
ARMY NURSE CORPS NEWSLETTER

“Ready, Caring, and Proud”

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New Deputy Corps Chief, COL Barbara Bruno

On 2 September, COL Barbara J. Bruno took the oath of office as the Deputy Chief, Army Nurse Corps. MG Gale S. Pollock, Chief, Army Nurse Corps, hosted the event held at the Stillwell House, Ft. Sam Houston, TX.

The ceremony began with the singing of the Star Spangled Banner by Ms. Laura Grindle and was followed by the invocation presented by Father James Schellenberger from BAMC. Approximately 75 of COL Bruno's family, friends, and colleagues were in attendance to hear MG Pollock commend COL Bruno on her numerous accomplishments and strong leadership traits. The oath was then administered with the assistance of COL Bruno's husband John and MG Pollock presented her with the traditional Hawaiin lei from the nursing staff at Tripler Army Medical Center. COL Bruno spoke about the future of the ANC, paid special tribute to her father and family then thanked those in attendance as well as those who sent words of encouragement and support. A receiving line and reception concluded the event.



The swearing in ceremony is performed by MG Gale Pollock. Assisting her is John Bruno.



(L-R) Laura Grindle, soloist who performed the National Anthem, MG Pollock and COL Bruno.



COL Karen Seipp, MG Gale Pollock, and COL Lark Ford after the ceremony.



(L-R) Nephew Mark Turgeon from New Hampshire, mother-in-law, Helene Bruno, mother, Jutta McMurry of El Paso, MG Pollock, John Bruno, COL Bruno, Father James Schellenberger, grandson Brody, and son Andrew Bruno.

Kudos and Publications

Congratulations to the ANC Officers selected for assignments as ROTC Nurse Counselors and USAREC Health Care Recruiters.

ROTC

- CPT Tina Morgan to Ft. Leonard Wood
- CPT Jennifer Fenti to Ft. Sam Houston
- CPT Sara Knight to Ft. Lewis
- CPT Pauline McCormick to Monterey, CA
- CPT Guy St Louis to Ft. Devens
- CPT Brett Buehner to Ft. Belvoir
- CPT Devin Bryant to Ft. Bragg
- CPT Laura Ricardo to Hunter Army Airfield

USAREC

- CPT Angelo Moore to Brooklyn, NY
- CPT Pat McVeigh to Elkridge, MD
- CPT Suellyn Masek to Nashville, TN
- CPT Jefferey Hillis to Orlando, FL
- CPT Warren Stewart to Santa Anna, CA
- CPT Christopher Rivera to New Orleans, LA

Officer Professional Development from the Desk of COL Barbara Bruno

The U.S. Army Medical Department was formed on 27 July, 1775, when the Continental Congress authorized a Medical Service for an army of 20,000 men. It created the Hospital Department and named Dr. Benjamin Church of Boston as Director General and Chief Physician. On 14 April, 1818 the Congress passed an Act which reorganized the staff departments of the Army. The Act provided for a Medical Department to be headed by a Surgeon General. Dr. Joseph Lovell, appointed Surgeon General of the United States Army in April 1818, was the first to hold this position in the new organization. The passage of this law marks the beginning of the modern Medical Department of the United States Army.

Throughout its early history, the size and mission of the U.S. Army Medical Department would wax and wane in response to military events around the world. There was, however, no formal regimental organization until World

War I. Then, in the late 1950s, the brigade replaced the regiment as a tactical unit. In the reorganization that followed, some Army units lost their identity--their lineage--their history. This loss did not go unnoticed and the U.S. Army Regimental System was created in 1981 to provide soldiers with continuous identification with a single regiment. Department of the Army Regulation 600-82, The U.S. Army Regimental System, states the mission of the regiment is to enhance combat effectiveness through a framework that provides the opportunity for affiliation, develops loyalty and commitment, fosters a sense of belonging, improves unit esprit, and institutionalizes the war-fighting ethos.

The U.S. Army Medical Department Regiment was activated on 28 July, 1986, during ceremonies at Fort Sam Houston, in San Antonio, Texas, the "home of Army medicine." Lieutenant General Quinn H. Becker, the U.S. Army Surgeon General and AMEDD Regimental Commander, was the reviewing officer. He was joined by general officers of the U.S. Army Reserves and the Army National Guard, representing the significant contributions and manpower of the reserve forces in the Total Army concept.

The home page address is <http://ameddregiment.amedd.army.mil/> The web site is designed to provide you with useful information about the U.S. Army Medical Department (AMEDD) Regiment. The history of the AMEDD Regiment, the symbolism behind our heraldic items, how to wear the Regimental Distinctive insignia, and various programs available to you and your unit. Please pay particular attention to the AMEDD Guide and the Order of Military Medical Merit.

The Office of the AMEDD Regiment is located in Abel Hall, Building 2840, on Fort Sam Houston, Texas. The Regimental staff can provide further information pertaining to the history of the Army Medical Department, the AMEDD Regiment and assist with any of the services described in the web page. The telephone number is Commercial (210) 221-8455 or DSN 471-8455. The fax number is 8697.

Nurses on the Front Line: Reflection on Working in a Forward Support Battalion by 1LT Ira Waite

"Come in the Army and be a leader in your field," they said at a recruiting station in high school. Well, they were right. Little did I know where that would take me and what I would learn. When given the assignment to deploy with the 1st Cavalry Division in the 115th Forward Support Battalion (FSB) I had no idea what to expect. Some of the most forward deployed nurses are located in the FSB. I am currently the officer in charge (OIC) of a forty-bed patient hold ward in Baghdad, Iraq taking care of the soldiers and civilians who are sick or injured from Operation Iraqi Freedom. We have treated a lot of soldiers in the last six months and cared for various illnesses and injuries.

