Professional Practice Manual
Fourth Edition
Acknowledgments

The Wound, Ostomy and Continence Nurses Society™ (WOCN®) has always focused on providing services to members. A 1990 membership survey led to identification of a thorough, practical professional practice manual. Ruth Bryant, MS, RN, CWOCN, Sue Currence, BSN, RN, CWOCN, and Kristy Wright, MBA, RN, FAAN, CWOCN, volunteered to take on the project.

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The third edition reflects not only changes in health care but also the increased utilization of technology in WOC nursing practice. This revision was spearheaded by WOCN President Laurie Lovejoy McNichol, MSN, RN, CWOCN, GNP, Kathleen Lawrence, MSN, RN, CWOCN, Kelly Jaszarowski, MSN, RN, ANP, CWOCN, and Mary Kay Wooten, MSN, RN, CWOCN. Margaret Goldberg, MSN, RN, CWOCN, was the project coordinator.
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We thank the WOCN members who freely shared their forms, procedures, and policies for publication in the appendices.

**Fourth Edition (2013)**

This fourth edition of the *Professional Practice Manual* is a compilation of information and resources to assist WOC specialty nurses in role development and implementation. The manual also addresses issues that impact professional practice and provides guidance about how to engage in public policy and advocacy.

Led by Sonya Perry, MSN, RN, CWOCN, members of the Professional Practice Committee (2010-2012), as well as experts from the Marketing Committee, Membership Committee, and National Public Policy Committee, contributed to this publication. Carole Bauer, MSN, APN-BC, CWOCN, coordinated the project.

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Mission and Philosophy of the Wound, Ostomy and Continence Nurses Society

Mission
The Wound, Ostomy and Continence Nurses Society (WOCN) is a professional nursing society that supports its members by promoting educational, clinical, and research opportunities to advance the practice and guide the delivery of expert health care to individuals with wound, ostomy and continence concerns.

Philosophy
The WOCN Society believes that nursing as a profession enhances health care services to a multifaceted society and includes prevention, health maintenance, therapeutic intervention, and rehabilitation. Wound, ostomy and continence (WOC) care is an area of specialty practice within the framework of nursing that strives to advance the health care and quality of life of all affected individuals.

The WOCN Society believes that continuing education and research provide the basis for current, comprehensive nursing practice for patients with WOC disorders. Learning may occur on a basic, advanced, or continuing education level and combines the acquisition of theoretical knowledge and clinical expertise. The WOCN Society provides quality continuing education for its members and for other health care professionals in order to enhance and improve WOC nursing practice.

By a process of accreditation, the WOCN Society promotes high standards of education and requires a baccalaureate degree with a nursing major or an equivalent as the entry level for WOC nursing education programs and for specialty courses in WOC management.
Preface
WOC nurse specialists and advance practice nurses impact patient care in a variety of health care settings. WOC nurses must demonstrate both clinical expertise and professional practice skills. As clinical experts and leaders, it is essential that WOC nurses perform within the full scope of practice through evidence-based care, education, research, advocacy, and public policy. WOC nursing is multifaceted and requires a wide array of clinical and organizational skills. This fourth edition builds upon previous editions of the Professional Practice Manual as a guidance tool for clinicians, teams, or independent practitioners. The manual is intended to provide a resource and reference that WOC nurses can use in developing, implementing, and expanding their specialty nurse role and practice.
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Chapter 1: Design and Implementation of WOC Nursing Specialty Roles

WOC Nursing Specialty Roles and Scope of Practice

WOC specialty nurses (hereafter, referred to as WOC nurses or nurse) strive to advance health care and quality of life for individuals affected with WOC concerns through the application of nursing science and practice. When designing and implementing a WOC nurse role, it is important to incorporate the foundational principles of WOC nursing practice. According to the Wound, Ostomy and Continence Nurses Society (WOCN) (2010), the theoretical principles that guide WOC nursing practice are as follows:

- Principles of self-care.
- Self-efficacy.
- Change.
- Growth and development.
- Adult learning.
- Health promotion.

WOC nurses influence patient care both directly and indirectly across the lifespan of individuals and the spectrum of health care. They provide expertise in health care services for prevention, health maintenance, therapeutic intervention, and rehabilitative nursing care. The value of the WOC nurse’s role is demonstrated by the achievement of positive patient outcomes, which is based on a comprehensive risk assessment, effective prevention and treatment strategies, and patient and staff education.

This chapter describes the primary roles, specialized skills, and functions that characterize WOC nursing. Additionally, the standards of practice for WOC nursing and role implementation issues are addressed.

Role Components

While it may be desirable to implement a WOC nursing role that encompass all aspects of WOC nursing, limitations in practice might be necessary. To implement the WOC nurse’s role and determine the type and level of services to provide, the nurse should consider the following factors:

- The type and number of patients in the population.
- The staff’s competence in the required care.
- The time available/allocated for the role (eg, full- or part-time position).

**Defining roles.** WOC nurses serve in a variety of roles. The primary roles for a WOC nurse include direct patient care provider, educator, consultant, researcher, and administrator (WOCN Society, 2010).

**Direct patient care provider.** A WOC nurse provides a significant amount of direct care, particularly for patients needing specialty and/or complex care (eg, patients with new stomas or fistulae), because it is not feasible to maintain competency of an entire staff for such care. As a direct care provider, the WOC nurse uses the nursing process to assess, diagnose, identify outcomes, plan, implement, and evaluate care for patients (see Appendix A). The WOC nurse must adapt the process to complement the developmental age of patients/clients and their caregivers.
Educator. A WOC nurse affects patient care by providing direct patient/caregiver education and educating other nonspecialty nurses and staff involved in caring for patients with specialized WOC needs (see Appendix A). Staff education can be provided in various ways such as the following:

- Orientation.
- On-the-job training.
- In-service education.
- Protocol development.
- Guideline development.

WOC nurses may also serve as educators in academia or other organized continuing education programs, focusing on 1 or more aspects of WOC care. Others might be faculty or clinical preceptors for a WOCN-accredited WOC nursing education program (WOCNEP). WOCNEPs can be provided in formal academic settings (eg, undergraduate or graduate programs) or can be stand-alone continuing education programs. WOCNEPs offer specialty education in 1 or more areas of the scope of WOC nursing practice.

Consultant/clinical expert. The WOC nurse can serve in the role of a consultant/clinical expert in his or her employing facility or can establish a private practice and be paid as an independent consultant, according to the terms of a contractual agreement (see Appendices B and C). Implementation of a consultant/clinical expert role is appropriate when a large number of patients require a specific type of care (eg, management of full-/partial-thickness wounds or uncomplicated pressure ulcers) and the staff has developed a level of competence and confidence in following up and providing the care. In this role, the WOC nurse partners with both the patient and other members of the health care team to coordinate individualized care that is based on the following:

- Assessment of the needs of the individual.
- Current best practice.
- Ongoing evaluation.

To maximize the effectiveness of the consultant/clinical expert role, specific guidelines should be established to clarify the responsibilities of the WOC nurse and the staff for the delivery of care and the ongoing evaluation and follow-up of the patient.

As a consultant/clinical expert, the WOC nurse might also be responsible for coordinating care for the patient population. Key considerations in planning care for specific patient populations would include the following:

- Identification of trends.
- Development of standardized treatment and prevention plans.
- Refinement of the plans based on outcomes.

Collaboration with other health care providers and groups is also an essential part of the WOC nurse consultant’s role. When working in a collaborative role, the WOC nurse has the potential to increase the pool of knowledge, provide a broader perspective about problems or issues, and suggest a comprehensive solution to improve the overall quality of care (WOCN Society, 2010).

Researcher. WOC researchers are in all areas of practice including academia and industry and in direct patient care settings. The focus of the researcher’s role is on the advancement of the science and/or art of WOC care. At the clinical level, the WOC nurse strives to incorporate evidence-based practice utilizing current research.
Administrator. The role of an administrator includes duties and responsibilities for management and oversight of clinical staff and services across a broad spectrum of care. WOC nurses might have both clinical and administrative responsibilities, and the specific expectations and time commitment for each role should be clearly identified.

