC calls. The goal is to have TOC calls become a standard of care in all UCH-affiliated practices. As other UCH-affiliated clinics begin to hire RNCMs, there is greater potential for improved patient quality of care and efficiencies.

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## Erratum

The March/April issue of *ViewPoint* included the article "Human Papillomavirus Vaccination: An Opportunity for Ambulatory Care Nurses to Promote Health and Wellness." It should be noted that the HPV recommended immunization schedule has recently changed to a 2-dose schedule for 9vHPV vaccine in younger adolescents beginning vaccination at 9 through 14 years of age. More information can be obtained at [https://www.cdc.gov/mmwr/volumes/65/wr/mm6549a5.htm#T1\\_down](https://www.cdc.gov/mmwr/volumes/65/wr/mm6549a5.htm#T1_down)



# 2016 AAACN Financial Report

AAACN is a volunteer nursing organization managed by Anthony J. Jannetti, Inc. (AJJ), a professional association management company. AJJ's association management team carries out many of the management responsibilities of AAACN, including planning and arranging the Annual Conference. One of the responsibilities of AJJ that is not as visible as the conference is the financial management of the organization. The Chief Executive Officer (CEO) of AAACN works directly for AJJ and oversees AAACN finances in conjunction with the accounting staff. The CEO works closely with the Treasurer, who is a member of the Board of Directors, elected by AAACN membership and then appointed as Treasurer. The Treasurer is actively engaged in the budget process, reviewing revenues, expenses, and investment reports regularly; questioning any variances; and presenting reports to the Board for their review and approval. One of those reports is an annual review of the financial status of the organization, carried out by the independent accounting firm of Haefele, Flanagan & Co. The Board reviews this report annually, and a summary, the 2016 AAACN Financial Report, is presented to members.

The annual report for 2016 showed net revenues of \$515,273. This was over AAACN's budgeted net revenues, and almost two times the net revenue reported in 2015. These increased revenues for 2016 are attributed to several positive factors and fall into several broad categories (see pie charts). While there are many sources that flow into each of these categories, a brief description of what constitutes each category follows. Membership revenues (26%), which includes membership dues; Education (54%), which includes conference attendance; Publications (6%), which includes AAACN resources, such as the *Scope and Standards of Practice for Professional Ambulatory Care Nursing*, *Scope and Standards of Practice for Professional Telehealth Nursing*, *Core Curriculum for Ambulatory Care Nursing*, *Care Coordination and Transition Management (CCTM) Core Curriculum*, and the

*CCTM Scope and Standards of Practice*; and Investments/Miscellaneous (14%), which includes income gained from royalties, interest, and dividends.

The balance sheet shows expenses as well as revenues. AAACN tracks expenses using four broad categories: Membership (27%), Administrative Operations (36%), Education (35%), and Publications/Miscellaneous (2%). Membership expenses are composed of the newsletter and journal of choice sent to each AAACN member, volunteer expenses, maintaining the AAACN website, and the annual Leadership Symposium. Administrative expenses include postage and phone costs, board expenses, independent legal and accounting fees, insurances, and the AJJ staff and management fees. Education expenses include organizing and executing AAACN's Annual Conference, delivering the certification review courses, and maintaining the AAACN Online Library through our partnership with Digitell.

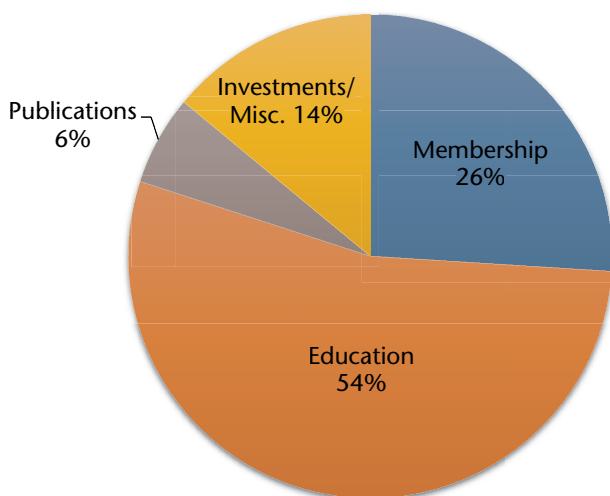
AAACN exceeded the amount of budgeted (expected) revenues by 28%, which is great news! Expenses for 2016 were in line with budget, and revenues were more than budgeted, thus leaving net revenues better than planned. This is a testament to the financial stewardship of AJJ and the Board of Directors. AAACN ended 2016 fiscally sound. Net assets at the beginning of the year were \$1,126,352 and increased to \$1,641,625 by the end of the year. For the fifth year in a row, and the fifth year in AAACN's history, total revenue exceeded \$1 million!