From sick call to battle injuries and combat stress, the nurse in the FSB must be able to care for a wide variety of patients. We have cared for patients with gastroenteritis, pneumonia, flu, fevers of unknown origin, open wounds, MRSA and even HIV. We have also played a significant role in the resuscitation and stabilization of casualties.

Our Brigade Surgeon has asked that we provide recuperative care for soldiers needing two to four weeks for recovery but not necessarily candidates for medical evacuation. We agreed, and our first patient came to us after having surgery on his foot to remove shrapnel. He needed to heal by third intention closure and therefore required wet to dry dressing changes every eight hours. He was in good spirits and welcomed the care we provided. The antibiotics and the dressing changes really helped and he was able to walk on his foot in about one month. He still had not healed completely but had scabbed over and was able to walk in a soft shoe before being discharged to light duty. Others like him have come with wounds to the limbs, trunk, and head and have all returned to duty with similar results. Some have stayed for just a few days, some weeks but all have received the proper nursing care.

I have had to learn a lot about running a ward, things like writing policy and procedures, creating SOP's, ordering the supplies, having linen cleaned, providing for morale health and wellness for patients and training personnel. Entering the Army as a Second Lieutenant and being new to a forward unit, I had little experience to draw from except for what I learned in nursing school. In all likelihood I was unprepared for this assignment. However, we have succeeded in making our patient hold one of the best inpatient hospitals here in Iraq.

***Forward Surgical Teams Take Medical Team Training to the “Frontlines” of Patient Safety
by LTC Kimberly Smith and MAJ Michael Schlicher***

The radio crackles in the early morning hours at the 126th Forward Surgical Team. The medic’s voice is barely heard over the whoosh of the helicopter blades and the screams of the trauma patient. “Good morning 126th FST, we are in route to your facility with a twenty-one year old male patient involved in a motor vehicle collision. He appears to have a possible amputation of the right lower extremity. The Glasgow Coma Score is 13 and we are starting two IV’s. We should be at your facility in about 15 minutes.” Without hesitation, the FST readies their team to accept their 8th trauma victim of this very early day.

Meanwhile, the FST Commander, Chief Nurse, Executive Officer, and Detachment Sergeant are finishing up their daily update briefing. Patient census, personnel events, training schedules, logistical needs, and other matters of situational awareness were discussed to ensure that all are on the same “playing field” and have the same “game-plan.” They prepare to “pass” this information on to the remaining sixteen FST members who are busy readying the hospital to accept more casualties. The daily update briefing concludes as the combat medic alerts them to the incoming patient.



The primary nurse quickly observes that all the right supplies and all the right equipment are in the right place for the incoming trauma resuscitation. The team members have prepared their work environment in advance. The place is ready to roll! The primary surgeon and the two combat medics join the primary nurse to review their team roles for the patient resuscitation. “Team talk” is used frequently in their discussion. The FST member has incorporated the team dimensions into their practice. They are all on the same “playing field” when the critically injured patient arrives. The team performs their mission quickly and precisely as the patient is safely resuscitated and prepped for the operating room. They meet afterwards for an after action briefing where they review their performance using the “TIPS” (Team Input Promotes

Success) cards. The TIPS cards allow each team member to collect their thoughts and feedback related to the overall and individual performance of the team. This feedback is discussed as a team and used to help improve patient safety and team performance through effective communication. The team was prepared for their mission, they were clear on individual and collective roles, and team communication throughout the resuscitation revolved around the patient with team tasks reinforced. A few suggestions for improvement were agreed upon. As the team began restocking the resuscitation area, the radio alerts to yet another trauma victim on the way.

Team training is crucial to mission success for the FST. These twenty member teams are composed of surgeons, anesthesiologists, critical care and emergency nurses, and combat medics. Their mission is to provide far forward life saving surgical support to our airmen, sailors, and soldiers on the frontlines of the battlefield. The FST must be precise in surgical care and team support under hostile and austere environments. The majority of the Army’s active duty and reserve FSTs have been deployed in the past three years in support of Operation Enduring Freedom and Operation Iraqi Freedom.

The 126th FST is one such team, yet their most recent trauma care experiences did not occur in the combat theater. It occurred in the busy “Ryder Trauma Center” which is co-located with Jackson Memorial Hospital and the University of Miami located in Miami, Florida. Operating within this busy inner city



hospital one finds the innovative and dynamic medical team training program, the Army Trauma Training Center (ATTC). The 126th FST just concluded their “clinical deployment” training rotation at the ATTC.

The Army Trauma Training Center (ATTC) provides clinical deployment training by immersing the FST into a dynamic trauma milieu with emphasis on total team training. The ATTC was developed by the Army Medical Department in September of 2001 with the recognition for clinical training in a like “combat casualty care” setting. The Ryder Trauma Center offers that setting without deployment. It is one of the nation’s busiest trauma centers caring for over 3600 level one trauma victims per year. The FST is quickly integrated into this environment to provide care for the large numbers of penetrating (gunshot and stab wounds), blunt (automobile, industrial accidents), and burn trauma victims. Twenty-six of the Army’s active duty and reserve FSTs have received training at the ATTC thus far.



The ATTC has recently incorporated Medical Team Training (MTT) into its training doctrine. The Tricare Management Activity MTT curriculum forms the foundation of the new ATTC program of instruction. This intense 14 day “in the box” training program is infused with the team talk, team tasks, and team development dimensions that form the cornerstone of the AMEDD patient safety initiative. An extension of this initiative is created into the combat casualty arena as the majority of all ATTC trained FSTs are deployed into the operational combat theater. These trained teams are making a real difference on the battlefield. They have been cited by Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, as one of the reasons for the lowest

“died of wounds” rate in recorded warfare. Bringing MTT into the combat arena through the training program at the ATTC exemplifies the energy and commitment of the AMEDD Patient Safety Program. The ATTC is honored to be recently designated as the “Center of Excellence in Combat Casualty Care Team Training”.