Dual roles. A WOC nurse may be asked to assume more than 1 role (eg, WOC nurse and patient educator, WOC nurse and case manager). To minimize role confusion and the potential for overload and burnout, the WOC nurse must determine his or her supervisor’s expectations for each role, and the duties and responsibilities for each role must be clearly defined and agreed upon in advance. Also, the WOC nurse must clearly delineate to the staff what the WOC nurse’s specific responsibilities are and the time available for each role component.

WOC Nurse Specialized Skills and Role Functions

WOC nurses have the specific background and educational preparation to manage patients with complex WOC needs. Common wound care problems managed by WOC nurses are pressure ulcers, vascular ulcers, neuropathic ulcers, draining wounds, traumatic wounds, and surgical wounds. Ostomy management includes care of patients with fecal and urinary diversions, fistulas, and percutaneous tubes. Urinary and fecal continence issues managed by WOC nurses include muscle or nerve dysfunction, congenital abnormalities, infection, surgery, sphincter deficiencies, and psychological disorders. Table 1.1 provides an overview of WOC nurses’ specialized skills and functions for managing common WOC issues (WOCN Society, 2010).

<table>
<thead>
<tr>
<th>Wound Management</th>
<th>Ostomy Management</th>
<th>Continence Management</th>
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<tbody>
<tr>
<td>• Risk assessment.</td>
<td>• Stoma site selection.</td>
<td>• Complex skin care.</td>
</tr>
<tr>
<td>• Patient, family, and staff education about risk and prevention strategies.</td>
<td>• Pre- and postoperative management and education.</td>
<td>• Prevention strategies.</td>
</tr>
<tr>
<td>• Identification of the underlying etiology and barriers to wound healing.</td>
<td>• Complex prosthetic fitting.</td>
<td>• Intermittent/self-catheterization instruction.</td>
</tr>
<tr>
<td>• Establishment of nursing diagnoses.</td>
<td>• Product selection.</td>
<td>• Behavior training.</td>
</tr>
<tr>
<td>• Collaboration for development of treatment plans including:</td>
<td>• Treatment of peristomal skin complications.</td>
<td>• Bowel training.</td>
</tr>
<tr>
<td>o Topical therapy.</td>
<td>• Sexual counseling.</td>
<td>• Product selection.</td>
</tr>
<tr>
<td>o Product selection.</td>
<td>• Dietary counseling.</td>
<td>• Prosthetic fitting.</td>
</tr>
<tr>
<td>o Advanced/complex treatment modalities.</td>
<td>• Vocational counseling.</td>
<td>• Pelvic muscle reeducation.</td>
</tr>
<tr>
<td>o Chemical cauterization.</td>
<td>• Long-term support.</td>
<td>• Biofeedback.</td>
</tr>
<tr>
<td>o Nutritional assessment and support.</td>
<td></td>
<td>• Urodynamic testing.</td>
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<tr>
<td>o Wound debridement.</td>
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</table>
Resource management. WOC nurses play important roles in managing resources to facilitate the delivery of cost-effective care and improved regulatory compliance (eg, establishing documentation standards and/or quality outcome measures) by the following activities (WOCN Society, 2010):

- Developing a formulary for supply management.
- Developing protocols for cost-effective resource utilization.
- Using proactive risk management strategies.
- Preventing complications and reducing recidivism.
- Improving continuity and coordination of care across settings.
- Increasing staff productivity.
- Developing new revenue-producing programs.
- Enhancing patient satisfaction and loyalty.
- Advocating for supply and service reimbursement.
- Establishing documentation standards.
- Developing and educating the staff about standard protocols and quality outcome measures.

Standards of Practice

All roles that are developed and implemented by the WOC nurse should be in accordance with the scope and standards of practice as defined by the WOCN Society. The following standards of practice were recognized by the American Nurses Association in their endorsement of WOC nursing as a specialty (WOCN Society, 2010):

- **Standard 1. Assessment**: The WOC nurse collects comprehensive data pertinent to the patient’s health or the situation.
- **Standard 2. Diagnosis**: The WOC nurse analyzes the assessment data to determine the diagnoses or issues.
- **Standard 3. Outcomes Identification**: The WOC nurse identifies expected outcomes for a plan individualized to the patient or the situation.
- **Standard 4. Planning**: The WOC nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.
- **Standard 5. Implementation**: The WOC nurse implements the identified plan.
- **Standard 5A. Coordination of Care**: The WOC nurse coordinates care delivery.
- **Standard 5B. Health Teaching and Health Promotion**: The WOC nurse employs strategies to promote health and a safe environment.
- **Standard 5C. Consultation**: The WOC nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect change.
- **Standard 5D. Prescriptive Authority and Treatment**: The advanced practice WOC nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.
- **Standard 6. Evaluation**: The WOC nurse evaluates progress toward attainment of outcomes.
- **Standard 7. Quality of Practice**: The WOC nurse systematically enhances the quality and effectiveness of WOC nursing.
- **Standard 8. Education**: The WOC nurse attains knowledge and competency that reflects current nursing practice.
• **Standard 9. Professional Practice Evaluation**: The WOC nurse evaluates one’s own nursing practice in relation to professional standards and guidelines, relevant statutes, rules, and regulations.

• **Standard 10. Collegiality**: The WOC nurse interacts with and contributes to the professional development of peers and colleagues.

• **Standard 11. Collaboration**: The WOC nurse collaborates with the patient, family, and others in the conduct of nursing practice.

• **Standard 12. Ethics**: The WOC nurse integrates ethical provisions in all areas of practice.

• **Standard 13. Research**: The WOC nurse integrates research findings into practice.

• **Standard 14. Resource Utilization**: The WOC nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

• **Standard 15. Leadership**: The WOC nurse provides leadership in the professional practice setting and the profession.

• **Standard 16. Advocacy**: The WOC nurse advocates for the patient with WOC care needs.

The *Wound, Ostomy and Continence Nursing Scope & Standards of Practice* (2010) is a valuable resource for every WOC nurse and is available from the WOCN Bookstore (http://www.wocn.org/Bookstore). To facilitate the application of the scope and standards of practice, the WOCN Society developed a white paper that clarifies the roles of WOC nurses and advanced practice WOC nurses and provides examples of how WOC nurses can apply the standards in their own settings (WOCN Society, 2012). The document also addresses how the scope and standards relate to achieving positive patient outcomes. The white paper, *Scope and Standards for Wound, Ostomy and Continence Specialty Practice Nursing: A White Paper from the WOCN Society*, is available on the Society’s Web site in the Members Library at http://www.wocn.org/MemberLibrary.

**Role Implementation Issues**

Implementation of the WOC nurse’s role requires ongoing assessment and reevaluation. Setting and prioritizing realistic short-term and long-term goals are vital to the evolution of the role. There are several areas to address in implementing a new WOC nurse role including establishing an effective mechanism for referrals and ensuring that patients have appropriate materials and supplies to meet their care needs. It is necessary for the WOC nurse to develop/maintain an effective record-keeping system and current policies and procedures. Also, establishing teams or task forces to help plan and implement care can be beneficial to the WOC nurse.

**WOC nurse referrals.** It is important to establish an effective referral mechanism and educate the staff about the referral process. In an acute care or extended care setting, the referral process is usually fairly straightforward. The staff can page the WOC nurse or use the voice mail or e-mail system to leave a message. Referrals can be initiated by a staff or a physician. In a home health care setting, the referral process can be challenging. When a WOC nurse is covering several offices, a fixed rotational schedule can be established (eg, consults from office A on Tuesdays, from office B on Fridays). Procedures about the referral process must be established and communicated to the staff and patients and their families including the following specific information:

• When/what types of patients/problems to refer (ie, indications for referral).

• How to refer (eg, who to call, preferred method of contact [e-mail, fax, phone], forms to use). A simple 1-page referral form can be developed to record information about the
reason(s) for requesting the consultation, the current management of the problem, specific concerns/issues, and other related data.

- What to expect after the referral is made (e.g., time required for a response to the referral, type of response [telephone call or in-person visit], the WOC nurse’s responsibilities vs the staff nurse’s responsibilities).

**Patient education materials.** An important component of the WOC nurse’s role is overseeing the development of patient education materials, and there are several options, which will be guided by each institution’s protocols and requirements. The options for obtaining or developing patient education materials include the following:

- Developing institution-based teaching literature.
- Adopting existing industry-sponsored teaching literature.
- Adopting existing literature that is provided as part of an electronic medical record system.

