

ViewPoint

The Official Publication of the
American Academy of Ambulatory Care Nursing

WHAT DO I KNOW?

Andrea Kossoudji



Did I try hard enough? Will he go to the emergency room? I was wondering if I had done my part. My thoughts were racing, and feelings of guilt were already starting to set in. Telehealth nursing is not easy; I never thought it would be.

Physical assessment is out the window and telephone triage can be life or death. While the COVID-19 pandemic has added a precarious component to effective triage, ambulatory care nurses have worked diligently to keep chronically ill, high-risk patients out of the hospital and medically managed in the comfort of

their own home. Not only have medical providers been advocating for patients to stay home, but many patients themselves have preferred receiving care through telehealth modalities during this unprecedented time. These preferences, likely rooted in fears of being exposed to the virus, have caused patient ambivalence about accepting recommendations regarding their disposition.

I had just returned from lunch and had a message from a patient requesting an ultrasound. I had previously completed a discharge call-back for this

patient just 2 days prior. He was status post coronary stent placement through the right femoral artery 7 days ago. Upon calling the patient back, he explained he had just left the cardiologist office for a follow-up due to leg pain. Am I really going to be conducting telephone triage within minutes of this patient seeing a cardiologist in a face-to-face visit? This seemed redundant at first. What would I be able to assess over the phone that the doctor didn't already know or physically assess? Upon further questioning and

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Many settings. Multiple roles. One unifying specialty.

Championing Diversity, Equity, Inclusion, & Social Justice



Anne T. Jessie

Systemic racism, senseless violence, and oppression of minorities has reached an intolerable level in our country. The tragic deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, Rashad Brooks, Daniel Prude, and others – before and since – has awakened us to our responsibility to demonstrate our ethical beliefs and values and to take action. Regardless of our ideological perspectives, political views, or religious beliefs, now more than ever we must stand against injustice.

Nurses are consistently rated higher in honesty and ethics than all other professions (Reinhart, 2020). Nurses have an ethical obligation to provide quality nursing care for all patients and communities and to promote, protect, and advocate for the rights, health, and safety of patients as individuals and as populations. This ethical code is exemplified in the *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association, 2015). No matter the practice setting or environment, nurses have an ethical responsibility to respect other human beings and ensure care is delivered in an equitable manner, removing barriers to care, and ensuring inclusion, recognizing diversity, and ensuring care delivery that is socially just. Care delivery models must solve for inequity of care delivery, particularly as it pertains to mitigating the digital divide, providing access to critical resources and services, as well as primary care physicians and specialists.

As nurses and leaders, we practice with compassion and respect for the inherent dignity, worth, and unique attributes of every person. Our commitment is to individuals, families, groups, communities, and populations. We advocate for and protect the rights, health, and safety of patients and communities.

Over the last few months, AAACN, as an organization, has taken time to listen, learn, and reflect on the powerful movement taking place across our nation. As inequality in care delivery has reached a crescendo that cannot be ignored, AAACN is committed to addressing diversity, equity, inclusion (DEI) and social justice as an integral part of our new strategic plan. At the Fall 2020 Board of Directors meeting, held virtually over 3 days in October, the Board reflected on such questions as:

- What does DEI mean in the ambulatory care setting?
- How does AAACN honor and incorporate the rich and varied backgrounds of our volunteer members and leaders into the fabric of our vision and strategy?
- What responsibility do we have as nurses to champion and promote equity and to advocate for fairness in our workplace, community, and within our association?
- How can AAACN improve DEI among staff, volunteer leadership, membership, and the Board of Directors?
- What role does AAACN play nationally to promote DEI?
- How does AAACN hardwire and ensure the sustainability of our focus on DEI?

In order to ensure that our organization fully represents the diverse nature of our membership, key stakeholders, and the individuals we serve, AAACN has added a fourth strategic goal devoted to DEI to our new strategic plan.

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 1.3 contact hour(s)

Direct Symptom Scheduling: An Adjunct to Nurse Triage

Beckie Kronebusch and Jean Johnston

Improving access to services, care delivery, quality of care, and patient outcomes are driving forces in primary care practices across the country. A recent study by Basu and colleagues (2019) discussed the impact of patient outcomes and mortality rates in communities with decreased access to primary care. The results from the study showed greater primary care physician supply was associated with improved mortality outcomes, but a disproportionate decline in primary care physicians in the United States may have important population health implications (Basu et al., 2019). Declining access to health services due to a shortage of primary care physicians and other resources can lead to unmet health needs, delays in receiving appropriate care, inability to receive preventive services, financial burdens, and preventable hospitalizations (Office of Disease Prevention and Health Promotion, 2020). Maintaining or improving access is crucial within health care delivery models and must take into account provider shortages, patient satisfaction, cost utilization, and efficiency (Smolowitz et al., 2015).

As the demand for primary care providers grows faster than the supply, solving the problem of access to care becomes a critical priority (Pettersen et al., 2012). Traditional models of accessing care are being evaluated and new methods are being considered to serve diverse settings and patient populations. Some alternative methods

implemented in recent years to improve access to care are convenience care, web-based visits, and patient portals. These are a few of the methods patients now utilize to access preventive and acute care and assist with chronic disease management. Telephone triage by nurses is also increasingly utilized in primary care practices across the United States to allow for an interactive process between the nurse and patient and “involves identifying the nature and urgency of client health care needs and determining the appropriate disposition” (Rutenberg & Greenberg, 2012, p. 5). Even as telephone triage has expanded and become a primary method of improving access to care for primary care patients, this system can become overwhelmed.

Wait times for speaking with a triage nurse can be lengthy, as can time spent on the call to evaluate the patient's condition using protocols and algorithms to review symptoms. Many symptom calls are brief and straightforward, but complex needs – such as a patient with multiple chronic diseases – can take much longer than the average call time. Additionally, the 10-20 minutes it takes to document and ensure accuracy in the patient's health record after a call can be time consuming, as can spending further time transferring the patient to schedulers and handing off care. A large Midwest health care organization regularly monitored call volumes and other metrics of the nurse triage system.

Responding to increasing call volumes and abandonment rates, and following a literature review, an innovative solution was proposed. The purpose of this article is to describe the development and implementation of a new process whereby specific patient reported, non-acute symptoms were determined safe to schedule without evaluation by telephone triage nurses.