***ROTC Nurse Summer Training Program at Landstuhl Regional Medical Center
by CPT Michael Wissemann***

ROAD TRIP!

This normally conjures up images of late night cross-country driving and days at the beach. Banish all stereotypes; this road trip for college students was different.

The Nurse Summer Training Program (NSTP) is a clinical program that mirrors the Cadet Troop Leadership Training (CTLT) in certain respects. They work at least 120 clinical hours, nights, days, weekends; whenever their assigned preceptors work. They must also plan and execute a group project and present an in-service presentation to a group of peers, soldiers, NCOs, and officers. Half the group planned graduation while the other half, led by CDT Mary Mortenson (Washington Univ of ST Louis), organized a staff ride to Normandy.

Cadets had come to Europe wanting to visit the area 60 years after D-day and were willing to pay for it out of their own pocket. MAJ Gray, European CTLT advisor found money in the form of the Olmstead Project, a pleasant surprise. The Olmstead project encourages cadets to gain a wider view of the world by exposing them to different cultures. At the conclusion of the experience, they write a one page essay on how their experience helped reshape their views.

In addition to the six NSTP cadets, we added CDT Joshua Archer (UGA) who had recently completed CTLT in Germany and had lots of knowledge to add of June 6th events. Also joining the group was Noel Platz (University of

SD), who as an MSC CTLT cadet at Landstuhl. She had assisted in juggling the cadets' schedules assuring that they were in the right place when needed.

We departed LRMC at 0500 on 5 August. Culture shock first occurred at 0900 when cadets awoke at the rest stop. The first of 4 tanks of fuel ran €15 (roughly \$130). Getting back on the road, we arrived at Mont St. Michael around 1400. Mont St. Michael is the sight of an abbey built on an island in 708 to worship St. Michael. Sitting about 1 km from land, it was accessible only at low tide until recently. Its military ramparts and walls, added in the 14th century, withstood all assaults of the English during the 100 years war.

We ate that night at an outdoor café in Cherbourg where we stayed. The next morning saw us shopping for food as we intended to use the van as a base of operations the next several days. We visited St. Mere Eglise, the first village freed the morning of June 6th. We visited the museum there and learned the legend of PFC Steele, who hung helplessly from the church suspended by this canopy. The scene was later recreated by Red Burton in "The Longest Day."

Next, CDT Archer led the cadets on a terrain walk of the assault of CPT Winters on fixed 88s during the second day of the invasion. This was brought to fame by the mini-series, *Band of Brothers*. After locating the area on private property, the owner was more than happy to allow some future US Army Officers access to the area. The trenches, still intact, served as a reminder that this battle didn't occur all that long ago.



Next we were off to Utah beach, about 5 km down the road. Americans from the 90th ID, suffered less than 200 casualties at this location. We were amazed by the tourists at the beach and the lack of remaining emplacements at the location. We visited the Ranger Museum at Grandcamp-Maisy and were then off to Omaha, where with the cemetery closing, we toured the beach. Again many French tourists were out enjoy the Normandy coast and splashing on the beach. We visited the 1st ID and 5th Engineer Brigade memorial. Many bunkers, still intact, made it easy to see how the Allies were caught in interlocking fields of fire and the importance of the Engineers. On the way back to the hotel we stopped at Point Du Hoc. GOLD!

Here, though now covered by grass, was a heavily pocketed battleground. Craters 20 feet deep, showed the remains of 60 year past and casemates for the 105 mm guns were fully intact. Heavily bombarded up until 30 minutes before the landing of the Rangers, the 6 guns located here were able to shell Omaha or Utah, over 12 km away. Rangers scaled the cliffs and assaulted the gun positions, suffering about 50% casualties, only to learn that the guns had been moved. The Rangers found them a few clicks away and eliminated them, saving hundreds of soldiers landing on the beach.

The next morning we returned to Omaha, this time to the cemetery, one of three remaining in France (at the completion of WWII, there were 27 that were later reconsolidated.). Off to Arromanches and Sword Beach. Here we saw where the British built a port within a week, in water deep enough to dock Cargo ships. This was crucial to the sustainment part of the operation. Without tanks, ammo, and food offloaded at this location, the Allies landing would have been short lived. The crux of the Arromanches was a 360 degree panoramic film. The film, showing rare black and white scenes and was accompanied only by sound, no narration. From here, it was a brief stop in Paris to visit some landmarks before heading back to Landstuhl. CDT Gosia Bujak (Univ. of Pittsburgh) even had the opportunity to do a reading in Notre Dame Cathedral during mass Sunday morning.

The Cadets thoroughly enjoyed themselves and a larger staff ride may be planned for next years' NSTP and CTLT cadets. One thing was for sure however; it wasn't your average college road trip.

CPT Michael Wissemann works in Operations and Training at Landstuhl Regional Medical Center.

Sexual Assault Responder Training from OTSG

Recent events in the CENTCOM Area of Responsibility and in CONUS have highlighted the absence of a standardized training program for caring for victims of sexual assault in our military treatment facilities (MTFs). In an attempt to correct this deficiency, a CD at Interactive 1 Level was developed by the AMEDD Center and School and provides a standardized initial training package for staff members. The content includes Myths and Facts about sexual assault, the general emotional reactions of sexual assault victims and provides a framework for developing a sensitive, compassionate response to victims of sexual assault. The information on the CD is designed to be used in group settings, large or small, in formal or informal training sessions and can also be used for individual training. This CD was distributed to the RMCs in June 2004.