When deciding on whether to develop or adopt existing literature, several factors must be considered such as:

- The accuracy, consistency, and level of evidence of the information provided.
- How well the literature meets the needs of the patient population being served.
- The literacy level of the information presented.

The Agency for Healthcare Research and Quality has published a toolkit to assist health care providers to structure the delivery of care and communications as if all patients have a low level of literacy (DeWalt et al., 2010). Included in the toolkit are resources and guidelines to develop easy-to-read tools and to assess existing patient teaching literature. The complete document is available at http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf. The Centers for Disease Control and Prevention (2010) also offers guidelines for creating simple and easy-to-understand educational materials that are available at http://www.cdc.gov/healthliteracy/pdf/simply_put.pdf.

To assess the reading level of patient educational materials, a simple process should be used. A few tips for developing and reviewing educational materials for readability and assessing the reading level are presented in Table 1.2.

<table>
<thead>
<tr>
<th>Table 1.2. Developing and Reviewing Educational Materials</th>
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<tr>
<td><strong>Guidelines for Development or Review of Educational Materials (WOCN Society, 2005, p. 5)</strong></td>
</tr>
<tr>
<td>1. Keep the layout simple. Avoid presenting multiple ideas or concepts on 1 page.</td>
</tr>
<tr>
<td>2. Use large print (at least 14-point type). Use a solid font. Use dark black ink on matte white paper.</td>
</tr>
<tr>
<td>3. Use simple illustrations that reinforce the message.</td>
</tr>
<tr>
<td>4. Use simple language. A fifth- or sixth-grade reading level is recommended for the general population.</td>
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<tr>
<td>5. Use specialized software or the McLaughlin SMOG Readability Formula to determine the reading level (Hedman, 2008).</td>
</tr>
</tbody>
</table>

**The SMOG Formula for Determining Reading Level**

| 1. Select 10 sentences toward the beginning, 10 sentences in the middle, and 10 sentences toward the end of the material. |
| 2. Count the total number of words having \( \geq 3 \) syllables in the 30 sample sentences. |
| 3. Calculate the nearest perfect square of the number of polysyllabic words. |
4. Add a constant of 3 to obtain the reading level.

Example: If the total number of polysyllabic words is 36, the square root is 6. When 3 is added to 6, a reading level of 9 is obtained.

**Guidelines for Keeping the Reading Level Low**

1. Use short, simple sentences.
2. Use 1- or 2-syllable words.
3. Express only one idea in each sentence.
4. Use the second person (ie, you).

**Supply formulary development.** It is part of the WOC nurse’s role to remain abreast of new developments and trends in product development unique to the practice setting. When considering development or evaluation of a supply formulary, the WOC nurse considers several criteria for the products such as safety, effectiveness, availability, cost and benefit, patient preference, and the impact on practice (WOCN Society, 2010).

**Record keeping.** A record-keeping system is essential to provide a record of the WOC nurse’s time and efforts and to document the services provided to patients and the staff. In addition, a comprehensive record-keeping system can provide data to answer important questions that might arise in role and employment negotiations with a superior such as the following: How does the WOC nurse’s role contribute to the goals of the organization, and how does the WOC nurse’s role contribute to positive patient outcomes and cost-effective care?

**Components of a record-keeping system.** An effective record-keeping system contains several components or types of information:

- Monthly activity reports (eg, the number and types of patient visits; the number and types of consultations to the staff; staff development activities; leadership and management activities).
- Annual report, including goals and accomplishments of the preceding year (eg, continuous quality improvement studies; revenue generated or saved) and goals and objectives for the upcoming year.
- Periodic reports concerning the prevalence and incidence of skin breakdown with comparison to national averages and earlier institutional studies.
- Periodic reports on patient outcomes (eg, the number of patients admitted to the organization with chronic wounds; the percentage of wounds healed or significantly improved at the time of discharge; average cost or number of visits required to achieve the desired outcomes; cost of support surfaces compared to the preceding year’s costs; and any correlation to prevalence and incidence data).

**Establishing an effective record-keeping system.** To establish a record-keeping system, it is advisable for the WOC nurse to consider the following actions:

- Determine the organization’s requirements and preferred format for data collection.
- Discuss ideas with others (eg, review and assess if other WOC nurses or other specialty nurses have data collection forms and programs that are suitable to modify and adopt).
- Determine if using commercially available software programs that are capable of generating reports are suitable and feasible to use.

**Policies and procedures.** In addition to other duties and role functions, a WOC nurse is responsible for reviewing and revising policies and procedures related to WOC disorders. Policies and procedures should be kept current and consistent with national guidelines for facility accreditation/certification, reimbursement requirements, and current best practices.
**Task forces.** The WOC nurse should establish appropriate task forces and nurse resource groups to help with planning, developing, and implementing programs and procedures/protocols to optimize patient care and outcomes (eg, prevention and management of skin breakdown; guidelines for ostomy and continence care). Involving other staff in teams or task forces is an effective strategy for developing staff and extending the impact of a WOC nurse’s role.

**Career development.** Career development is the planning and implementation of career plans and involves the individual and the employer. Employers as well as individual nurses recognize and benefit from career development programs. Career development promotes nurse empowerment and may include self-appraisal, clinical ladder programs, tuition reimbursement, and educational leave (Marquis & Huston, 2006). Supporting career development programs can be justified for organizations because the programs:

- Decrease turnover due to frustration or lack of work advancements.
- Provide equal opportunities for all.
- Improve nurses’ control over their career roles.
- Improve competitiveness of the organization to attract highly educated professionals.
- Build new talents and skills.
- Improve the quality of work life.

**Position descriptions and performance appraisals.** The WOC nurse can shape and define his or her role within the organization by participating in construction or revision of position descriptions and performance appraisal forms. A position description is a working tool that describes the requirements for a specific position (eg, educational background, clinical experience, leadership experience, and board certification) and the expected performance standards for the position. Most organizations have a standard format for position descriptions. It is essential that a description of a WOC nurse’s position accurately reflect the types of patients seen, the level of involvement with each type of patient, the setting in which care will be provided, and the professional responsibilities. Also, it is important that the duties and responsibilities in a position description are consistent with state board of nursing licensing requirements in the state(s) in which the nurse practices.

A performance appraisal form is developed from a position description. The performance appraisal form lists activities that demonstrate accomplishment of the specific expectations listed in the position description, including organizational, departmental, and/or individual goals. The position description and performance appraisal forms should be congruent.

Sample position descriptions and performance appraisal forms are provided in Appendices A to N, which can be adapted to meet individual needs or to meet a specific employer or institution’s requirements (WOCN Society, 2005). Appendices A to L provide position descriptions for nurses in varied roles and settings such as WOC nurse in a hospital/acute care setting, WOC nurse consultant/clinical expert in a hospital/acute care setting, WOC nurse consultant/clinical expert in home health care, WOC nurse clinical nurse specialist, WOC nurse practitioner in adult health, WOC nurse in independent practice, WOC nurse in industry, certified wound care nurse, certified ostomy care nurse, certified continence care nurse, certified foot care nurse, and wound treatment associate. Sample performance appraisals for a WOC nurse in acute care and a nurse practitioner are provided in Appendices M and N, respectively.

These sample position descriptions and appraisal forms are not intended to be all inclusive but are representative of information that might be included. The forms can be modified and adapted to fit other roles and settings (eg, extended care, ambulatory care, palliative care).
References


Chapter 2: Effective Role Negotiation

For successful role implementation, WOC nurses will benefit from developing and refining negotiation skills. This chapter discusses how to negotiate, describes methods and elements of negotiation, provides tips on how to prepare and conduct a negotiation, and discusses factors that WOC nurses should address in role negotiation.

Successful Role Negotiation: Attitudes and Approaches

Career advancement requires negotiation skills (Williams, 2007). It is important for WOC nurses to know their worth and become comfortable with promoting their unique qualifications, skills, and abilities that can benefit an employer.

Successful role negotiation requires all parties to share their ideas and listen to the ideas and issues presented by others. It is important to maintain an open attitude. It is best to begin the dialogue with a positive opening statement.