Project Development

All call metrics were noted to be increasing. These were: call volumes, wait times, length of calls, after call work time (the time it takes to complete orders, verify documentation, etc.), call abandonment rates (calls made by patients that are abandoned by the patient before speaking to a triage nurse), and clinic appointment access. In response to this evidence, a discussion ensued within the organization emphasizing the need to investigate and improve ways of accessing primary care rather than simply increasing the supply of primary care providers. A team from primary care was assembled to assess the current process which required all patients calling with symptoms be transferred to and evaluated by a telephone triage nurse in order to access services and prior to being scheduled into the primary care clinic. A solution was needed to improve the process.

A literature review related to primary care nurse triage, scheduling, and appointment access showed a lack of

available evidence to guide the group. However, a limited number of recommendations were found which provided some guidance in the discussions to address access to primary care. The study which provided the most support for the proposed solution discussed a primary care practice's adoption of prioritizing patients with more acute needs and examining scheduling as a tool for the primary care practice to expand panels and efficiently accommodate new patients (Candon et al., 2018). Studies which also closely aligned with appointment access and provided support for the proposed solution were those concerning *open access* which means keeping appointment slots open to be filled that same day. How many 'slots' are kept open on a daily basis varies by organization. This type of scheduling focuses on understanding demand and capacity to reduce wait times (Ansell et al., 2017). The review team agreed open access was a solution intended to "increase capacity in the team's schedule to accommodate patients' desire for same-day and future scheduled appointments" (True et al., 2013, p. 540). The clinic leaders implemented the open access solution in order to best serve patients with acute needs while continuing to look at other options.

After reviewing the evidence from the literature search, it was determined there was an opportunity to develop an alternative scheduling process to expedite patient access within the primary care practice. The proposed solution was patients calling with certain symptoms would not be sent through the nurse triage process but be directly scheduled for an appointment with a provider by the patient appointment coordinator, thus improving access to telephone triage nurses for those with higher acuity symptoms. Triage leadership proposed the solution to the organization's primary care practice leaders and it was approved. The group charged with developing the new process – which included an approved

Table 1.
Symptoms for Scheduling with and without Triage by Age

Symptoms	Age 0-4	Age 5-17	Age 18-64	Age 65+
Skin problems not related to diaper rash	Direct schedule	Triage	Triage	Triage
Skin growth, mole, wart	Direct schedule	Direct schedule	Direct schedule	Direct schedule
Ear or hearing problem without pain	Direct schedule	Direct schedule	Direct schedule	Direct schedule
Acne concerns	Triage	Direct schedule	Direct schedule	Direct schedule
Breast problems	Triage	Direct schedule	Direct schedule	Direct schedule
Weight loss concerns	Triage	Triage	Direct schedule	Triage

symptom list for direct scheduling – consisted of a multidisciplinary team including a provider, nursing, and scheduling staff. The team had a significant amount of experience in triage and familiarity with the primary care practice.

The multidisciplinary team reviewed triage call dispositions, which described the outcome of a call, or what the nurse recommended as a care option for the patient. Dispositions by triage nurses included:

- Self-care at home.
- Routine clinic appointment within 3 days.
- Appointment request for the same day.
- Urgent appointment within 12 hours.
- Emergent appointment within 4 hours.
- Emergency department recommendation.
- 9-1-1.

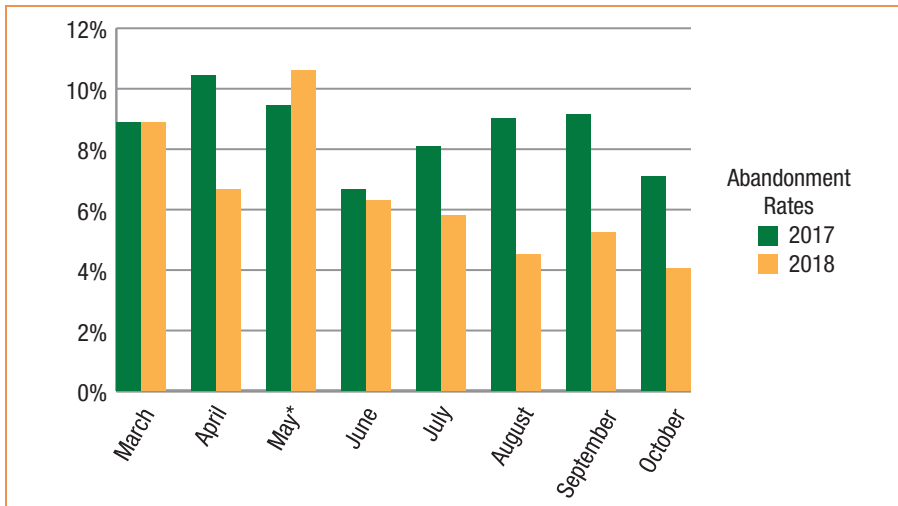
Nurse triage dispositions of 200,000 calls from a recent 2-year period were reviewed by the group. These were broken down by age groups. Analysis of the calls identified all symptoms resulting in emergency department dispositions or emergency services transportation (9-1-1). These symptoms were excluded from the potential direct scheduling list being developed. Calls that frequently resulted in treatment via symptom-based protocols used by registered

nurses or ended in recommendations for self-care at home were further eliminated. Calls were further analyzed for non-emergent, high-volume symptoms that ended in the patient safely waiting greater than 72 hours to be seen by primary care providers. The calls that ended in non-emergent dispositions and routine appointments became the focus for potential inclusion in the direct scheduling list as the identified symptoms resulted in scheduled appointments.

The symptom list which resulted after this analysis included skin problems not related to diaper rash, skin growths such as moles and warts, ear or hearing problems without pain, acne concerns, non-pregnancy related menstrual concerns, breast problems, and weight loss concerns for patients ages 18-64 years (see Table 1). The list of symptoms and conditions that could be directly scheduled as a routine appointment within 3 days without first being triaged by a registered nurse was broken down by age appropriateness. This was communicated to scheduling and triage staff after approval by leadership.