New Competency Resource launched for the AMEDD

The new Tri-Service Healthcare Competency Assessment Website was created to 1) standardize the template (not the content) for initial and ongoing competency assessment tools across the AMEDD and to 2) share examples from Brooke Army Medical Center's custom designed library of over 350 unit and/or job specific clinical and administrative competency tools. The tools incorporate Balanced Scorecard goals, soldier readiness, scope of practice, age, language, and cultural-specific competencies in a format that targets technical, critical thinking, and interpersonal skills.

The posted tools, accessed at <https://akm.amedd.army.mil/competency> have had all formatting removed so that they can be downloaded and edited to meet the needs of your unit or facility. This information is not prescriptive in nature but only shared to help other facilities as they tackle the issue of competency assessment and JCAHO compliance. More tools and materials are being added everyday as they are being converted from the BAMC format. LTC Kimberly Armstrong at the AMEDD Center and School is spearheading this project and may be contacted at (210) 221-6073, DSN 471-6073, or at Kimberly.Armstrong@amedd.army.mil for any questions.

Critical Care Website now live

The new **Critical Care Website** will be a one-stop shop for military critical care nurses to obtain vital information regarding patient care and professional development. This site will include important links to professional organizations and will contain research-based SOPs for peers to review and modify for their own facility. Click on the Enterprise Consultancy Website at <http://ec.amedd.army.mil/> and select the nursing button on the left menu. MAJ Lisa Snyder is working in conjunction with COL Juanita Winfree, on this project. You may contact MAJ Snyder at lisa.snyder@us.army.mil.

Attention Mobilized Reservists: HRC-St. Louis will fund Continuing Health Education Training

HRC-St Louis is now funding one continuing health education (CHE) training of up to 5-days for US Army Reserve Soldiers per FY while mobilized. This does not include TTAD Soldiers. HRC-St Louis will need a worksheet, "Request for PDE Orders on Mobilized Reservists," a memorandum from the unit commander authorizing absence from duty station in a TDY status, and a copy of mobilization orders. The orders will not cover a rental car or the registration fees. Airline reservations must be made through Carlson Travel or it will not be reimbursed. Professional Development Education (PDE) is funded only if required for promotion.

POC is Mr. Dave McClory, 800-325-4629 x 0466 or 314-592-0466 or e-mail david.mcclory@arpstl.army.mil

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Greetings from Oakbrook Terrace, IL,
From the desk of the Army Nurse Corps Fellows
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Have you ever wondered how the Joint Commission develops a standard? If so, this article is for you!

How a standard becomes a standard: From concept to publication

Some may believe standards are “cooked up” at the Joint Commission by two or three staffers who meet in a dark, smoke-filled room who decide among the three of them that a new standard is needed. The myth continues as the staffers proceed to write the standard in ten minutes and get it published as quickly as possible. This couldn’t be further from the truth. Standard development is a very rigorous process and includes multiple clinical experts along the way. Continue reading for an *abbreviated* version of the reality of how a standard is developed.

1. First, the need for a new or revised standard is identified through: input from a myriad of healthcare disciplines via expert panel discussion, surveyor findings, sentinel event data, consumer concerns along with many other communication avenues open to the Joint Commission.
2. Once an issue is identified a project team is assigned to develop the standard. The team seeks advice from qualified experts in the applicable topic area and external workgroups are convened when appropriate.
3. New or revised standard and associated elements of performance are developed and presented to the Professional and Technical Advisory Group (PTAC) and to the Standards and Survey Process Committee for approval.
4. A field review of any new requirements is conducted in order to solicit feedback from accredited organizations, professional associations, and other interested parties. Feedback from the field review is collected via the JCAHO website using a web-based survey tool. Feedback from the field review is aggregated, analyzed, and used to further modify the new or revised standards.
5. Concurrent with the development of the new or revised standards, aggregation and decision rules (used to render the overall accreditation decision) are modified as appropriate and changes to the survey process (if made necessary by the proposed standards changes) are developed and tested. Survey process testing also includes an evaluation of the “surveyability” of the new or revised standards themselves, e.g. the question “Is the requirement measurable?” is investigated.
6. After input from the field review is incorporated into the standard, the new or revised standards and survey process changes are presented to the applicable Professional & Technical Advisory Committee (PTAC) for comment and recommendations before the standards are presented to the Standards and Survey Process Committee (SSP). [—see glossary for definition of these two committees and other terms contained within this article, along with definitions of some of the Joint Commission advisory groups established to gain input from a variety of stakeholders within the healthcare system].
7. New and revised standards and survey process changes, along with any comments made by applicable PTACs, are presented to the SSP committee for its approval.
8. Following approval by the SSP committee, the new or revised standards are sent to the Board of Commissioners. The Board members have two weeks to review the standard and, if desired, extract any part of the standards for further discussion by the Board. If such extraction occurs, the Board meets to discuss and resolve the issues surrounding extraction. If a standard is still in question following the board discussion, it is returned to standards development staff for further study. If no such extraction occurs, the standards are confirmed.

9. When new or revised standards impact scoring, modified decision rules are developed and presented for approval to the Accreditation Committee of the Board of Commissioners.
10. After approval by the SSP Committee and Board confirmation, the new or revised standards and any related documents are prepared for publication. The updated information is announced both in *Joint Commission Perspectives* and the applicable accreditation manual(s).
11. Typically, new standards are implemented on either January 1 or July 1 of the year following completion of the development project that led to approval.
12. Survey experience with the new or revised standards and related accreditation decision outcomes are monitored as part of an ongoing process to evaluate the appropriateness, “understandability”, and surveyability of the standard.