AAACN leadership continues to strive to be good stewards of its resources in order to most effectively carry out our strategic plan and continue our mission of advancing the art and science of ambulatory care nursing.

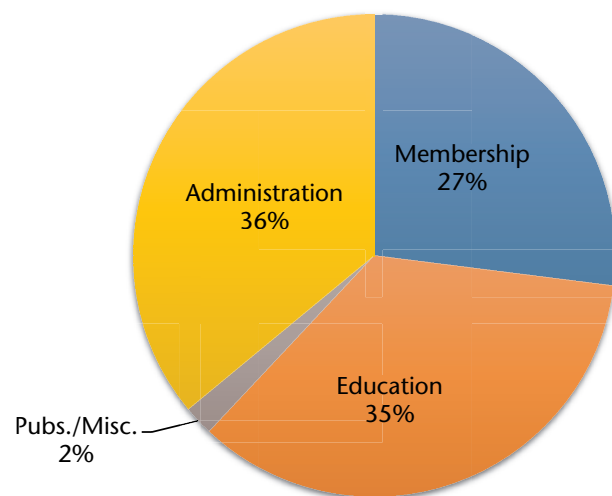
**Kristene Grayem, MSN, CNS, PPCNP-BC, RN-BC**, was AAACN Treasurer, 2016-2017. She can be contacted at [kgrayem@chmca.org](mailto:kgrayem@chmca.org)

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## Revenues



## Expenses



## Safety Corner

continued from page 1

tourniquets, and tube holders that the lab supplies for our use. If blood is withdrawn too quickly through a syringe rather than extracted through a vacuum tube, red cells can burst, resulting in hemolyzed cells. Hemolysis will cause blood specimens to turn bright red and will interfere with analysis of many tests. A hemolyzed specimen will need to be recollected using a new venipuncture site and, of course, new equipment. Allow alcohol applied on the venipuncture site to air dry or wipe it off with a clean cotton ball. If the needle is inadvertently contaminated by wet alcohol, it could also hemolyze the specimen. The preferred site for vein access is the antecubital fossa rather than small hand veins. Butterfly style needles may be appropriate to use in the hand or smaller veins of some patients including infants, small children, the elderly, oncology patients, or those who suffer hand tremors. However, a butterfly needle costs more than the traditional phlebotomy needle and is not necessary for the majority of patient sticks (D. Hubbard, personal communication, July 7, 2016). Some ACNs who have not received phlebotomy training prefer butterfly needles because they find them familiar to the intravenous therapy needles they have used before.

According to one reference, there is some conflicting information about whether collection technique contributes to hemolysis (Proehl, 2016). Yet physicians in

England reported on the variation of phlebotomy specimens collected by hospital phlebotomists compared to house staff in the emergency department, which did suggest it affects the results. In this study, phlebotomists utilized phlebotomy needles and vacuum tubes. By comparison, the house staff reportedly used some phlebotomy and some intravenous cannula needles, along with a mixture of vacuum tubes and syringes when obtaining specimens. Not only were the specimens collected by the house staff more frequently hemolyzed compared to those collected by the phlebotomists (10.7% versus 2.9%), the house staff-collected specimens were more commonly contaminated with chemicals in vacuum tubes because of improper draw order (Berg, Ahee, & Berg, 2011).