Methods of negotiation. There are 3 methods of negotiation that have been described: soft, hard, and principled (Fisher, Ury, & Patton, 2011). With soft negotiation, the negotiator wants to avoid conflict at all costs and gives in easily to reach an agreement. The hard negotiator, on the other hand, holds out for as long as possible because he or she views the negotiation as a battle of the wills. The soft negotiator may end up feeling exploited, while the hard negotiator may feel exhausted and might have damaged his or her relationship with the other side.

The third method of negotiation is called principled negotiation. This type of negotiation looks for mutual gains for both parties and, where conflicts exist, strives to apply independent and objective standards to reach a fair agreement. Additional information about the 3 methods of negotiation (Fisher et al., 2011) and their approaches is presented in Table 2.1.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positional Bargaining: Which Game Should You Play?</td>
<td>Change the Game – Negotiate on the Merits</td>
</tr>
<tr>
<td>Soft</td>
<td>Hard</td>
</tr>
<tr>
<td>Participants are friends.</td>
<td>Participants are adversaries.</td>
</tr>
<tr>
<td>The goal is agreement.</td>
<td>The goal is victory.</td>
</tr>
<tr>
<td>Make concessions to cultivate the relationship.</td>
<td>Demand concessions as a condition of the relationship.</td>
</tr>
<tr>
<td>Trust others.</td>
<td>Distrust others.</td>
</tr>
<tr>
<td>Change your position easily.</td>
<td>Dig in to your position.</td>
</tr>
<tr>
<td>Make offers.</td>
<td>Make threats.</td>
</tr>
<tr>
<td>Disclose your bottom line.</td>
<td>Mislead as to your bottom line.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Accept one-sided losses to reach agreement.</td>
<td>Demand one-sided gains as the price of agreement.</td>
</tr>
<tr>
<td>Search for the single answer: the one <em>they</em> will accept.</td>
<td>Search for the single answer: the one <em>you</em> will accept.</td>
</tr>
<tr>
<td>Insist on agreement.</td>
<td>Insist on your position.</td>
</tr>
<tr>
<td>Try to avoid a contest of will.</td>
<td>Try to win a contest of will.</td>
</tr>
<tr>
<td>Yield to pressure.</td>
<td>Apply pressure.</td>
</tr>
</tbody>
</table>

Elements of negotiation. Although every negotiation is different, the basic elements of negotiation remain constant. With any type of negotiation, there are 3 stages: analysis, planning, and discussion.

During analysis, you are trying to figure out the situation. It is a process of gathering information, organizing, and thinking about the negotiation. In this stage, consider the 4 components of the negotiation: the people, your interests, the interests of the other side, and note any options already on the table.

In the second stage, again consider the factors you gathered in the analysis phase. Now you will generate ideas and decide what to do? How do you handle the problems identified?

The final stage in negotiation is the discussion. This is when you will actually meet with the other parties involved in the negotiation. It is best to focus the discussion on the 4 elements that were identified in the first 2 stages. In the discussion stage, both sides should come to understand the interests of the other and jointly generate options that are mutually advantageous.

Preparing for negotiation. To be successful in a negotiation, it is necessary to properly prepare in advance, rehearse, and come prepared for the encounter (Agrawal, 2011). Preparation should include gaining an understanding of the organization’s overall goals and information about the administrator’s decision making and negotiating style. It is also necessary to determine your overall goal before meeting with an administrator or supervisor. Simons and Tripp (1997) have proposed a list of questions that can be considered in preparation for any negotiation:

- Why do you want this job?
- What do you hope to accomplish?
- What are the issues involved with obtaining your goal?

By anticipating the issues involved in obtaining your goal in advance and identifying the issues that are most important to both you and the administrator, you can negotiate more effectively. Therefore, after identifying your goals and issues, the next step is to prioritize them. Putting this information into a table or other format to display the issues, goals, etc, might be helpful to identify any areas where you are not willing to compromise or specific issues you can use in bargaining.
The second step in preparing to negotiate is to understand the other side’s point of view. If the company that you are seeking to negotiate with is unfamiliar to you, research the company to find out its mission and goals. Try to determine what issues are likely to be important to the company or are nonnegotiable.

The third step is to understand the situation. Is there a deadline? What topics or questions do you want to avoid, and how will you respond if the other side asks anyway? If attempting to use principled negotiation, what is the other party’s interest rather than its position? For example, is the other party’s interest to improve pressure ulcer prevention for its institution? If so, you may use that interest as part of your plan.

Finally, you need to determine the relationship between you and the other party. Are you negotiating with someone you will continue to work with on a daily basis? If so, what are the consequences of the strategy you have chosen for negotiation? Can you trust the other party? What do you know about the other party? What do you know about the other party’s style and tactics? How much authority does the other party have (Simons & Tripp, 1997)?

**Conducting the Negotiation**

**Be professional.** Communicate professionalism through your conduct and appearance. It is usually best to schedule the conference in advance with an administrator. When meeting with an administrator, be ready to present a draft of a role design, a draft position description, and a list of concerns and issues. This approach communicates that you take the position and the meeting seriously and have done advance planning. Start the dialogue with a positive opening statement such as:

> I appreciate having the time to talk with you about the potential to improve our patients’ outcomes … through implementation of the WOC nurse role. I have a number of ideas and have prepared a draft role implementation plan. However, I realize that you have a more global view, so I would first like to hear your ideas about implementation of this role. (Wound, Ostomy and Continence Nurses Society [WOCN], 2005, p. 31)

This approach allows you to hear the administrator’s concerns or issues. Knowing the specific concerns or issues provides you with an opportunity to modify your presentation to address any issues that are raised.

**Aim for a win-win approach.** In a win-win approach to negotiation, the intent is to address the issues and solve the problems in a manner acceptable to everyone. Try to stay focused on goals and issues rather than on “your ideas” and “their ideas.” For example, you might say, “If I understand you correctly, one of the organization’s goals is _________. Is that correct?” If the response is affirmative, follow with, “In looking at ways to meet that goal, what options do you see? Would you like me to perform a literature review? I could generate a list of possible approaches and then we could sit down again to analyze the list and select the best approach.”

Be prepared to offer options. For example, if you propose a full-time WOC specialty nursing position, sell your proposal based on the benefits to the organization. If the administrator resists, you can offer an alternative proposal to demonstrate your worth to the organization. For example, you could propose a trial period during which time you function half-time as a WOC specialty nurse and half-time as a staff nurse. During the trial period, you would document the services provided and the impact on patient outcomes and agency costs (Williams, 2007).

**Know your bottom line.** It is important for you to know when to walk away from a negotiation (Agrawal, 2011). If you are unable to negotiate a position that is acceptable to you,
what are your options? If no alternative proposal is acceptable to the administrator, you will need to have an exit line ready so that you can leave the meeting gracefully, such as: “This is not exactly what I had hoped for and I need time to think about it further. Can I get back to you?” or “This approach is very different from what I had anticipated and I need time to think about the things you have said and the proposals you have made. Can we schedule a follow-up meeting next week?”

**Factors to address in the negotiation.** When negotiating a role, there are multiple factors to address. Specific areas to negotiate involve agreement regarding specific duties and responsibilities, compensation, hours/days of work, etc. Following are some of the key factors to include in a role negotiation:

1. *Role design.* Determining the specific expectations, duties, and responsibilities of the role is essential in role negotiation. Considerations for role design and implementation are addressed in Chapter 1, and sample job descriptions are provided in Appendices A to L.

2. *To whom do you report.* In general, you should report to someone whose scope of authority is consistent with yours (eg, if you have systemwide responsibility, you need to report to someone who also has systemwide authority).

3. *The “basic package.”* Details such as a pager, office space, access to a computer, and secretarial support should be specified.

4. *Salary and benefits.* Most WOC specialty nurses are paid at a higher rate than staff nurses because they have completed additional education and have systemwide responsibility. The results of a WOC nursing salary and productivity survey, conducted by the WOCN Society (2012), provide data about salaries, benefits, and caseloads of WOC nurses in different roles and settings across the United States that can be helpful in determining wages. The results of the survey are free to members from the WOCN Society in the Member Library (http://www.wocn.org/MemberLibrary) and available to purchase in the WOCN Bookstore for nonmembers (http://www.wocn.org/Bookstore). Additional employee benefits to consider during a role negotiation are budgetary allowances for reimbursement of continued education (eg, conference fees; travel and hotel expenses), professional membership dues, and/or certification fees.