We hope this overview is helpful. For questions or clarification, please feel free to contact us.

Lisette & Rob

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Visit the JCAHO website at www.jcaho.org

Glossary of JCAHO Advisory Groups:

Accreditation Committee of the Board of Commissioners --- Subcommittee of the Board of Commissioners responsible for reviewing and approving Joint Commission accreditation decisions.

Advisory Council on Performance Measurement — Convened in 1995, the 19-member council is composed of experts in outcomes measurement. The council established an initial evaluation framework and the criteria used to review performance measurement systems and measures for the ORYX initiatives, and is active in the implementation of core measures. This group also developed the attributes of core performance measures. Three JCAHO Board members serve as liaisons to the Council and a Business Advisory Group member (see below) attends Council meetings.

Board of Commissioners ---The Board of Commissioners is the Joint Commission's governing body, providing policy leadership and oversight. Board members govern the Joint Commission with a dedication to its mission to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The full board meets three times a year, with an additional retreat focused on the Joint Commission's strategic direction.

Board members have diverse experience in health care, business and public policy. The board consists of 29 individuals, including physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a former health insurance executive and educators. Commissioners serve three-year terms that are renewable.

Board members have clinical experience in the health care fields that the Joint Commission serves, including ambulatory care, behavioral health care, health care networks, home care, hospice, hospitals, laboratories, long term care and assisted living. In addition, advice from experts in these fields is routinely obtained. In 2002, an at-large home care representative was invited to participate in Board of Commissioners meetings, and in 2004, an at-large

long term care representative was added. These direct links to the current health care environment enable board members to guide the Joint Commission in developing state-of-the-art evaluation services.

Business Advisory Group — Created in 1997, this group provides counsel to JCAHO on employer priorities in the evaluation of health care quality and identifies what is important to purchasers when measuring the quality and safety of health care. The 25-seat panel includes a cross-section of individuals representing both businesses and business coalitions of varying sizes and geographic locations. Four JCAHO Board members serve as liaisons to the group.

Committee on Health Care Safety — Established in 1978 to provide advice to JCAHO regarding standards and survey procedures relating to the physical environment of patient care. The 14 committee members are experts in security, fire safety, emergency management, medical equipment or building utility systems. Four seats are reserved for representatives from the Centers for Medicare and Medicaid Services, Occupational Safety and Health Administration, National Fire Protection Association and International Fire Marshals Association.

Core Measures Advisory Panels — In 1999, four advisory panels were appointed to assist with the development of the initial core measure sets for hospitals. Each panel included a state hospital association representative, a member of JCAHO's Advisory Council on Performance Measurement, a Centers for Medicare and Medicaid Services representative, a purchaser and a consumer. The panels identified the clinical logic for the assigned measure set and evaluated candidate measures against the Advisory Council on Performance Measurement's attributes of core performance measures and made recommendations to the Board of Commissioners about which measures should comprise the sets. In 2002 an Advisory panel was established for development of an initial set of Intensive Care Unit core measures. The panels now provide input on an "as-needed" basis regarding the development of technical specifications for national implementation of core measures.

Infection Control Expert Panel — Established in 2003, the 20-member panel recommends ways in which JCAHO infection control standards can be strengthened to help prevent the occurrence and devastating impacts of nosocomial infections and suggests how JCAHO can better ensure that accredited organizations are truly in compliance with the standards.

Liaison Network — Established in 1992 to improve communications with health care professional groups. The Liaison Network includes more than 220 professional organizations and ensures that JCAHO gets important input when developing its services and products. It also helps maintain and strengthen the relationships between JCAHO and these organizations.

Nursing Advisory Council — Established in 2003 to advance solutions for addressing critical issues in health care such as the nurse staffing shortage, the 30-member council is charged with addressing recommendations emanating from the white paper issued in August 2002, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*. The council meets several times a year to counsel JCAHO on present and evolving nursing-related issues that affect health care quality and patient safety; provide the nursing perspective on new JCAHO initiatives that may affect the nursing profession and patient care; and identify ways to optimize the effects of nursing-related changes to JCAHO's standards and accreditation process.

Professional and Technical Advisory Committees (PTACs) — The first PTAC was created in 1979 to advise the hospital accreditation program on proposed standard and survey procedure changes. PTACs for the other accreditation programs were formed in subsequent years. Members of the six PTACs include professionals from each respective field who represent national organizations as well as advocates. Each PTAC is composed primarily

of individuals nominated by selected professional organizations. All have public or consumer group representation. Two Board members serve as liaisons to the PTACs.

Program Advisory Councils — Comprised of representatives of organizations accredited in the specific programs, the Program Advisory Councils provide advice on 1) improving the value of each accreditation program, 2) developing new products, 3) standards or survey process changes, and 4) environmental influences that will enhance or diminish program advancement. Their advice complements feedback received from the Professional and Technical Advisory Committees. The advisory councils include:

Ambulatory Advisory Council — Established in 2000.

Behavioral Advisory Councils — Established in 2002, the three councils are made up of providers of mental health, addictions, and children/youth services.

Home Care Advisory Councils — Established in 2000, the four councils are made up of providers of home health, home medical equipment, hospice and pharmacy services.

Hospital Advisory Council — Established in 1994.

Laboratory Advisory Council — Established in 2000.

Long Term Care/Assisted Living Advisory Council — Established in 2001.