The draw order of tubes will depend on whether the tubes are glass or plastic and the specific recommendations from the tube manufacturer. Draw order is important because some vacuum tubes contain chemical additives. Additives can adhere to the tube stoppers when they are inverted in the needle holder. This allows some of the additive to come in contact with the end of the needle that enters the vacuum tube and this can cross contaminate the next specimen that is drawn with this needle. This is problematic if a tube containing lithium heparin is drawn before a Protime or Partial Thromboplastin Time. Contamination with heparin can falsely elevate the results. Insufficient sample volume and improperly mixing of blood with tube additives can also lead to errors (D. Hubbard, personal communication, July 7, 2016; Proehl, 2016). When a tube containing potassium ethylenediaminetetraacetic acid (EDTA) is drawn prior to a chemistry test, it causes false hyperkalemia and hypocalcaemia (D. Hubbard, personal communication, July 7, 2016; Lima-Oliveria et al., 2014). Obviously, it will be difficult and even dangerous for a provider to manage anticoagulant therapy or recognize and treat electrolyte imbalances if laboratory results are inaccurate.

Improperly filled tubes will skew the ratio of blood and tube additives, causing incorrect results. Allow tubes to fill until the vacuum stops or there may not be enough blood to run multiple tests that are ordered from that tube. Under-filled tubes will be marked as "quantity not sufficient." One of the reasons that blood only trickles into a tube is because the needle may not be in the middle of the vein. Gentle repositioning should be attempted to see if a better flow can be established. If repositioning the needle is not successful, a new venipuncture should be performed. As soon as tubes are filled, gently mix by inverting the tubes 5-10 times or per manufacturer recommendations. This allows the blood to mix with additives and prevents clotting. The ACN should be familiar with tube preparation as to whether a tube needs to be refrigerated or spun in a centrifuge before transporting to the lab (D. Hubbard, personal communication, July 7, 2016).

To reduce specimen identification errors, nurses in Wisconsin implemented a performance improvement strategy with specimen labels verified in the presence of the patient (Rees, Stevens, Mikelsons, & Darcy, 2012). Our health system has recently adopted this practice and the



lab is tracking mislabeled specimens. The lab requests that all labels contain two patient identifiers, the date and time of draw, the test to be run and initials of the person who collected the specimen. The specimen draw time is the most frequent information missing from our labels. In this instance, lab marks the time of draw as a minute after midnight. The provider will need to check with staff when the lab marks the time as 00:01, as some results such as a cortisol or glucose level may vary depending on time of draw.

The ACN is encouraged to consult with the appropriate reference lab on a regular basis to ensure specimens are collected, stored, handled, and labeled correctly. There is a large amount of literature written on this subject worldwide. Varieties of laboratory-specific resources are available online. An excellent example of a robust staff resource from a Canadian Lab is included in the reference list as an example (Calgary Laboratory Services, 2016).

The advantages and disadvantages of obtaining blood specimens from various venous access devices is beyond the scope of this column; however, it is important to mention the implantable central venous ports and peripherally inserted central catheters that allow easier administration of intravenous medications, such as chemotherapy or antibiotics. While it is certainly tempting to withdraw specimens from these pre-existing lines, if not performed correctly by properly qualified personnel, serious adverse events – including systemic infections – can follow. These are dangerous and expensive complications. Clear guidance as to if, or how, port access is allowed by the ACN is

needed. Perhaps someone would like to write an article on this subject.

In conclusion, all ACNs who participate in the phlebotomy process should adhere and ‘stick’ with best practice phlebotomy collection practices as reviewed in this article. Any number of steps in the process can adversely affect a laboratory result. The ACN should work with available laboratory professionals to guarantee the staff in your facility has the knowledge and training to deliver the safest care possible.

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## President's Message

*continued from page 2*

personal, and professional wellbeing” (para. 1). Given our commitment to advancing the art and science of ambulatory care nursing, it is crucial for our health that we find and maintain this balance. Throughout the year, many resources and opportunities will become available to assist us on our healthy nurse journey. Belonging to and engaging within a professional organization is a great start. Being an active member of AAACN provides an important social and professional connection. There is ample evidence to support the health benefits of belonging. People who feel a social connection and the social identity derived from active professional membership experience positive effects on their mental health and on their cardiovascular, immune, and endocrine systems (Haslam, Cruwys, Haslam, & Jetten, 2015). Research has shown that people who volunteer have better self-esteem and are healthier than non-volunteers (Detollenaere, Willems, & Baert, 2017). So, if we get involved and stay involved with this great organization, we will be doing something positive for our health, our profession, and the health of the nation.