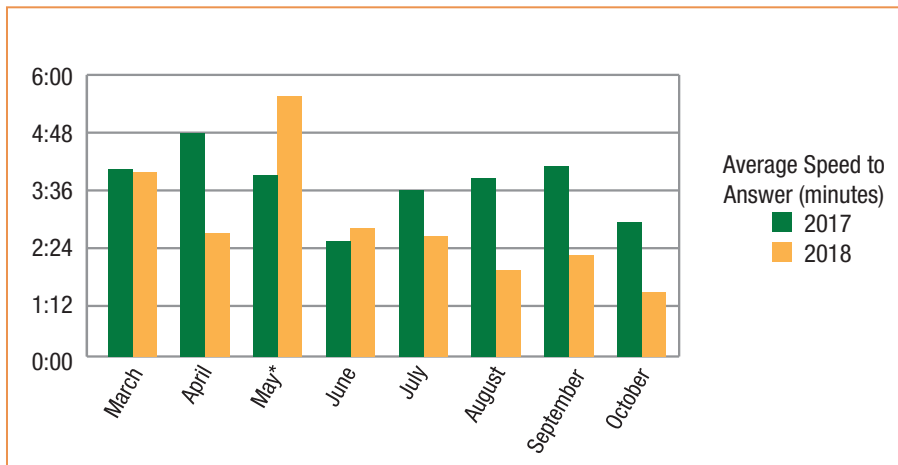
In the primary care clinics, patient appointment coordinators answered all calls before they were transferred to nurse triage if the patient described symptoms. With the new process, schedulers were not expected to determine the urgency of the symptom

Figure 1.
Abandonment Rates in 2017 & 2018



Note: *New electronic medical record implementation occurred in May 2018.

Figure 2.
Average Speed to Answer Measured in Minutes in 2017 & 2018



Note: *New electronic medical record implementation occurred in May 2018.

but be guided by the ‘approved’ list of identified symptoms and directly schedule those patients to routine clinic appointment. This list differs from a ‘hot list’ or ‘red flag list’ that is used in some settings for clerks to direct certain conditions to a registered nurse. As discussed by Rutenber and Greenberg (2012), the problem from these types of “cheat sheets” (p. 426) lies in low-acuity complaints which could be disguising serious issues requiring assessment. Nursing care is inherently based in assessment. This skill is honed for use in triage where the patient is not physi-

cally present, and decisions are based on the patient report. The triage nurse is trained to elicit responses to ascertain what might lie beyond the symptom being reported, even when the patient does not fully grasp the significance of what they are reporting and may downplay the seriousness. “Reliance on the red flag process to identify high-acuity patients is risky business and in fact represents telephone triage by unqualified personnel,” (Rutenber & Greenberg, 2012, p. 426).

Improving access to the telephone triage nurse was a goal of the new

scheduling process. *Direct scheduling*, defined for the purposes of this article as adding a patient to a clinic provider’s schedule without first being triaged by a registered nurse, allows a patient with certain conditions to receive a safe level of care while reducing call wait time and time on the phone with the nurse that can otherwise be used for other patient needs. Scheduling processes in place ensure the patient is scheduled appropriately, based on symptom and clinic appointment availability. Operationally, many organizations want to balance patient safety and risk, while managing cost, and this is one method of doing that.

Results & Discussion

Implementation of the direct scheduling process began in February of 2018 and continues today. Data from pre-implementation was compared to that collected during monitoring of the new process through October 2018. Data continued to be reviewed monthly by interprofessional leadership involved in the project for the remainder of 2018. Starting in 2019 a quarterly review process was instituted. The call metrics described earlier, and patient experience data, are included in this ongoing data review. In general, the new process improved call metrics data. After implementation, the exception to this trend was May 2018 when both call abandonment rates and average speed to answer, which is the time it takes for a nurse to begin speaking with a patient, increased due to a new electronic health record implementation which affected most organization processes.

Call metrics showed a decrease in call abandonment rates after the direct scheduling process was activated (see Figure 1). Initially, the call abandonment rate remained stable during the first month of implementation in March 2018 (8.87%) when compared with March 2017 (8.87%). In April, and continuing through October 2018, the abandonment rate was consistently lower as compared month to month with 2017, with the only

exception being in May 2018. The abandonment rate in May 2017 was 9.43% and increased in May 2018 to 10.62% due to the previously discussed electronic health record implementation. June of 2018 decreased slightly to 6.3% from June 2017's rate of 6.67%. The call abandonment rates of between 2-4% for the months of July through October 2018 remained lower than 2017.

Average speed to answer was also measured and compared for the same time period (see Figure 2). In March of 2017, the average speed to answer was 3 minutes 57 seconds and remained stable in March 2018 at 3 minutes 56 seconds. In April 2017, it was 4 minutes 44 seconds and decreased in April 2018 to 2 minutes 37 seconds. An increase was demonstrated when comparing May 2017 (3 minutes 50 seconds) to May 2018 (5 minutes 31 seconds) due to the electronic health record implementation. In June, the rate again decreased from 2 minutes 44 seconds in 2017 to 2 minutes 28 seconds in 2018 and remained lower than comparable 2017 answering rates through 2018.

As expected, there was a proportional decrease in call volumes after implementation of direct scheduling. Eliminated triage calls in 2018 were estimated at 5,571, or approximately five percent based on 2017 call volumes through the triage line of 115,000. When comparing data from January to December 2017 to the same time frame in 2018, total volume of calls taken by nurse triage showed an overall decrease. This trend could possibly be related to increased use of online portal.

Patient experience measures are also an important aspect of patient care. These are collected and reviewed regularly through standard processes. Patient feedback received regarding the scheduling and triage process also contributed to the need to improve access and the scheduling process. Comments from patients are reviewed for themes with patient experience representatives in the organization. Consistent patient

comments were "Did not want to go through nurse to make an appointment," and "Wanted to speak directly with doctor's office and felt speaking with triage was a waste of time." During anecdotal discussions with staff in the primary care practice, it was noted patients/caregivers seemed more satisfied when able to schedule directly for their child with ear pain, as their main goal in calling was being able to have their child evaluated by a provider on their child's care team. Similarly, provider, nurse, and patients express satisfaction when able to be seen directly for skin issues like acne, rashes, and warts, as they must be physically examined, and treatment determined. As the electronic health record's functionality improves by securely sending and receiving photographs, this process could change with additional options for these types of skin conditions.

Conclusions

The new scheduling process improved access to the primary care practice by identifying specific symptoms which are now consistently scheduled for a provider appointment without going through telephone nurse triage, thus allowing greater access for patients with other acute symptoms to speak with a registered nurse. The triage nurse can more appropriately address emergent needs, assist patients calling for medical information, or provide advice to manage symptoms and conditions at home. This includes those patients who are certain at the outset of the call that they need to be seen by a provider.