Public Advisory Group — Formed in 1999 to counsel JCAHO on current and evolving health care issues that are of concern to the public. The group also defines public expectations for quality in health care and offers insights for improvements in the accreditation process. The 25 individual members and organization representatives are from public advocacy groups, disease-prevention associations, consumer groups and others. Three JCAHO Board members serve as liaisons.

Sentinel Event Alert Advisory Group — Formed in 2002 to advise JCAHO in the development of its National Patient Safety Goals and associated recommendations. The group conducts thorough reviews of all *Alert* recommendations, identifies those that are candidates for National Patient Safety Goals, and recommends them to JCAHO's Board of Commissioners. The group also recommends topics for *Sentinel Event Alerts*. A JCAHO Board member serves as a liaison.

Work Group on Accreditation Issues for Small/Rural Hospitals — Formed in 1994 to address the issues facing small and rural hospitals. The 14 members include executives from small and rural hospitals around the country and three physicians who practice in rural areas. The group takes into consideration the tensions between cost and quality, the reality of providing health care in a rural setting, and the need for an accreditation process that provides value to all of its users. The group provides advice to JCAHO regarding how the standards and survey processes affect these organizations.

Quality of Life Study by LTC Hyacinth Joseph

Title: Stress and Quality of Life in a Sample of Prostate Cancer Survivors

Authors: LTC Hyacinth J. Joseph AN; Joan Ruttle-King RN; LTC Gregory Theibault MC; Marsha DeWitt RN

Background: Health-related quality of life (HRQOL) is an important outcome in evaluating the effectiveness of prostate cancer therapy. Studies have shown that the various treatment regimens may produce significant physical, physiological and psychosocial complications, which in turn may have a profound effect on body image, family dynamics and quality of life. Researchers emphasize the need for studies that will provide a better understanding of prostate cancer survivorship, and the treatment-related concerns of patients and their families.

Study Design/Methodology: This descriptive/cross-sectional study assessed perception of stress and quality of life in a sample of prostate cancer survivors. Data was collected via an anonymous pencil and paper questionnaire consisting of (a) the Perceived Stress Scale, (2), the UCLA Prostate Cancer Index Short Form and (3), demographic variables. Three research questions were answered: 1) what are the demographic characteristics of prostate cancer survivors who elect to participate in the research study? 2) how do prostate cancer survivors report their stress levels and QOL? and 3, are there variations in the reported levels of stress and QOL based on specific demographic variables? Survey packages containing an introductory letter, the research instruments and a returned self-addressed stamped envelope were mailed to patients who were diagnosed and treated for prostate cancer in the Pacific. One hundred and thirty five completed surveys were returned via postal mail (a 65% response rate). The data was analyzed using SPSS Version 11.5.

Results: The respondents ranged in ages from 39 to 92 years with a mean of 70.5 and standard deviation of 9.93 years. Eight percent of the men (n= 10) were between age 39 and 56 years. The majority was married/living with a spouse (69%) retired (86%), with 3% currently on active duty. The four primary ethnic/racial groups represented in the sample was White/European Americans (62%), Asian Americans (10%) African Americans (5.1%) and Filipino Americans (5.1%). Sixty nine percent of the respondents were diagnosed between 1998 and 2003, with 24% diagnosed in 2002. Treatment options included surgical intervention/prostatectomy (50%), followed by radiation (25%), a combination of radiation and hormone therapy (10%), watchful waiting (7%), and hormone therapy (6%). Seventy six percent of respondents described themselves as being in "good to excellent" health, and 75% felt they had received sufficient information on treatment options and their associated side effects.

Overall, the respondents reported a relatively low level of stress (mean =19.76; standard deviation= 5.30). No association was found between stress and QOL, but significant findings were noted for stress levels based on ethnicity ($p < .05$), year of diagnosis ($p < .001$) and the amount of information the men reported they had received prior to treatment ($p < .05$). The survivors also reported an exceptionally low level of QOL. Total QOL scores ranged from 111-1200 with a mean and SD of 646 and 212.96 respectively. Approximately 65% of all scores were under 700. A significant correlation was noted for QOL and organ-specific symptoms, with respondents indicating they were experiencing a disproportionately high rate of sexual problems (loss of sexual functioning and sexual satisfaction) compared to bowel and bladder problems. They were also most bothered by the sexual (mean = 40.24) compared to bowel (mean = 79.95) and bladder (mean = 74.75) symptoms they were experiencing. The reported sexual concerns were highest among respondents who had undergone surgical intervention as well as combined radiation/hormone therapy, and lowest among those who had selected watchful waiting.

Discussion and Implications: *Patient education is one of the most important aspects of nursing care. Information early in an illness can influence a patient's attitude for the duration of treatment and often can affect treatment outcomes. The personal and intimate nature of complications from prostate cancer treatment makes it essential that patients and their families receive adequate information on treatment options and their associated side effects at the time of diagnosis. Future studies should consider (1) the QOL of spouses, (2) the decision-making processes of families, (3) the role of social support in reducing stress, and (4), whether sexual counseling would be beneficial in improving QOL.*

Acknowledgements: The authors would like to thank COL Benjamin Berg and SFC Alfredo Garcia for their assistance with this project.

The views expressed in this abstract are those of the authors and do not reflect the official policy or position of the Department of the Army, Department of Defense, or the U.S. Government.

Human Resources Command (HRC) Update

ASK BRANCH

Starting with this issue our contribution to the Army Nurse Corps Newsletter has received a facelift. We feel that our past contributions have been helpful; however, we want to provide more focused information to our officers. The information that has traditionally filled this section to include assignment information can now be found on our website at <https://www.perscomonline.army.mil/OPhsdan/default.htm>.