5. *On-call status.* In an acute or extended care setting, a WOC or specialty nurse generally does not “take call.” Often the WOC nurse is in a consultant role and therefore is not responsible for direct patient care. Staff nurses are present per facility policy to meet the standard of nursing availability to meet patients’ direct care needs. However, in a setting with multiple WOC specialty nurses, the responsibility for taking call is often rotated. If you do “take call,” you should be compensated, just as operating room and recovery room nurses are compensated for call time. In a home health setting, a WOC specialty nurse may or may not be expected to take call, depending on factors such as the size of the organization or the number of nurses who are rotating call status. If you do take call in a home health setting, there should be some type of compensation. The rationale for on-call compensation is as follows: Being on call requires you to remain available even on your own, off-duty time, so your time is only partially yours and can lead to burnout.

6. *Coverage for the absence of the WOC nurse.* Staff development is a critical component of the WOC nurse’s role. Protocols and guidelines are essential for the staff to utilize in the absence of a WOC nurse. Nonetheless, you are responsible for your caseload, particularly in areas where the staff is not able to provide certain highly specialized care. For example, you might need to come in on a weekend to provide preoperative teaching and
stoma-site marking for a patient who is having surgery on Monday morning. If arrangements can be made in advance, the alternative is to provide the care during the preceding week on an outpatient basis. Also, you might have a patient and his or her family who are not independent in managing a complex wound, ostomy, or fistula, but the patient is being discharged over the weekend. Therefore, you will need to either come in for an additional teaching visit or make another arrangement to ensure the patient’s needs are met.

References


Chapter 3: Legal Aspects of Nursing

According to the American Nurses Association (ANA), “the Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently” (2010, p. 2). The ANA further states that the standards can change as the dynamics of professional nursing evolve and that specific clinical circumstances or conditions might affect the application of the standards at any given time (ANA, 2010). In 2010, ANA endorsed WOC nursing as a specialty practice (Wound, Ostomy and Continence Nurses Society, 2010). Therefore, it is important for WOC nurses to be aware of the standards and scope of practice as a foundational guide to excellence in practice and to recognize the legal implications of standards and definitions of the scope of practice.

The legal aspects of nursing have an impact on the manner in which care is delivered to patients by nurses. Legal concerns shape the environment in which nursing is practiced and determine how documents are kept or shared. Ultimately, nurses and the nursing care they provide are judged based on a legal definition for the standard of care for nurses. Written “standards of care” and “guidelines” are available as resources for determining how nursing care is to be delivered and the quality of care. However, the legal definition of the standard of care for nurses is not a “guideline” or a “policy” set by any one individual or institution. Rather, it is the embodiment of collective knowledge for what is required of the average nurse and sets the minimum criteria for proficiency.

Federal and state laws also impact the manner in which nursing is practiced. Health care is one of the most regulated sectors of commerce, and much of the regulation of the industry comes from federal and state laws. Other regulatory requirements are imposed by various government-sponsored programs, such as Medicare, or are self-imposed to conform to various other government and private initiatives. Due to the potential for civil and criminal liabilities and sanctions in regard to health care, nurses should be familiar with key statutes and regulations regarding the delivery of patient care (Carroll, 2006).

This chapter is meant to provide an overview of the legal standard of care for nurses and its impact upon nursing practice. Nursing malpractice is described and suggestions are provided for minimizing risks for malpractice suits. The chapter also includes an overview of laws that affect the practice of nursing.

History of the Standard of Care for Nurses

Ordinary negligence. In previous decades, prior to the growth of professional nursing practice, nurses were judged by the same standard of care as the ordinary man or woman. A nurse was not considered a professional who delivered specialized care. Often, if nursing notes were written, they were not considered part of the medical record.

Over time, the scope of nursing practice has expanded, technologies have changed, and nurses have elected higher levels of education. With these changes, there was a change in the manner in which the standard of care for nurses was viewed, that respected nursing special body of knowledge and expertise. With the growing body of nursing knowledge comes more responsibility, not just in the use of advanced technology but also in the manner in which nursing care is delivered.

The legal notion of the standard of care for nurses, much like the Constitution, is a living concept. It is broad and allows room for interpretation and expansion as the practice of nursing and the environment of nursing practice evolve and change. Guidelines and policies, on the other
hand, are static and provide more specific information regarding the delivery of certain aspects of nursing care as interpreted by individual institutions or organizations.

**Nursing malpractice.** In 1975, nurses were finally identified as professionals worthy of the protection of the law afforded to other medical professionals, when statutory protection was afforded to nurses who might be sued on the basis of nursing practice. Since July 9, 1975, a negligence claim against a nurse has been characterized as malpractice (*Chase v. Sãobin*, 1994). This meant that nurses were identified as providing specialized care and treatment based upon the principles of nursing. A nurse’s knowledge and the delivery of nursing care were no longer compared to the standard of an ordinary man or woman. In Michigan, the Revised Judicature Act of 1961 states that a civil action for malpractice may be maintained against any person professing or holding himself or herself out to be a member of a state licensed profession.

In the past, physicians or other health care professionals could offer their opinions on the standard of care for nurses. No longer can physicians testify about the standard of care for nurses. Only a nurse is considered to have the special body of knowledge, education/training, and experience to provide testimony regarding what the average nurse would do, under the same or similar circumstances, for a patient presenting in the same or similar manner.

**Protection afforded by statutes.** Protection for nurses is afforded by statutes in each individual state. Individual states determine and interpret the laws. Additionally, the state courts interpret statutes and produce written opinions explaining the interpretation of the law.

In some states, nurses are protected under statutes governing the “statute of limitation.” The statute of limitation is the period of time following an alleged injury during which a plaintiff (injured party) may bring his or her claim. If a nurse is subject only to ordinary negligence, the statute of limitation may be lengthened significantly. Generally, the statute of limitation for medical actions is 2 years from the date of the incident alleged to be the cause of the injury, although this may vary in pediatric or wrongful death cases. Statutes of limitation also vary from state to state.

As stated previously, nurses are protected by laws allowing only nurses to testify regarding what a nurse would do in a similar situation with a similar patient. However, some states, such as Michigan, still maintain a local standard of care for nurses. As a result, the nursing standard of care in Michigan is that of a reasonable nurse in the same or similar situation, with the same or similar patient, *in Michigan*. However, as nursing practice expands and advanced practice nurses become more specialized and are nationally certified, there is a shift toward a national standard of care for nurses in advanced practice.

**Legal Definition of the Nursing Standard of Care**

The legal definition of the standard of care for nurses is a broad statement. It is unlikely to be found in the state statutes, public health codes, or nurse practice acts. Rather, the standard of care is established by the average reasonable nurse, practicing in the same or similar circumstances and delivering care to the same or similar patient. Hospital/facility policies or other guidelines do not necessarily define the standard of care for nurses as it might be defined in the legal environment. An institution’s guidelines are generally more specific about the care and treatments provided in that particular institution.

Nurses are considered to have a general nursing knowledge rather than thought of as specialists, such as physicians might be. It is important for nurses to understand that the standard of care for nurses is only that of the reasonable, ordinary nurse and it is the standard of care at the time of the incident that is applicable. Additionally, if testimony about nursing is to be
provided, it must be from a nurse with experience in the area of nursing in question. For example, a wound care nurse would be held to the standard of a reasonable wound care nurse, practicing under the same or similar circumstances, in the year the incident occurred.

More specifically for a wound care nurse, the standard of care would be that of an average nurse practicing in the area of wound care and delivering nursing care to a same or similar patient under the same or similar circumstances. There is a trend toward a national standard of care for those nurses whose credentials indicate that they are certified by a national association of nurses.

**Advanced practice nursing.** In cases of advanced practice nurses such as a certified RN anesthetist (CRNA) or nurse practitioner (NP), the standard of care would be for a CRNA or NP. In general, advanced practice nursing requires specific qualifications including an advanced degree in a specific area of expertise. Advanced practice nursing may also require certification by a national association and specific licensing by the state through the board of nursing. The state boards of nursing may define the nursing scope of practice through statutes.