The AAACN Annual Conference is a great place to get started on our healthy journey. The conference is very stimulating and rewarding for new and returning AAACN

members. It provides us a place to meet face to face, share ideas, stimulate creativity, and refuel and re-ignite our passion. Now is the time to put our ideas and our passion to work, to complete our ongoing projects, to develop new resources and alliances, and ultimately to strengthen the voice of ambulatory care nursing. I look forward to ensuring that this is another successful year for us – the owners, the customers, and the workforce of the American Academy of Ambulatory Care Nursing. I hope to interact with many of you over the coming year, and I look forward to seeing you all next year in Orlando!

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## Understanding the Legal Risks Of Nurse Leaders – Part 1

Nurse leaders or managers serve a very important role in healthcare organizations because they are responsible for directing, organizing, and supervising the work of the healthcare team assigned to their departments. They are often the first line of defense in ensuring the delivery of patient care is within the standard of nursing care. Nurse managers must also be prepared to meet the increased professional responsibilities of the position and be cognizant of the legal risks that come with a different level of accountability (Brothers, 2015). More often than not, nurse managers have little to no management training, but are expected to function within the law and are held legally responsible if they fail to do so. This column will provide some common legal risks nurse managers face and recommendations to minimize those risks.

### Background of the Scope of Practice Of a Nurse Manager

When a nurse achieves the position of a nurse manager/leader, it signifies the organization's recognition of one's professionalism, leadership, and expertise in working with others. The duty to manage staff requires a nurse leader to be aware of those foreseeable and unreasonable risks of harm that the patient might be exposed to if the staff member does not provide the requisite care or provides care negligently. The duty of a nurse manager is not a *higher* duty of care as compared with a staff member, but rather it is a *different type of liability*, with different duties

(Brent, 2015). The duty (as defined in the job description) requires the nurse manager to supervise his/her staff in a non-negligent manner. Neglectful supervision may occur when a nurse manager does not adhere to or follow a policy governing patient care, which results in patient injury. One of the best ways to avoid liability as a nurse manager is to emphasize to the healthcare team the importance of preventing unreasonable risks and utilizing a sound risk management approach.

One of the greatest concerns of a nurse leader is that he/she may be held liable if a patient is injured or harmed by a staff member's negligence. This is a valid concern as in some situations a nurse manager may be held accountable for the staff's actions, but in most instances, the hospital/organization is held liable for the staff member's actions. Under the legal doctrine of *respondet superior*, the organization or healthcare facility is responsible for the negligent actions of its employees. The nurse manager is not held liable under this doctrine because he/she is not the employer of the negligent staff member (Brothers, 2015). The potential liability of the nurse manager exists due to his or her role as the nurse manager. However, the nurse manager may be liable in instances where he/she fails to delegate tasks appropriately, fails to provide safe staffing, or fails to properly supervise staff personnel.

In 1994, the U.S. Supreme Court in *NLRB v. Health Care & Retirement Corporation* defined a nursing supervisor as:

A nurse, who assigns, oversees, and provides direction to licensed and unlicensed personnel. This definition not only exposes nurses in formal supervisory positions to supervisory liability but expands the legal responsibility to staff nurses, particularly those who assume the responsibility of charge nurse. The "supervisor" may be found negligent in failing to assign or supervise appropriately. Furthermore the corporation, under the doctrine of *respondet superior*, is liable for the actions of both the nurse performing the assigned care and the nurse making the assignment. (Dearmon, 2008, p. 481)