We have decided to call the HRC section "Ask Branch". With this new format we will present questions that we at Branch not only receive from our officers in the field but also questions that we engage in with officers throughout Human Resources Command. For this inaugural issue ANC Branch staff members have prepared the questions but our desire for future issues is that you all will submit questions that you have been approached with, pondered, or guessed the answers. A combination of field questions and HRC questions will be presented each month.

Q: When will the LTHET Board results be released?

A: The LTHET Board will be in session from 4 – 8 October and the results will be released 8-12 weeks after the convening of the board.

Q: What is authorized for filing on my fiche?

A: Performance Fiche

1. Only OERs/AERs that have been processed through the OER branch are authorized to be filed on the fiche.
2. Course completion certificates for courses that are 40 hours or more.
3. Only Official College Transcripts are authorized
4. Only Award Certificates or Award Orders with permanent order numbers are authorized for filing. DA Form 638-1 (Recommendation for Award) is not authorized for filing on the fiche unless the award was disapproved or downgraded.
5. Awards and decorations from all aspects of military service (officer and enlisted). Evaluations from enlisted service are not authorized.
6. Combat/Skill badges (EFMB, parachutist etc) orders

A: Administrative Fiche

1. Initial physical examination (periodic for General Officers and Colonels only)
2. DD 2143. Oath of office (DA 71s)
3. Orders bringing you onto active duty
4. Promotion orders
5. Initial entry paperwork (Appointment Paperwork)

Q: How do I apply for Regular Army? Do I need to apply for Regular Army?

A: Regular Army integration normally occurs at the second competitive category promotion as an AN Officer. For a due course officer (one that came in as a 2LT), that means after selection for MAJ, the officer may select to accept Regular Army integration. However, in special circumstances officers may not make it to their second competitive category promotion before reaching 20 years of active federal service. Any officer who will reach 20 years of federal service prior to reaching their second competitive category promotion as an AN Officer, should apply for Regular Army integration if he/she desires to remain on active duty beyond 20 years. Please link the **REGULAR ARMY INTEGRATION BOARD MESSENGER** 03-098 for eligibility requirements and application guidelines.

Officers who will reach their second competitive category promotion as an AN Officer prior to 20 years of active federal service need not apply for the RA integration.

Q: When do all my documents have to be in for a board?

A: We prefer that you have all documents forwarded to ANC Branch NLT than 14 days prior to the convening of the board to ensure that the PERMS section has adequate time to add them to your OMPF. All OERs to be viewed by the board must be received from your PSB/MILPO by the date specified in the MILPER message pertaining to the board your file is going before.

Q: If I am PROFIS am I subject to Stop Move/Stop Loss?

A: PROFIS personnel are not subject to Stop Move/Stop Loss. They are still allowed to move and separate. However, from a MEDCOM and HRC perspective, moves for PROFIS officers will be limited or delayed to prevent disruption in deployments and the PROFIS system. Also, those officers pending retirement, REFRAD, or ETS who are PROFIS will be moved out of the PROFIS position as soon as possible in order to prevent disruption and allow for a new officer to be trained.

Q: How do I request schooling/training?

A: Officers must submit a DA 3838 to HRC for all AMEDD short courses. You may fax the DA 3838 to 703-325-2392 or DSN 221-2392.

Q: Who can receive Board Certification Pay (BCP)?

A. In order to qualify for BCP it is required that the officer:

1. Be a Registered Nurse in good standing on active duty in the Army Nurse Corps.
2. Have a Clinical Masters Degree in the clinical specialty for which BCP is requested
3. Have privileged to practice as a Health Care Provider in the Clinical Specialty for which BCP is requested:
 - a. Nurse Anesthetist (66F)
 - b. Nurse Practitioner (Adult, Family, Pediatric and Obstetric and Gynecological)
 - c. Nurse Midwives
 - d. Community Health Nurse and Clinical Nurse Specialist – Eligibility will be determined on an individual basis in accordance with established criteria. Any CHN or CNS who meets all the eligibility criteria to include privileging in the specialty for which BCP is requested.

Please let us know how you feel about the change to our format. We look forward to future questions and comments to our Education Technician, Mrs. Twanda Patton, at PATTONT@hoffman.army.mil.

AJN Photo Submissions – A Chance to Share Your Experiences with other Nursing Professionals

The American Journal of Nursing (AJN) has requested photos of Army Nurses from recent operations--either peacekeeping, humanitarian or related to the Global War on Terror. The AJN Editor would like to include them in a military photo spread. If you took interesting photos, while involved in one of these missions, please contact Nicole Mladic at 312.861.5274 or email Nicole.Mladic@mslpr.com.

2004 ANC-CHEP Guidelines

The new 2004 ANC-CHEP Guidelines are now completely revised and posted on the Department of Health, Education and Training website. Many thanks to LTC Deborah Van Laar for all of the hard work she put into these Guidelines before leaving this office and heading into retirement. You can find the 2004 ANC-CHEP Guidelines on the web at <http://www.cs.amedd.army.mil/dhet/>. When you get there click on "Army Nurse Corps" and scroll down to the [ANC-CHEP Guidelines](#) button. Click and you're there. As you scroll to each chapter in the table of contents you can click and it will take you to that chapter. The examples of forms in Chap 5, 6 & 7 still won't open, but will work soon. There are few significant changes that I will mention here:

- Disclosure/vested interest statements are required for all presenters
- Disclosure/vested interest statements are required on all marketing material and must be made at the beginning of each presentation
- Disclosure/vested interest statements can be made on the "official" form or can be one sentence added on the CV/Bio stating that the presenter has no vested interest in the topic being presented.
- No signatures are required on the application or the certificate
- All packets must have a marketing tool of some sort. It can be a flyer or a Tri-fold or a Powerpoint of some sort.
- Terminology has changed from EDI to Provider Directed Activity and EDII to Learner Directed Activity.
- There is a new statement on the certificate and an example is included in Chap 5.
- There is a new application.