The legal standard of care for an advanced practice nurse would be that of an average and reasonable advanced practice nurse. Specifically, the legal definition of the standard of care would be that of an average and reasonable advanced practice nurse, practicing in his or her area of expertise and caring for a same or similar patient under the same or similar circumstances. Nurse practitioners may practice in dependent or independent roles in many different settings. If the NP is associated with an institution, he or she should evaluate the employment contract to determine if he or she is classified as an employee or an independent contractor. Employee status will impact decisions regarding whether to purchase individual malpractice insurance.

**Nursing malpractice.** Malpractice is negligence, misconduct, or breach of duty by a professional that results in injury/damage to a patient (Reising & Allen, 2007). According to Reising and Allen, common malpractice claims arise against nurses when nurses fail to:

- Assess and monitor.
- Follow standards of care.
- Use equipment in a responsible manner.
- Communicate.
- Document.
- Act as a patient advocate and follow the chain of command.

**Elements of malpractice.** To prove malpractice, all 4 of the following elements must be proven by the plaintiff: the nurse had a duty to the patient, the nurse breached the duty, a patient injury occurred, and there was a causal relationship between the breach of duty and the patient injury (Reising, 2012). Therefore, in determining if malpractice has occurred, these 4 elements must be carefully considered. First, did the nurse have a duty to the patient? This means that the nurse was actively engaged in providing nursing care to the patient. Second, was there a breach of that duty? In other words, did the nurse commit an act or omission in the act of taking care of the patient and did that act or omission result in harm to the patient?

The third element is “proximate cause.” The question here is whether the action or omission caused any harm to the patient. If the action did not result in harm or injury, there was no malpractice. Finally, the fourth element is damage. What harm occurred as a result of the action of omission during the delivery of nursing care? A nurse might have a duty to a patient and commit an action or omission during the course of nursing care, and it might not constitute malpractice if the action or omission did not result in harm to the patient.
In the following case, examples of malpractice related to wound care are presented. An 80-year-old patient was admitted to a nursing unit, and a wound was identified on her right heel. Although care was provided for the wound on her heel, the nurse failed to complete a head-to-toe skin assessment and assess the patient’s risk for pressure ulcer development. As a result, a large pressure ulcer developed on the sacrum. When this wound was finally identified, it was a stage IV pressure ulcer and took several months of additional treatment for healing, including nursing home care.

An analysis of the case would be as follows: Did the nurse have a duty? Yes. She was actively engaged in delivering nursing care to the patient. Did the nurse breach the duty? Yes. The nurse failed to completely assess the patient and, as a result, a sacral ulcer developed. Was the nurse’s failure to completely assess the patient a cause of harm to the patient? Yes. At admission, the patient did not have skin breakdown on the sacrum. The wound was discovered upon transfer to another facility.

Finally, was there damage? Yes. A wound developed on the sacrum, and damage included the economic costs for additional hospital and nursing home care, a decline in mobility, and emotional distress.

In fact, this was an actual case that resulted in a settlement. The key point is to protect your patients and yourself by implementing the complete nursing process and thorough documentation.

Minimizing the risk of malpractice. Nurses should be cognizant of legal risks in providing care. Reising (2012) suggests that the following actions can help minimize a nurse’s risk of being sued for malpractice:

- Know and follow your state’s nurse practice act and your facility’s policies and procedures.
- Stay up to date in your field of practice.
- Assess your patients in accordance with policy and their physicians’ orders and, more frequently, if indicated by your nursing judgment.
- Promptly report abnormal assessments, including laboratory data, and document what was reported and any follow-up.
- Follow up on assessments or care delegated to others.
- Communicate openly and factually with patients and their families and other health care providers.
- Document all nursing care factually and thoroughly and ensure that the documentation reflects the nursing process; never chart ahead of time.
- Promptly report and file appropriate incident reports for deviations in care.

What to do if you are sued? How a lawsuit for medical malpractice is initiated may differ in each state. However, whether you are served with a complaint or a letter of intent to sue, your first response should be to contact your supervisor or employer and/or legal department: They will help you determine insurance coverage. Never speak to a representative of the plaintiff (ie, the person who is bringing the lawsuit).

After you have contacted the legal department, you will be assigned an attorney to guide you through the case. Do not discuss the case with anyone other than your employer or legal representative. An attorney will contact you for an interview and will likely provide you with a copy of the medical records in question for review. The nurse is a key partner in the defense of the case, and the nurse’s knowledge of the medical record is very valuable.
If a lawsuit results in a judgment against a nurse, the state may require that the judgment be reported to the state board of nursing. Sometimes, there is an investigation by the board of nursing into the facts of the case, necessitating legal representation of the nurse during the investigation. However, most actions do not result in specific judgments against nurses.

Many nurses ask whether they should carry their own malpractice insurance in addition to that provided by their employer. First, it is important to understand the amount of insurance coverage that the employer provides and what is covered. A staff nurse working in an institution such as a hospital is unlikely to need additional coverage, unless he or she practices outside of the hospital (e.g., works at first aid stations at baseball tournaments; works at camps not affiliated with the hospital). However, a nurse with an independent practice or who is identified as an independent contractor may require individual coverage.

Other Important Legal Considerations

Federal and state statutes and regulations. In addition to nursing malpractice, there are multiple federal and state laws and regulations that impact the practice of nursing and may impose liability. The following discussion presents a brief overview of some of these: state/federal statutes governing privacy, the use/disclosure of a patient’s protected information, peer review for negligent or unprofessional conduct, patients’ rights to make decisions about their medical care, conditions of participation for Medicare/Medicaid reimbursement, requirements for reporting suspected/actual elder or child abuse, and professional practice acts and licensure.

What is the Privacy Act? The Privacy Act (1974) regulates the collection, use, maintenance, and distribution of personally identifiable information about individuals that is kept in the record systems of federal agencies. This act impacts all health care providers and health care plans that transmit health care information in electronic form. It has been described as a consumer protection act.

The Health Insurance Portability and Accountability Act. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA, 1996) to limit the ability of an employer to deny health insurance coverage to employees with preexisting medical conditions. The law also directed the US Department of Health and Human Services (USDHHS) to develop privacy rules, including, but not limited to, the use of electronic medical records. In recent years, this has expanded to include other considerations for electronic transmission of health care information.

Among other things, HIPAA gives individuals the right to obtain their own medical records and request amendments to their medical records (USDHHS, n.d.-a) and allows the individual to learn where the records have been disclosed (USDHHS, n.d.-b).

HIPAA provides that individuals must be provided with medical records within 30 days of a request. It also prohibits release of personal health information without permission. Generally, a HIPAA-compliant, signed authorization must be presented in order to obtain medical records. An individual who believes his or her health care information has been inappropriately exchanged may file a complaint with the provider or USDHHS Office for Civil Rights. The provider can be liable for both civil and criminal penalties. Recently, the rule has been expanded to hold individuals liable to the consumer. This becomes especially important when the manner and number of ways that information is exchanged across the Internet are considered.

As health care and technology rapidly grow and expand, new issues will occur. Interpretation of statutes will be challenged and can change, laws will be revised, and new
legislation can be introduced. There are significant penalties for failure to meet HIPAA requirements. Previously, penalties were limited to the institution. Recently, new federal laws have been enacted that allow individuals to be held accountable for breaches of the Privacy Act. Therefore, nurses need to keep up with the changes that affect their nursing practice. Resources for information regarding legal/regulatory updates include the professional journals and nursing organizations. In addition, in a hospital-based practice, the departments for risk management, quality, and/or legal affairs can help the nurse keep abreast of changes.

Social networking. Social networking can have a significant impact on health care practice. Society has become adept at using computers, cell phones, Facebook, and Twitter for exchange of information. However, the ease of exchange of information does not exempt the health care provider from obtaining a HIPAA-compliant consent form. There have been cases of practitioners sharing an interesting case or sharing health care information over social networking sites. Without the patient’s consent, it is not appropriate to share information, especially when the information is not shared on a secured network and is out there for the world to see. This can result in civil and criminal penalties. Therefore, it is important to be aware that a HIPAA-compliant authorization must be obtained for any exchange of health care information.