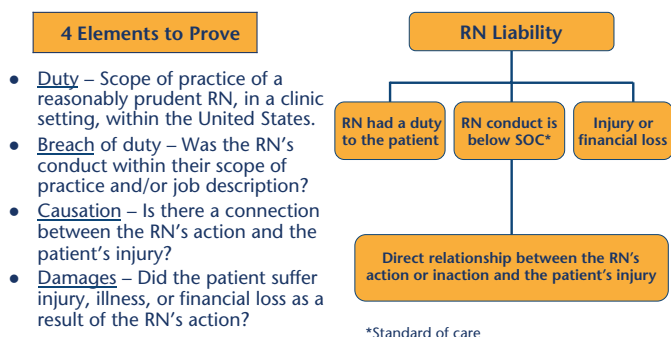
In determining whether a nurse with supervisory responsibilities has been negligent, the nurse is measured against the standard of care of a competent and prudent nurse in the performance of supervisory duties in an ambulatory care setting within the United States. Four elements must be established to hold a person accountable for negligence (see Figure 1). The four elements that must be proven are: duty, a breach of that duty, causation, and damages.

Consequently, negligence may occur when a nurse acts or fails to act when a reasonably prudent nurse would have taken action in a similar situation.

Nurse managers are expected to be competent in a number of skills and behaviors in such areas as human resource management, quality improvement and risk management, maintaining competency of healthcare team, financial and budget management, interprofessional collaboration and communication, upholding the standard of care in nursing practice, and following policies and procedures. "Experienced and new managers alike must place emphasis on two areas of concern – upholding the stan-

**Figure 1.**  
Four Elements to Prove Professional Liability

### Professional Liability/Malpractice Claim



Source: Paté, 2010.

dard of nursing practice and following established policies and procedures” (Brothers, 2015, p. 3). Therefore, when the nurse leader promotes and supports these two elements, accidents/injuries to patients are prevented, and staff members are competent and knowledgeable to provide the requisite care.

The risks for anyone in nursing management are similar. The supervised staff (licensed and unlicensed personnel) are accountable for their own practice; however, the nursing manager’s scope of responsibilities must involve the monitoring of compliance to organizational policies, ensuring safe staffing levels, and enforcing current nursing practice (Duclos-Miller, 2016).

There are several sources of potential liability against the nurse manager, such as negligent supervision, inadequate staffing, legal implications of policies and procedures, and the use of float staff and rapid response teams. In this column, negligent supervision of employees will be covered.

As a director, nurse manager, or leader, one must ensure that patients receive the appropriate care and the team members providing the care have appropriate supervision. Accordingly, when a patient is injured and there’s suspicion that staff members were not adequately supervised, an allegation may be made that the nursing supervision was inadequate or negligent. The claim of negligent supervision may be based upon any of the following (Duclos-Miller, 2016):

- Delegation of patient care to a staff member who is unable to perform the care required.
- Failure to personally supervise staff when you knew or should have known that supervision was needed.
- Failure to take the necessary steps to avoid patient injury when present and able to intervene.
- Inadequate staffing of the unit/clinic (perceived as negligent judgement in the nurse manager role).

When a healthcare team member is found guilty of providing negligent care, the healthcare organization will most likely be held responsible for actions of their employee and will bear the burden of compensation, as it has deeper pockets financially than the individual. However, it is the nurse leader’s responsibility to ensure the hiring of competent staff members, ensuring a comprehensive orientation and meticulous supervision of all team members, to reduce the organization’s liability.

If a case of malpractice does occur, all aspects surrounding the case will be examined (Duclos-Miller, 2016):

- Could this event have been prevented?
- Were patient safety practices enforced?
- What was the competency level of the team member involved?
- Did personnel have adequate staffing, supplies, and knowledge to prevent the event?
- How was the case managed once the event was discovered?
- Did everyone meet the standards of care when providing services?
- What led up to the adverse event?
- What was your role (nurse leader) in the event, both expected and anticipated?

In summary, the nurse leader’s overall duty is to prevent injury to the patient, so a proactive risk management style is vital. Supervision of others must be constant, active, and consistent with the standards of practice. Continue your own professional development through seminars, continuing education courses; obtain additional degrees and/or certifications; and establish networking contacts with other nurse managers for personal and professional support.

This column is the first in a four-part series on “Understanding the Legal Risks of Nurse Leaders.” Future topics include: legal significance of policies and procedures, liability risks of staffing, and risks involved in the use of float staff and rapid response teams.