This process will continue to be examined and evolve using call metrics and patient experience data. In this era of measuring call metrics, clinic appointment access, and other measures, innovations like the change to direct scheduling can be directed to where they will have the most affect. This list continues to be reviewed for further symptoms that could be expanded to direct scheduling while

monitoring safety, outcomes, and cost utilization. ●

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Erratum

In the January/February 2020 issue of *ViewPoint* (Vol 42, No 1), the Continuing Nursing Education article by Christensen titled "Inside and Out: Overview of Common Female Genital Infections in the Ambulatory Care Setting," contained an incorrect contact hour credit value. The correct value is 1.1 contact hour(s).

Care Coordination and Transition Management Certification Update

As you may know, AAACN collaborated with the Medical-Surgical Nursing Certification Board (MSNCB®) to create the Certified in Care Coordination and Transition Management (CCCTM®) certification program that launched in 2015. AAACN supports the CCCTM credential and provides the certification preparation resources for the exam. In August 2019, new applications for the CCCTM certification program were suspended while MSNCB evaluated the future of the program.

The MSNCB Board of Directors transferred the CCCTM certification program to the American Nurses Credentialing Center (ANCC) effective October 31, 2020. As of October 31, 2020, ANCC became responsible for all activities related to CCCTM certification renewal and is evaluating options for re-introducing initial exam testing.

If you are currently CCCTM certified, and your certification expires after October 31, 2020, please contact ANCC at certification@ana.org for more information about how to renew your certification through ANCC.

CCTM is a top priority for AAACN. The AAACN Board of Directors is moving forward with revising several CCTM resources. Stay tuned for new task force volunteer opportunities soon. AAACN is committed to CCTM practice and being the leader in growing and supporting this critical nursing role, our members, and all of those who have invested in CCTM.

Get Prepared for the Ambulatory Care Nursing Certification Exam

Are you preparing to take the Ambulatory Care Nursing Certification Exam? Or, do you want to increase your specialty knowledge? AAACN is pleased to offer exclusive member savings on the Nurse.com Ambulatory Care Nursing Certification Review Course Focused CE Series: a unique blended learning model that combines online webinars, self-paced CE course readings, and online forums to discuss course material with your peers.

The next Ambulatory Care Nursing Certification Review Course Focused CE Series is January 18, 2021 through March 2, 2021. Learn more at www.aaacn.org/chcr



Already Certified?

AAACN offers many educational opportunities for you to earn the contact hours you need for certification renewal. Learn more at www.aaacn.org/focce

New AAACN Member Resources Coming Soon

AAACN volunteer leaders are working diligently on several must-have new resources for members that will be available in 2021!

Nurse Executive Toolkit: An online toolkit that interprets the Nurse Executive Competencies developed by the American Organization of Nurse Leaders specific to the needs of nurse executives in ambulatory care settings to strengthen and empower the nurse executive in the ambulatory care environment.

Academic-Practice Partnership Guidelines: Guidelines that outline academic priorities, practice priorities, and mutual priorities necessary for creating and sustaining educational experiences for undergraduate nursing students in ambulatory care settings.

Telephone Triage Nursing Online Course: Comprehensive and current education on telephone triage nursing based on the content of Carol Rutenberg's course will be available for purchase in the Online Library.

RN Role/Value Proposition: A starter toolkit for new ambulatory care leaders that will include a business case description

and a return on investment (ROI) template, talking points, and exemplars that support AAACN members as they advocate for implementing and expanding the RN role in ambulatory care.

RN Residency White Paper: An update to the 2014 Ambulatory Nurse Residency White Paper.

Want to get involved in AAACN?

Visit the Get Involved section of the AAACN website (www.aaacn.org/get-involved) to learn more about current volunteer opportunities.

Thank you for Being a AAACN Member!

Many AAACN members are up for membership renewal in December. Be sure to renew your membership by December 31, 2020, to continue accessing all of your member benefits! Log in to your AAACN member account at www.aaacn.org to renew.

Using Simulation to Identify and Manage Ambulatory Care Workplace Violence

Michelle Glanert-Kempf, Sven P. Oman, Amy Lannen, Pamela Delano, and Michelle Perregrini

Workplace violence (WPV) in health care is prevalent and disrupts clinical care. There are opportunities to lessen this burden on the health care system. This column will review the impact of WPV on health care, the existing literature on identification and management, and the use of simulation as an educational approach.

Health care WPV has consequences. Workers experience psychological trauma, physical injury, and feelings of incompetence. This leads to reduced productivity, absenteeism, lack of trust, low morale, and is associated with increased turnover of staff (Allison et al., 2017). WPV, as defined by the Occupational Safety and Health Administration (OSHA), “is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site” (OSHA, n.d, para. 2). Health care WPV is often overlooked or tolerated because it is confounded with illness (Arnetz et al., 2015). Health care personnel often believe assailants are not responsible for their actions due to conditions impacting their mental status. In the United States, health care professionals experience the highest rates of violent injuries in the workplace and are four times more likely to be victimized compared to other industry workers (OSHA, n.d.). The actual incidence is likely higher since reporting is voluntary and health care workers may lack knowledge regarding what acts constitute violence that warrants reporting.

Hospital WPV prevalence ranges from 31-53%. There was an average of 24,000 annual incidents nationwide between 2011 and 2013, with nearly 75% occurring in health care settings. Approximately 95% of nurses have experienced WPV during their careers. While WPV accounted for only 12.2% of all injuries in 2016, the incidence rate – 12.7 cases per 10,000 full-time workers in health care – was approximately three times greater than that of all occupations (Dressner & Kissinger, 2018).

The Joint Commission (2018) published a *Sentinel Event Alert* to prepare health care professionals for verbal or physical violence, or the potential for violence from patients or visitors. One action item included training interprofessional staff and conducting practice drills. An approach by Gillespie and colleagues (2012) evaluated WPV knowledge gains following a series of web-based education modules versus a hybrid of web-based and classroom teaching. The education focused on preventing, managing, and recovering from WPV. WPV knowledge significantly improved from the pre- to the post-test following both methods. There was no difference in knowledge gains between the two groups.

Thompson and colleagues (2019) observed nurses’ attitudes towards aggressive patients changed as a result of an educational program. Nurses were surveyed and interviewed before and after a didactic presentation on managing aggression and viewing a DVD of a challenging clinical scenario with an

aggressive patient. Three major themes emerged:

- 1) The need for real interaction with patients; nurses in the study were aware they needed to listen and clarify what patients wanted.
- 2) The importance of a team-based approach to reflecting on their clinical practice; discussion and review of prior scenarios were seen as ‘useful.’
- 3) The importance of the realism of the videos; the study participants could relate to these clinical scenarios, particularly when things didn’t go well. The DVDs were powerful teaching tools because of the visual aspect and ability to replay the event.