Please call or email with any questions that you may have.

Carol A. McNeill

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The 18th Annual Pacific Nursing Research Conference

3-5 March, 2005

Wakiki Beach Marriott Resort, Hawaii USA

Theme: Research Across the Life Span

The Call for Abstracts is now available on the Henry Jackson Foundation website:

<http://hjff.org/events/index.html>

If you would like any additional information, please contact LTC Patricia A. Wilhelm @ <mailto:patricia.wilhelm@us.army.mil>

The annual Armed Forces District (AFD) ACOG/AWHONN Conference, "Building a Bridge to the Future: Leading the Way in Women's Health" 17-20 October in San Diego, CA

The combination of high quality presentations, attendance of numerous vendors networking with other Army, Navy and Air Forces Nurses presents a great professional opportunity for Army OB/GYN nurses. The Advance Program and Registration information is available at www.awhonn-af.org. The AFD conference is also the venue for presentation of awards to outstanding Army nurses working in the Women's Health arena. The three categories of the Awards of Excellence are education, research, and practice. Awards will also be presented to a junior nurse, and an advanced practice nurse, (midwife, practitioner or clinical nurse specialist). Award winners and the senior nurses at their facilities will be notified as soon as the selections

are made in the hopes that recipients can attend the conference. Chief Nurse Executives of the winners are asked to please consider sending the awardees to the conference to receive their awards in person. This conference is given in conjunction with AFD ACOG. Each year a number of awards are presented to physicians and most of them attend. There are only a few awards presented to nurses and historically, awardees have not been able to attend. Hope to see you all there!

Tri-Service SIG Military Pre-Conference 6 APRIL 2005 *Call for Abstracts*

The co-chairs for the American Academy of Ambulatory Care Nurses (AAACN) Tri-Service Special Interest Group (SIG) are pleased to announce we are planning an exciting Tri-Service Ambulatory Nursing Pre-conference for **6 APRIL 2005** at the Weston Horton, San Diego, California the day prior to the start of the American Academy of Ambulatory Nursing Annual Conference scheduled for 7-11 APRIL 2005.

The purpose of this pre-conference is to provide a forum to discuss success stories, best practices, collaborative practice as well as challenges encountered by ambulatory care nurses within the Military Health Care System. This will be accomplished through lectures, poster sessions and panel discussions

We are currently requesting abstracts for lectures and/or poster presentations with relevance and pertinence to the theme of the 06 April 2004 AAACN SIG in San Diego "Charting a Course for Ambulatory Care in the Military Health Care System"

Guidelines for Submission:

- Please submit an electronic lecture proposal and/or abstract submission using Microsoft Word and the attached template located at the end of this message. In the text of your email, please include a single point of contact, their email, the topic, and whether you are submitting a presentation, poster, or both.
- The poster session will consist of visual displays. Your presence is requested during morning registration, breaks, and lunchtime.
- Attendees are responsible for conference registration fees as well as travel and lodging costs.
- Submission date: Abstracts must arrive on or before: **01 NOV 2004**.
- Notification of acceptance and further instructions will be sent no later than Friday 15 Oct 04.
- For questions or concerns please contact COL Secula @ 210-221-7885 or Lt Col Naughton @ DSN 382-2343 Comm: 253- 982-2343.

Email Abstract submissions to one of the following:

Monica Secula, COL, ANC Monica.Secula@AMEDD.army.mil	Corinne Naughton, Lt Col, USAF, NC Corinne.Naughton@mcchord.af.mil	LCDR Harry Foster Smith, NC, USN HFSmith@nmcscd.med.navy.mil
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ABSTRACT TEMPLATE**1. Author contact information:** (If more than one author is listed, indicate which one is the contact person)

- Name/Rank:
- Duty Title:
- Military Affiliation:
- Address:
- Email:
- Phone:
- Fax:

2. Abstract Submitted for : (Select all that apply)

- Lecture Presentation
- Poster Presentation

3. Purpose:**4. Rationale:****5. Significance:****6. Description:****7. Methodology of research:****8. Findings:****9. Conclusions:**

Office of the Chief, Army Nurse Corps	
<p style="text-align: center;">Fort Sam Houston Office COL Barbara Bruno, Deputy Chief ANC mailto:Barbara.bruno@amedd.army.mil LTC Sheri Howell, AN Staff Officer mailto:Sheri.howell@amedd.army.mil MAJ Eric Lewis, AN Fellow mailto:Eric.lewis@amedd.army.mil AMEDD Center and School ATTN: MCCS-CN, Room 275 2250 Stanley Road Fort Sam Houston, TX 78234 210.221.6221/6659 DSN 471 Fax: 210.221.8360</p>	<p style="text-align: center;">Washington, DC Office LTC Christine Johnson, AN Staff Officer mailto:Christine.Johnson@belvoir.army.mil Headquarters, DA Office of the Surgeon General 6011 5th Street, Suite #1 Fort Belvoir, VA 22060-5596 703.806.3027 DSN 656 Fax: 703.806.3999</p>
AN Branch HRC: www.perscomonline.army.mil/ophsdan/default.htm	AN Website: http://armynursecorps.amedd.army.mil/

The ANC Newsletter is published monthly to convey information and items of interest to all Army Nurse Corps Officers. If you have an item that you feel would be of interest to your fellow ANC's please e-mail articles to MAJ Eric Lewis. The deadline for submissions is the third week of the month prior to the month you want the item published. All officers are eligible to submit items for publication. We reserve the right to review and edit any item submitted for publication.