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## Kathleen Martinez Appointed to AAACN Board of Directors



Kathleen Martinez

Kathleen Martinez, MSN, RN, CPN, has been appointed as a Director on the Board of Directors effective at the close of the AAACN 2017 Annual Conference. Kathleen will complete the remaining one-year term of Kathy Mertens, MN, MPH, RN, who will vacate her Director position to serve as President-Elect of AAACN.

Kathleen is Clinical Policy Oversight Manager at Children's Hospital Colorado and has been an active member of AAACN since joining in 2011. She most recently volunteered on the Nurse-Sensitive Indicator Task Force and the RN Role Position Paper Task Force and contributed to two important AAACN publications released within the last year.

## Apply for AAACN Scholarships and Awards

Did you know AAACN offers scholarships and awards to recognize members and advance ambulatory care nursing practice? We received a record-breaking number of applications for the 2017 scholarships and awards and proudly recognized a winner in every scholarships and award category.

These awards and scholarships are a member benefit and we encourage all eligible members to apply! Applications are due by November 15 annually. Complete your application online at [aaacn.org/membership/scholarships-and-awards](http://aaacn.org/membership/scholarships-and-awards)

*Note: For most scholarships and awards, you must be a member for two continuous years at the time of application.*

### Scholarships and Awards

- Candia Baker Laughlin Certification Scholarship – One \$1,000 scholarship to assist with ambulatory care nursing certification
- Care Coordination and Transition Management Certification (CCCTM) Grants – Two \$255 grants to cover the CCCTM exam fee (sponsored by the Medical-Surgical Nursing Certification Board)
- Education Scholarship – One \$1,000 scholarship to assist with nursing education
- Research/Evidence-Based Practice (EBP) Project Award – One \$1,000 award to conduct research or an EBP project

### Conference Scholarships

- Conference Scholarship – One \$1,000 scholarship (nurse for more than two years)
- Conference Scholarship for New Nurses – One \$1,000 scholarship (nurse for less than two years)
- Conference Scholarship for Nursing Students – One \$1,000 scholarship for student seeking initial licensure only

### Excellence Awards (sponsored by the Nursing Economic\$ Foundation)

- Administrative Excellence Award – One \$500 award
- Clinical Excellence Award – One \$500 award

## Join Us in Orlando in 2018

AAACN will visit Orlando for its 43<sup>rd</sup> Annual Conference, May 9-11, 2018, at the Walt Disney World Dolphin Hotel. You'll learn the latest trends and hot topics in ambulatory care, telehealth, and care coordination, and experience beautiful accommodations and the magic of the theme park capital of the world. Save the date and plan to join us in Orlando next year!

## Write to Win

Did you know *ViewPoint* holds an annual Writer's Award contest? This honor is given to encourage and recognize excellence in ambulatory care nursing, and the winner receives complimentary registration to the AAACN Annual Conference. What are you waiting for? Write for us! Visit [www.aaacn.org/viewpoint](http://www.aaacn.org/viewpoint) to get started.

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## The Unique Primary Care Needs of Transgender Youth

Care for the transgender youth in this country is at a crossroads. More patients in this population are feeling safe enough to seek primary care for preventive care or sick visits rather than wait until they require urgent or emergency care interventions. Ambulatory care nurses in primary care settings will see more patients who identify as transgender, but guidelines for providing anticipatory guidance or nursing care are lacking. This column will provide some context and resources for care and the needs of transgender youth in primary care. Nurses will be able to provide higher-quality care when they have a better understanding and knowledge of different cultural considerations (Faught, 2016).

In the U.S. Transgender Survey by the National Center for Transgender Equality (NCTE, 2015), 33% of respondents reported at least one negative experience (e.g., refusal of treatment or verbal harassment) related to a healthcare provider. Twenty-three percent of the NCTE survey respondents had not utilized health care at all due to a fear of mistreatment. Culturally affirming, non-judgmental primary and preventive care must be available for transgender individuals; otherwise, these patients may avoid seeking needed care, even urgent care.

The gender identity of the transgender individual differs from the sex he/she was assigned at birth. This is defined as *gender dysphoria*. "The World Professional Association for Transgender Health estimated prevalence at approximately 1 in 11,900 *transgender female* (male-to-female) youth and 1 in 30,400 *transgender male* (female-to-male) youth" (American College of Obstetricians and Gynecologists [ACOG], 2017, p. 2).