Health Care Quality Improvement Act. The Health Care Quality Improvement Act (1986) encourages hospitals, state licensing boards, and professional societies to identify and take corrective action for health care workers who may be found by peer review to be engaged in negligent or unprofessional conduct. This act encourages peer review, and, if performed correctly, it might provide immunity from civil liability. Many states encourage “peer review” and internal investigations of incidents that have resulted in harm to patients and provide statutory protection of peer review activities within an organization. In addition, hospitals/facilities and personnel have a strong interest in providing quality care and preventing future harm to their patients through such review activities.

Patient Self-Determination Act. The federal Patient Self-Determination Act (PSDA, 1990) mandates that individuals receiving medical care must be given written information about their rights under state law to make decisions about medical care, including the right to accept or refuse medical or surgical treatment (Crego, 1999). The law applies to all health care facilities providing services and receiving federal reimbursement, including nursing homes, home health agencies, clinics, and hospitals. The essence of the legislation was to empower the public with the right to make end-of-life decisions. The PSDA defines the rights of competent patients to make binding, legally enforceable decisions about their health care preferences that are to be followed should they later become unable to express their wishes. This includes assigning a patient care advocate for medical decision making and endorsing a witnessed and notarized living will for end-of-life decisions. Many state legislatures have added additional legal steps and actions that need to be taken for end-of-life decisions that may vary greatly from state to state.

Medicare Conditions of Participation 42CFR s 482 et seq. There are distinct requirements that must be met for a provider to participate in the Medicare program (ie, conditions of participation [COP]). These COP are found in various codes of federal regulations (C.F.R.). They include COP for hospitals, COP 42 C.F.R., 482 (2008); home health care agencies, COP 42 C.F.R., 484 (n.d.); comprehensive rehabilitation facilities, COP 42 C.F.R., 485 (n.d.); and requirements for long-term care facilities (Legal Information Institute, n.d.).

In addition, the Office of the Inspector General (2000) published its Compliance Program Guidelines to reduce the incidence of pressure ulcers and malnutrition in long-term care facilities. These are especially important issues for WOC nurses who provide or oversee care in
these facilities. With an increasingly aging population, these regulations are important, especially because a condition of payment for services by Medicare and Medicaid requires adherence to the Compliance Program Guidelines. Moreover, failure to comply may result in criminal and civil liability as well as monetary penalties.

**Elder abuse and neglect.** Elder abuse has become a growing problem. Various states have mandatory requirements for reporting elder abuse and neglect. To encourage reporting, many states have enacted immunity provisions protecting individuals who report abuse and/or neglect from civil liabilities. Also, some states, in addition to having mandatory reporting requirements, include penalties for individuals who fail to comply. Nurses are often observers of abuse or neglect and should be aware of reporting requirements.

The National Center on Elder Abuse (NCEA, n.d.), directed by the US Administration on Aging, is committed to helping national, state, and local partners to be fully prepared to ensure that older Americans live with dignity, integrity, and independence and without abuse, neglect, and exploitation. The NCEA is a resource for policy makers, social services, health care practitioners, the justice system, researchers, advocates, and families. A visit to the Web site (http://www.ncea.aoa.gov) provides phone numbers for each state where abuse can be reported.

**Reporting child abuse.** WOC nurses are in a unique position to identify and report suspected child abuse. Children who are chronically ill or require wound care and/or ostomy care are at risk for abuse. Since the early 1970s, federal and state legislation has been enacted to protect children from abuse. Those who report abuse are generally protected from liability. Although federal statutes have been enacted regarding prevention of child abuse, it is largely the states that administer these laws and take action. For example, according to the Child Protection Law (1975), the state of Michigan requires reporting of any suspected abuse and does not allow a health care practitioner to make a medical judgment as to the cause of the abuse. Rather, any suspected child abuse must be reported orally and a written report provided within 72 hours. Information may be provided to the investigators in the written report regarding the suspected cause of abuse or neglect.

**Professional practice acts and licensure.** For each group of health care professionals, licensed by the state, laws and regulations are in place that define the scope of practice and outline the oversight authority vested in their professional regulatory boards. Most states have a nurse practice act that serves as a general guideline regarding the practice of nursing and licensure requirements. Generally, the scope of nursing practice is defined for licensed practical nurses, RNs, and advanced practice nurses. The scope of practice of an individual practitioner is an important consideration because practicing outside of the scope of nursing can open the individual to civil liability and censorship by the board of nursing.

The scope of practice of nurses can also be further defined by hospital policies and procedures. The policies and procedures of individual organizations should show evidence of compliance with licensing board requirements and legislative requirements, as well as with guidelines established by such agencies as The Joint Commission. National and state nurse associations are other resources that provide guidelines for the practice of nursing.

**Conclusion.** In this chapter, a general overview of the legal aspects of nursing has been presented. The legal definition of the standard of care for nurses is defined as that of what a reasonable and prudent nurse would do when caring for a same or similar patient in the same or similar circumstances. The reason for having such a general definition is to allow for changes in the manner in which nursing is practiced. Guidelines and hospital policies and procedures are more specific but may change from year to year. As a result, the nursing care provided to a same
or similar patient under the same or similar circumstance in one year is likely to be different from care in previous or later years. For specific legal issues or questions, nurses are encouraged to seek guidance from their facility’s legal or risk management departments whose personnel are versed in local laws and regulatory requirements.

References


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**Additional Resource**

Chapter 4: Consultant Role

WOC nurses are recognized for their skills and expertise and are frequently called on to serve as consultants. This chapter presents an overview of consultation and its relevance to WOC nursing. The process of consultation and the characteristics and skills that consultants should have are presented. The chapter also discusses types of consultative roles, how to conduct consultations, how to establish and maintain a consultant role, ethics and legal implications of consulting, and considerations in contracting for services and reimbursement as a consultant.

Consultation and the WOC Nurse

The concept of consultation is often introduced in basic WOC nursing educational programs. During the educational process, the concepts of consultation are further defined and knowledge of the process is enhanced during the supervised experiences of the practicum. Consulting relationships can be either internal or external. An internal consultant is a member of the organization (i.e., employee). An external consultant can be an independent contractor or self-employed from outside the organization. Consultants function in various roles, including patient advocate, technical specialist, educator, collaborator, researcher, process specialist, and subject or product expert (Dyck, 2002). There are many definitions of consultation including the art of influencing people at their request and providing assistance to the client to enable them to problem solve and manage their work, health, or psychosocial issues (Dyck, 2002). The concept of consultation is different from that of collaboration, comanagement, and referral. The key difference between these concepts is the degree of responsibility that the consultant assumes for the problem. Yet, in many instances, these terms are used interchangeably due to lack of clarity about the consultative process (Barron & White, 2005).

Care provided by multiple disciplines through the process of consultation can be complementary and beneficial to the patient. Consultants are often called on for their expertise in specific areas that may be outside of the primary provider’s scope of practice. When making or responding to requests for consultation, the WOC nurse consultant should be mindful of situations or circumstances that affect a patient’s ability to be compliant with the recommended care such as unemployment, lack of insurance, inability to afford medications, lack of transportation, inadequate caregivers, etc.

The health care delivery system is currently in the midst of change involving cultural and value shifts, economic constraints, and political mandates, which are creating a shift in the responsibility for care (Tomajan, 2012; Waters, 1998). With these changes, nurses are expected to provide professional leadership, education, and expert clinical practice. Consultation is viewed as an essential role component for WOC specialty nurses and advanced practice registered nurses (American Nurses Association, 2010; Wound, Ostomy and Continence Nurses Society [WOCN], 2010). Advanced practice registered nurses have acquired the knowledge and practice experience to prepare themselves for specialization, expansion, and advancement in the practice of health care (Ellerbe & Regen, 2012; Robert Wood Johnson Foundation, 2012; Waters, 1998) and are expected to influence patients, other providers, and the systems in which they work.

It takes creativity and knowledge to be able to balance the demands of the consultant role (McSherry, Mudd, & Campbell, 2007). McSherry and colleagues conducted a small descriptive, qualitative study in Britain and found that some ambiguities existed regarding the nature, function, and value of the nurse consultant’s role. Factors that influenced the role of the consultant included poorly defined roles, workload expectations and demands, the degree of
support for the role, the role’s impact on practice, and relationships with other staff, peers, and colleagues.