Another tool to improve the management of WPV is post-incident analysis. By examining the factors that lead to an incident of WPV, employees are able to enact policies and adjust procedures to help prevent future issues. In one study addressing post-incident analysis, Bresler and Gaskell (2015) highlighted the interplay between patient characteristics, their environment, and interactions with the health team that led to violence. The authors saw the need for a systematic approach to managing WPV consisting of memory aids for recognizing risks for violent behavior, observation of patient behavior, and root cause analysis in the post-event period; looking closely at both patient and health care provider outcomes in the hospital and ambulatory care setting.

The Joint Commission (2020) established a requirement that health care leaders create and maintain a culture of safety and quality which includes psychological and physical safety as well as distinguishing acceptable behavior from unacceptable. Education which focuses on environmental safety awareness, identifying aggressive/agitated behaviors, and de-escalation techniques has historically been directed towards emergency departments and inpatient psychiatry (Security Industry Association, 2017). Though Kinsley & Pritchett (2019) recently addressed verbal abuse and nurse safety in ambulatory care, there are opportunities to improve WPV education in this setting.

The authors recommend an inter-professional education (IPE) approach to improve WPV identification and management in the ambulatory care setting. IPE, as defined by the World Health Organization (2010) is experiential learning whereby, “students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes” (p.10). In the authors’ facility, IPE involves teams of learners from different disciplines interacting in a controlled environment that closely mimics their actual clinical setting. Clear learning goals and guidance from a subject matter expert allow the learning to translate back to direct patient care. Key players in the ambulatory care setting can include registered nurses, physicians, advanced practice providers, medical assistants, and administrative staff. Post-scenario guided debriefing affords learners an opportunity to reflect on their practice and identify areas for improvement.

Simulation has been used successfully in this 300-bed acute and ambulatory care academic center to teach challenging clinical scenarios including medical error disclosure, code status discussions, and breaking bad news. Successful simulation training completed by the authors in the inpatient setting

involved a patient with access to a gun. The scenario was interprofessional involving nursing, security, and physicians. Identified gaps included communication, use of de-escalation techniques, knowledge of policies, and state law. Improvements in communication and increased understanding of the roles and responsibilities of each learner were positive outcomes from this scenario. Because of this success, the authors plan to use simulation to address the need for WPV education in our ambulatory care. Expected objectives are to recognize and manage risk factors and signs of impending WPV, identify necessary adjustments to policies to increase staff safety, and to increase staff awareness of reporting avenues and resources. The clinical impact of this will be evaluated by comparing baseline-reporting rates of WPV to those post-simulation. ●

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Building a Leadership Pipeline, Part 3: Nurse Leader Retention

Karol DiBello

This is the third article in a three-part series exploring building and maintaining a leadership pipeline. The first article in the series discussed three key leadership characteristics one may look for when hiring future leaders: innovation, emotional intelligence, and resilience. In Part 2, these three characteristics' relationships to mentoring emerging and new leaders were discussed with input from ambulatory care nursing leaders from across the country during the COVID-19 pandemic. Retention, which is key to maintaining a leadership pipeline and the final piece of the puzzle, is the topic of this column. Growth in ambulatory care settings has increased by two to four percent over the last several years compared to acute care settings which has increased at only one percent (Berlin et al., 2020). Given the growth, along with the aging of ambulatory care nursing – 36 percent of whom are over the age of 55, attracting new and emerging nurse leaders and retaining this multigenerational workforce is critical (Berlin et al., 2020).

Efendi and colleagues (2019) determined nurse retention is a complex and evolving concept including psychological, political, managerial, and health care factors. Nurse retention can be defined by the actions employers may take to keep nurses in their employ, the number of employees that stay, and the length of time they remain with a particular organization. The most common attributes of nurse retention include the motivations or intentions that impact a nurse's desire to stay as well as strategies, such as the creation of a positive workplace environment and positive institutional culture among others (Efendi et al., 2019).

Why do nurses, and nurse leaders in particular, leave or stay in their jobs? A Press Ganey (2018) Nursing Special Report on the intent to stay – a proxy for retention – illustrates

the differences one may see in a multigenerational workforce. For instance, outside of retirement, dissatisfaction with the work environment was the most common reason cited for nurses leaving a job within the next year. Interestingly, while older nurses were more likely to cite dissatisfaction as a reason for leaving a position, younger nurses – or those with less than 4 years of experience – were more apt to leave to pursue other nursing opportunities. Predictors of intent to stay across generations on the other hand included job satisfaction, joy in work, leadership support, opportunities for career development, and being recognized and praised for their work, especially in newer nurses. For nurses practicing for 20 years or more, influence over their schedules and quality of care were more significant predictors of intent to stay.

Among nurse leaders, the more satisfied the leader is in their leadership position, the less likely a nurse will be to leave their position (Hudgins, 2016). Higher satisfaction, especially with work life balance, contributes to lower levels of burnout which has a significant impact on intent to stay (Kelly et al., 2019; Moloney et al., 2018). Role support, opportunities for professional development, having the support of their director while feeling heard, and being able to stay balanced while meeting their work demands are key contributors to millennial nurse managers' intent to stay (Saifman & Sherman, 2019).

The American Organization for Nursing Leadership (AONL) (n.d.) formerly known as the American Organization for Nurse Executives, developed a series of principles that can be used to recruit and retain a multigenerational workforce of nursing leaders. The five guiding principles include:

- 1) Acknowledging and celebrating generational differences.
- 2) Creating choices that encourage work life balance.
- 3) Operating from the perspective of outcomes rather than structure and process.
- 4) Respecting initiative and competence.
- 5) Nourishing retention.

They suggest organizations “place as high of a value of retaining leadership talent as they do a loyal customer” (Martin & Warshawsky, 2017, p. 420). Having hired and mentored new and emerging nurse leaders from the perspective of innovation, emotional intelligence, and resilience, how might these characteristics integrate with the AONL principles?



Innovation

Innovation involves creating new ways of operating or even taking old operations and tweaking them to meet current needs. Nurses, a remarkably resourceful group of professionals, are masters of innovation from the bedside to the boardroom. AONL suggests the following innovative ways leaders can address work-life balance:

- Offer flexible scheduling options.
- Allow new and emerging leaders to work remotely when possible.
- For those interested, offer blended roles that allow both dedicated leadership time as well as dedicated time for direct patient care.
- Consider offering concierge services as well as on-site daycare in the workplace.