Many parents initially bring their child to the primary care practice when they are unsure of the actions they should take or when they need help understanding the child's behavior. Confusion about their own feelings or experiences of being rejected or bullied by others is a common occurrence with transgender youth. Initially, for the younger pediatric patient, the transition process is mostly a social one with a change in gender expression or role only – such as a girl refusing to wear dresses – but as a child ages, many youth feel stressed due to their changing body as puberty approaches (Bostock-Cox, 2016; Vanderburgh, 2009).

Transgender patients are at risk for depression, low self-esteem, and family and peer rejection. The U.S. suicide attempt rate is 4.6%, but the NCTE survey of transgender people revealed that 40% of respondents had attempted suicide in their lifetime. Compared to 14% of the general population, 29% of those surveyed were living in poverty,

### Glossary of Terms

**Female-Affirmed:** Replaces the term *male-to-female* as a language that is descriptive and non-pathologizing (Vanderburgh, 2009)

**Male-Affirmed:** Replaces the term *female-to-male* as a language that is descriptive and non-pathologizing (Vanderburgh, 2009)

**Cross-Sex Hormone Therapy:** Estrogens with or without anti-androgen may be used for a male transitioning to a female to develop secondary sex characteristics, and similarly testosterone may be used for a female transitioning to a male (Deutsch, Bhakri, & Kubicek, 2015)

**Gender Identity:** A person's fundamental and innate sense of being male, female, or somewhere in between

**Transgender:** A person whose gender identity differs from the sex they were assigned at birth

**Transgender Female:** Individuals with a male natal gender, but female gender identity

**Transgender Male:** Individuals with a female natal gender, but male gender identity (ACOG, 2017)

and 30% had been homeless (NCTE, 2015). Many will face financial difficulties because often the gender transition, which many desire, is not covered by health insurance.

The care of a transgender patient requires a multidisciplinary team of healthcare professionals, including a social worker or behavioral therapist, clinical pharmacist, and possibly legal counsel as gender change has many moral, ethical, and legal implications (Bostock-Cox, 2016). Including a pharmacist in the care team facilitates an in-depth discussion about cross-sex hormone therapy and the available alternatives. Through shared decision-making, the patient can clarify his or her goals and expectations. Typical timelines and physical outcomes can also be discussed (Newsone, Colip, Sharon, & Conklin, 2017).

In the health care system, primary care providers are still often the first ones to come into contact with a person experiencing gender dysphoria and to begin to coordinate their care. Nurses in primary care may feel that they have inadequate knowledge to provide care or anticipatory guidance to this patient population. A nurse might be involved in assisting the youth in navigating the healthcare system as he/she suppresses puberty to affirm gender identity or begins the physical transition with the use of cross-sex hormones and then considers available surgical interventions such as genital surgery, facial feminization surgery, chest reconstruction, or vocal cord surgery (Bostock-Cox, 2016). Routine preventive and wellness care must continue while monitoring ongoing cross-sex hormone therapy, as the therapy may predispose female-affirmed persons using estrogen to cardiovascular disease, lipid disorders, or thromboembolism. Male-affirmed per-

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# ViewPoint

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## Emerging Clinical Issues

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sons on testosterone may experience more atopic vaginitis, erythrocytosis, and acne than others (Radix, Meacher, & Sanchez, 2015). Medical necessity and the organs that are currently present dictate the care required. Mammography and prostate checks may still be required. Those who still have a cervix should be offered cervical cancer screening due to the remaining risk (Bostock-Cox, 2016). Transgender males may still be at risk for pregnancy if they have female reproductive organs. Discussions should happen before any transitions begin regarding options in potential fertility preservation such as reserving of the patient's sperm or eggs (ACOG, 2017).

From the first discussions with parents and/or patients through the reassignment of gender, primary care nurses can facilitate access to healthcare services and other resources and provide patient-centered, non-judgmental, and individualized care that is fundamental to the nursing process. Nurses can find more information on the Centers for Disease Control and Prevention (CDC) website at <https://www.cdc.gov/lgbthealth/transgender.htm> (CDC, 2017).

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