From an individual perspective, AONL suggests leaders can:

- Encourage independent problem solving and innovation.
- Encourage the creation of proactive strategies to meet anticipated needs (AONL, n.d.; Martin & Warshawsky, 2017).

Emotional Intelligence

A recent meta-analysis found that higher emotional intelligence led to higher job satisfaction, organizational commitment, and intent to stay (Miao et al., 2017). *Emotional intelligence* is the ability to understand and gauge one's own feelings and emotions while managing environmental pressures. In recognition of the importance of emotional intelligence in effective leadership, AONL offers several retention strategies in which leaders can model and support emotional intelligence for new and emerging nurse leaders:

- Always assume the best in people.
- Acknowledge and encourage leadership styles that are consistent with individual personalities as well as positive outcomes.
- Support autonomy and independent problem solving.
- Create an environment where inter-generational experience and skills are valued.
- Foster a work environment that promotes meaningful work and job enjoyment (AONL, n.d.; Martin & Warshawsky, 2017).

Resilience

Hudgins (2016) found the more resilient the leader, the greater the satisfaction they had in their position. *Resilience* – an essential characteristic in today's health care environment – is the ability to adapt to change and recover from challenges. Healthy coping strategies, a positive worldview, being aware of weaknesses while focusing on strengths, and empowering others through delegation are all ways to build individual resilience (Hudgins, 2016). In addition to assuring nurses have the right resources and time needed to do their work, AONL

The American Organization for Nursing Leadership's Five Guiding Principles to Recruit and Retain a Multigenerational Workforce of Nursing Leaders

- 1) Acknowledging and celebrating generational differences.
- 2) Creating choices that encourage work life balance.
- 3) Operating from the perspective of outcomes rather than structure and process.
- 4) Respecting initiative and competence.
- 5) Nourishing retention.

Source: AONL, n.d.

suggests the following ways leaders can support resilience in new and emerging leaders:

- Encourage professional development, socialization, and certification.
- Encourage interprofessional collegiality.
- Provide a clear picture of the broader organizational structure and operations.
- Create a career management ladder that builds not only on skills and experience, but also knowledge (AONL, n.d.; Martin & Warshawsky, 2017).

This final column in the Leadership series has offered a look at the drivers of a nurse's intent to stay such as job satisfaction, leadership support, and work-life balance, along with some suggestions offered by AONL to manage those drivers. Building a leadership pipeline while addressing the needs of a multigenerational workforce may seem daunting given the demands of today's fast paced and ever-changing health care environment. Understanding the impact of these basic leadership characteristics, however, can provide a useful framework for hiring, mentoring, and retaining new and emerging nurse leaders while building a strong leadership pipeline that meets the demands of ambulatory care nursing now and into the future. ●

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Telehealth Trials & Triumphs

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triage, the patient was complaining of severe leg pain, leg swelling, and shortness of breath.

"The patient had just left the cardiologist office. This can't be right!" I thought. I wondered, what had the cardiologist recommended?

"Oh, he just wants me to get an ultrasound to rule out a pseudoaneurysm," the patient replied.

"And what about the shortness of breath?" I asked.

"Oh, that's because of the medication I'm on. He switched it. He told me I would get better."

The patient was confident this was not a medical emergency. My clinical reasoning and nursing judgement were telling me otherwise. After information gathering and cognitive processing, I dispositioned the patient to immediately report to the emergency room for further evaluation. The patient responded, "But you're just a nurse. What do you know?"

The patient was clearly frustrated, detailing how he had just been evaluated by a doctor – a cardiologist. "He's a doctor! Why didn't he tell me to go to the ER?" he prompted.

I further explained my concerns about his leg swelling, pain and obvious shortness of breath during the conversation.

"Why would I go there? With all this COVID stuff going on? I'm not going. I was just discharged from the hospital on Monday. I'm not going!"

I voiced my concern, and that delaying care could potentially result in death. I'm not sure if he was really listening. COVID-19 is all he was thinking.

"I'm at risk for that you know!" he shouted.

I spent over 10 minutes trying to convince him that going to the emergency room was the best option. He eventually agreed, but was he just pacifying me? Perhaps he was tired of listening and just wanted to get off the phone. Did I try hard enough?

The following morning, I received notification that the patient was pending admission for bilateral pulmonary emboli. What a relief. I contacted the patient post-discharge to conduct a telephone follow-up. He started the conversation, "I can't believe it. You knew something was wrong. I am forever grateful you called."

COVID-19 has certainly changed the environment in which we operate. This is true not only from an assessment standpoint, but it has also increased the burden in which telehealth nurses must convince a patient to seek care when necessary. Being a patient advocate and asking just a few additional questions may be the difference between life and death, no matter where the patient encounter takes place – in the emergency room, the ICU, in primary care or, yes, even on the phone. ●

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From the President

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As a nursing organization, AACN will enlist the help of our members and join leaders in communities, health care, and policymaking to speak out and take action to create a community of acceptance that is against racism, social injustice, and health care disparities. We will continue to raise our voice as we have much work yet to do. Together, we can make a difference in the lives of those we serve.

As we look forward to the close of 2020 – an exceptionally challenging year for us all – on behalf of AACN, I would like to wish all the happiest of holiday seasons with new or renewed traditions and a fresh look at the promise of a new year. Stay safe and well! ●

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The Impact of In-Situ Mock Codes on Ambulatory Care Clinical Staff

Kara Simpson, Susan Hamner, Marianne Haugh, Caitlin Eykyn, and Corrie Scharrenberg

No matter what the setting, survival rates for patients experiencing cardiac arrest range from 24-45% (Institute of Medicine, 2015; American Heart Association [AHA], 2020). A quick response with the appropriate interventions can improve survival rates. 'First Five Minute' (FFM) drills can help prepare care team members to provide this timely intervention.

At an urban, academic medical center in the Southeast, statistics were kept which reflected survival to discharge rates for patients in all care settings between 2016 and 2018 (see Figure 1). Ambulatory care services called for emergency response teams 51 times in 2017. During an annual learning needs assessment session, staff requested additional practice in emergency responses. To meet this need, members of the nursing professional development department partnered with the critical interventions coordinator (CIC) to implement the FFM mock code drills. Current literature exists to support this practice in the inpatient setting, but there is little published evidence to support this practice in the ambulatory care setting (Josey et al., 2018; Morton et al., 2019). The team – consisting of the nursing professional development practitioners (NPDPs) and the CIC – decided to implement drills to collect data to determine if response times and patient outcomes would improve.

The ambulatory care FFM drills were implemented in the second quarter of 2017. The NPDPs covering the ambulatory care clinics and the CIC conducted unannounced, FFM drills involving cardiopulmonary arrests in both adult and pediatric clinics at on-campus and off-campus locations. To ensure staff availability and decrease the impact on patient care, the NPDPs arranged with the clinic managers for optimal times to conduct the educational drills. Medium fidelity, in-situ simulation

included: manikin torso, compression feedback device, and rhythm simulator that interfaces with the defibrillator. The compression feedback device allowed the NPDPs to monitor the quality of compressions related to compression rate and depth. Clinical staff members involved in drills included registered nurses, licensed practical nurses, certified medical assistants, registered medical assistants, ophthalmology personnel, and respiratory therapists. Performance criteria included:

- Call for help (correct phone number and appropriate team).
- Flatten table or place patient on the floor and start compressions.
- Obtain code cart or emergency equipment.
- Place backboard (if applicable) and begin ventilations with a device (bag-mask or one-way).
- Set up oxygen (if applicable).
- Place defibrillator pads and defibrillate if indicated.
- Achieve high-quality chest compressions (based on feedback device).
- Assign roles (team leader, compressors, airway, recorder, runner, etc.) (AHA, 2016).

At the prearranged time, two or three of the NPDPs/CIC came to the clinic as quietly and unobtrusively as possible, went to an empty exam room, closed the door, and placed the manikin either on the exam table or in a chair in the room. When everything was set up and the person recording with the stop clock was ready, one of the NPDPs would rush out into the hallway, find a care team member, and let that person know that a patient was in distress. The care team members came quickly and, after a momentary pause when it was discovered that the patient was a manikin, proceeded as if it

Figure 1.
Cardiopulmonary Arrest Survival Rates for All Care Settings

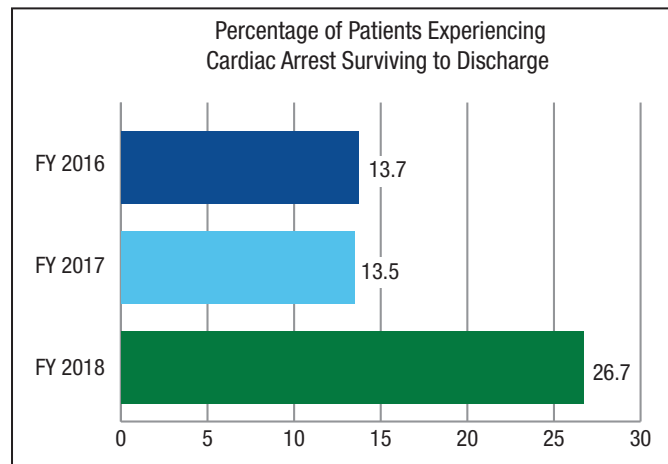
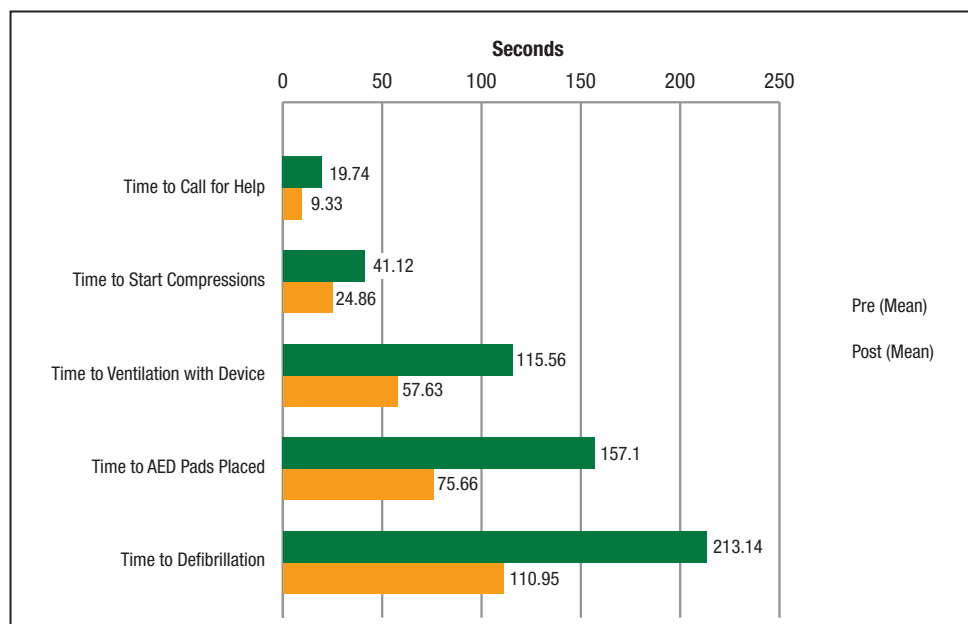


Figure 2.
Results for Ambulatory Care First Five Minutes Drills



were an actual emergency. The drills were usually performed with three to six staff members depending on the size of the clinic and staff availability. The first scenario was performed without any coaching or prompting from the NPDPs or CIC. NPDPs observed performance, timed actions, and recorded on a data sheet. After the first scenario, a debriefing session using a standardized tool highlighted successes and areas for improvement. The debriefing approach was non-punitive encouraging self-assessment of performance to enhance learning and retention. The NPDPs and CIC highlighted quality performance and benchmarks with associated rationale to

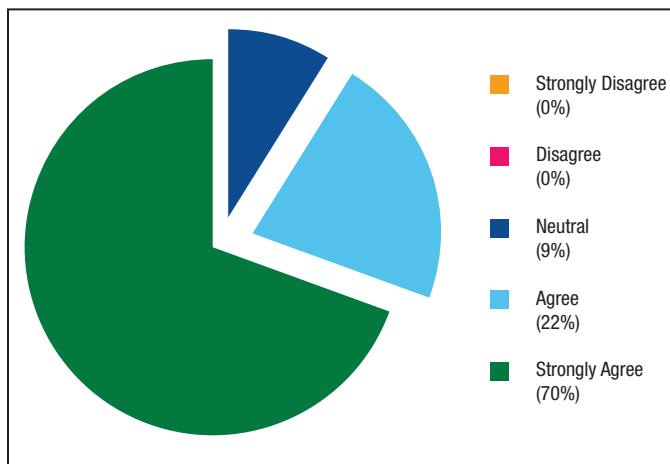
improve outcomes according to the American Heart Association's basic life support guidelines (AHA, 2016).

The same team performed a second scenario with a different staff member acting as the first responder applying the information discussed during the debriefing. The second debriefing served to recognize quantitative improvements and foster confidence and competence. The NPDPs and CIC shared performance results with participants after the second scenario and celebrated improvements.

Between the second quarter of 2017 and the fourth quarter of 2018, 287 clinical care team members participated

Figure 3.

Staff survey response: "I am more confident in my role during an emergency situation after this simulation."



in 65 FFM drills. There was a statistically significant improvement in the following (see Figure 2):

- Time to call for help.
- Time to start compressions.
- Time to ventilation.
- Time to place defibrillator pads.
- Time to defibrillation.

During FFM drills, the NPDPs identified many barriers to timely response times. Due to infrequent utilization, many staff members were unfamiliar with the location of emergency supplies. Lack of standardization of supplies and equipment location created confusion with staff members floating to multiple locations. Based on these findings, leaders created a task force to look at the standardizing emergency equipment throughout all clinics.

All participants received surveys after the training. The overwhelming response from the clinical care team members to the FFM drills was extremely positive; however, a few staff members reacted negatively to the unannounced drills. Out of 216 surveys returned, only two participants disagreed with the statement, "I am more confident in my role during an emergency situation after this simulation" (see Figure 3). The comments section revealed the majority of the staff loved the drills and wanted to see more of them in the future. The NPDPs received feedback from staff in two high acuity clinics stating advance notice of the drill would have been appreciated. After receiving these comments and further discussion, the NPDPs now allow the managers to determine whether the staff will be notified of upcoming drills. The majority of the drills continued to be unannounced to the care team members. Based on these results, FFM drills are now part of the annual education plan within the ambulatory care setting at this organization.

FFM drills have also been added to the ambulatory care skills class during orientation.

Results of FFM drills showed increased staff confidence and skill in performing high-quality CPR. Additionally, the drills bridged the gap between the classroom and clinical setting, as well as maintaining quality resuscitative skills. FFM drills enhanced teamwork and reinforced critical components to effective emergency response while increasing the number of competent clinicians which ultimately impacted patient survival rates as seen in Figure 1. Since the implementation of these drills, when a patient experienced sudden cardiac arrest in one of the ambulatory care locations that had participated in an FFM drill, staff quickly assessed the patient and noting a pulseless rhythm, started CPR, and provided defibrillation. Within minutes of collapse, the patient had a return of spontaneous circulation, prior to the arrival of the emergency transport team, who then took the patient to the emergency department for evaluation and care.

In-situ mock codes also served to identify unexpected barriers. Identification of these barriers allowed the organization to improve processes thereby improving patient safety and patient outcomes. This learning program, the FFM of an emergency response, is easily adapted for various patient populations and clinical settings. In addition to ambulatory care clinics, this program has been offered in women's services, children's services, adult inpatient units, ICU populations, peri-operative areas, and mental health areas. ●

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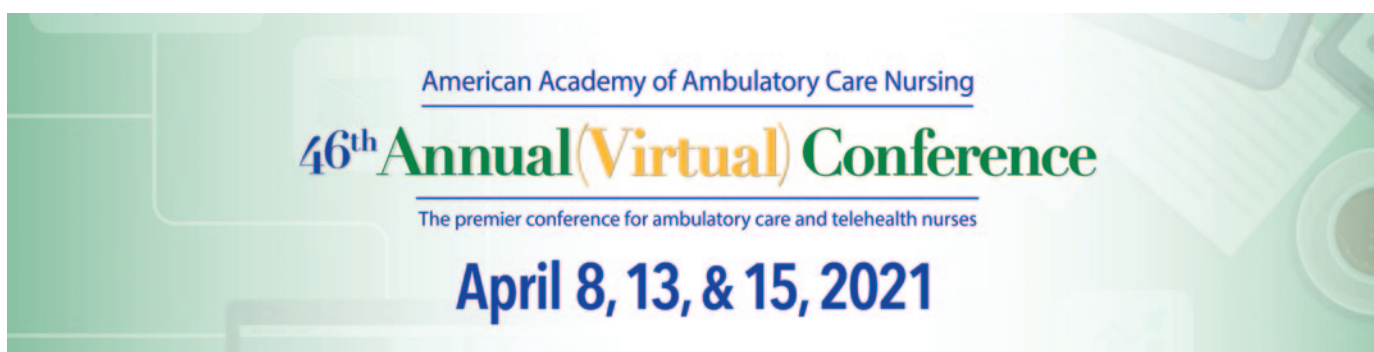
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AAACN 2021 CONFERENCE UPDATE

Save the New Dates!

AAACN has continued to evaluate the ever-changing landscape and the impact of COVID-19 on the health and safety of our members, conference participants, and staff. While we had hoped to meet in person in Washington, D.C., for the AAACN 2021 Annual Conference, we realize this is not going to be possible. The AAACN Board of Directors has made the decision to hold the 2021 Annual Conference as a virtual event.

We are excited to invite you to the 2021 AAACN 46th Annual (Virtual) Conference, which will take place over 3 days: Thursday, April 8; Tuesday, April 13; and Thursday, April 15.*

If you attended the 2020 Virtual Conference in August, you've already experienced the virtual platform and made virtual connections. You can expect another exciting experience in 2021!

- Live sessions on April 8, April 13, and April 15
- Access to an additional 15+ on-demand sessions, posters, and the exhibitor directory
- Live networking and happy hours with colleagues
- Virtual networking in the Event Forum, Social Wall, and Chat Lobbies
- Flexible registration and CNE packages and pricing
- Prizes for participating in the Leaderboard Challenge
- Pre-conference session on Tuesday, April 6 (separate fee will apply)

We look forward to connecting virtually, learning together, and celebrating ambulatory care nurses at the 2021 AAACN Annual (Virtual) Conference.

More information to follow soon on the anticipated virtual conference dates, times, speakers, and registration.

“ A truly well planned, comprehensive, well thought out and executed conference. No matter where we stand next year, be it in person or virtual, I will not have any doubts about signing up again.”
—MarieLouise Assing, RN
2020 AAACN Virtual Conference Attendee