**Process of Consultation**

The process of consultation in nursing borrows from the consultative process that is practiced by business and other helping professions (Wilson, 2008). WOC nurse consulting is similar to nursing consultation in other areas such as psychiatric nursing, occupational health nursing, and legal nurse consulting. A key concept in the consultative process is that the consultant may be involved with the problem, but they do not “own” the problem or solution; the client (physician) owns the problem and makes the final decisions (Dyck, 2002). According to Dyck, consultation involves the following process:

- Developing an effective client relationship with mutual respect and trust.
- Assisting the client to explore and clarify problem situations or opportunities for involvement.
- Helping the client interpret and understand experiences, behaviors, and feelings to implement a plan of care.
- Contracting with the client to commit to specific goals.
- Providing challenging and supportive feedback.
- Identifying and referring the client to appropriate professional experts to enhance skill and knowledge development.

The consultant must strive to establish a warm, respectful, and accepting relationship due to a potential sense of vulnerability on the part of the consulter. The consultant should communicate that the consulter’s problem is important and worthy of consideration. During the process of consultation, self-awareness and interpersonal skills are essential. To be a successful consultant, the WOC nurse must first value himself or herself and the specialized body of knowledge and expertise that characterizes the specialty. More specifically, the WOC nurse consultant must be aware of his or her personal strengths, weaknesses, and motives. Additionally, a good consultant must be able to withhold judgment, avoid stereotyping, and see the issues realistically without prejudice (Barron & White, 2005). Dyck (2002) offers the following tips for consultants to follow:

- Remain open minded and objective.
- Be nonjudgmental.
- Do not take advantage of a situation to show how bright, knowledgeable, and experienced you are.
- Do not meet defensiveness with pressure and arguments.
- Do not overpraise or unfoundedly reassure the person being helped.
- Practice ethical consulting.

**Characteristics of Consultants**

Nursing consultation involves many nursing activities such as teaching, assessing and monitoring, evaluating outcomes, and developing policies and procedures (Wilson, 2008). When consulting, knowing the level of responsibility that is being requested from the consultant is important. Developing consultative skills allows the WOC nurse to utilize acquired expertise to enhance their colleagues’ nursing practice. The consultant should utilize evidence-based recommendations and should act within established guidelines of practice. Recommendations should result in efficient use of products to provide cost-effective care.
It is helpful for the consultant to possess operational expertise, health care knowledge, and network capabilities. Frequently, the consultant works independently and without administrative support. The WOC nurse must be comfortable with the process of obtaining and interpreting data. Objective analysis of the data is essential to present a nonbiased recommendation to the client (Smeltzer, 2002). The consultant should also be aware of characteristics about the systems, relationships, and changes within the organization. These include but are not limited to the quality of relationships and interactions between patients and staff, time pressures, lack of adequate resources, organizational politics, power imbalances, and rapid or frequent systems changes during the consultative process (Barron & White, 2005).

Traits that are particularly desirable in a consultant include being optimistic, forward-looking, flexible, and adaptive (Waters, 1998). A summary of the characteristics and skills with associated behaviors or activities that are important for consultants to possess is given in Table 4.1.

Table 4.1. Important Characteristics and Skills for Consultants

<table>
<thead>
<tr>
<th>Characteristics/Skills</th>
<th>Behaviors/Activities</th>
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<tbody>
<tr>
<td>Interpersonal skills</td>
<td>1. Listening</td>
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<td>2. Assertiveness</td>
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<td>3. Conflict management</td>
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<td>4. Issue resolution</td>
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<td>6. Reassurance</td>
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<td>7. Giving feedback</td>
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<td>Business skills</td>
<td>1. Strategic planning</td>
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<td>3. Project evaluation</td>
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<td>4. Cost and benefit analysis</td>
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<td>Analytical skills</td>
<td>1. Data gathering</td>
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<td>2. Management</td>
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<td>3. Analysis</td>
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<td>4. Interpreting and reporting skills</td>
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<tr>
<td>Consulting skills</td>
<td>1. Knowledge</td>
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<td></td>
<td>2. Ability to use the process to adhere to professional ethics</td>
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Types of Consultation

The role of the WOC nurse may involve both consultation and comanagement. It is important to understand which role is being sought when services are requested by another professional. In comanagement, both professionals manage different aspects of care, whereas, with true consultation, the recommendations of the consultant may or may not be instituted by the consulter. Knowledge of the purpose of the consultation and the goal or desired outcome anticipated from the consultation is essential.

The concept of consultation was first clarified by Gerald Caplan (1970), who is now thought to be the “father” of mental health consultation theory. Caplan defined 4 different types of consultation:

- **Client-centered case consultation.** This is the most common type of consultation. The goal is to help the consulter develop a plan of care for a particularly difficult or complex
problem. The consultant sees the patient to assess and make recommendations. This is often a one-time evaluation and may need follow-up.

- **Consultee-centered case consultation.** The primary goal is to assist the consultee to acquire the knowledge needed to address the problem. The consultant must define the problem the consultee is having (ie, lack of knowledge, skill, confidence, or objectivity). The consultant then educates the consultee in order to address the patient’s problem. This is often the type of consultation sought from advanced practice nurses.

- **Program-centered administrative consultation.** Deals with planning and administration of clinical services such as a new program or some type of organizational functioning.

- **Consultee-centered administrative consultation.** Deals with the consultee’s difficulties, which interfere with the organization’s objectives.

### WOC Nurse Consultative Roles

**WOC nurse as a consultee.** Consultations between fellow WOC nurses occur so that a WOC nurse can also be the consultee at times. Consultation between fellow WOC nurses offers the benefit of collegial networking, which has the potential to enhance knowledge, practice, and collaborative opportunities for all involved. In the role of the consultee, the WOC nurse must be able to identify and articulate the nature of the problem. The WOC nurse consultant provides a detailed assessment and evaluation along with recommendations to achieve the expected outcomes.

**WOC nurse--staff nurse consultations.** The WOC nurse specialist may provide formal, direct patient consultations or consult only with staff to assist with general problemsolving to enhance the patient’s care. It is important for consultants to establish good working relationships with the staff nurses. If positive relationships are established, staff should perceive the consultant as approachable, respectful, and helpful so that they will initiate contact with the consultant when complex issues arise.

**Physician--WOC nurse consultation.** WOC nurse consultation at the request of physicians involves identifying the nature of the patient’s problem, performing a detailed assessment, and thoroughly evaluating the problem. Recommendations are provided to the physician with expectations for outcomes. This type of consultation can result in a trusting relationship where the physician, confident in the WOC nurse’s abilities and previous good patient outcomes, consults the nurse repeatedly for future patients with challenging WOC problems.

### Conducting the Nursing Consultation

**Assessment.** The consultative process begins with assessment of the problem for which the consultee’s expertise is requested. It should include a review of the patient’s records, interviews with staff, and direct assessment of the patient. The consultant must confirm that the problem falls within the consultee’s expertise. The consultant also confirms that the consultee will remain clinically responsible for the patient.

**Recommendations and interventions.** The next step in the consultative process is to consider interventions. The consultee may intervene directly (ie, comanagement) or assist in the clinical decision-making process by providing alternative perspectives and recommending specific interventions. For example, more data might be required and further testing may be recommended by the WOC nurse consultant. If the consultee accepts the consultee’s recommendations, a decision is made about carrying out the interventions and by whom. Also, a
time frame for the consultant’s service needs to be determined as to whether the consultation is only for one time or will be ongoing.

**Documentation.** The WOC nurse consultant should document the consultation in a standard and easily retrievable form, which varies among different practice settings and institutions. The consultant should seek guidance about documentation forms/format from the facility’s administration and/or medical records administrator.

**Evaluation.** Following the interventions, a review and evaluation of the care and confirmation of the patient’s outcomes are performed. Reassessment is conducted as needed.

**Establishing and Maintaining a Consultant Role**

When initially developing the role as a consultant, the WOC nurse should establish priorities and identify alternative resources for the staff when the consultant is not available. Requests for consultations may increase as the services become more recognized and valued. To be successful as a consultant, it is very important to clarify when/how the WOC nurse is available and to respond in a timely fashion to referrals. The consultant should have backup resources for emergencies, and the consulter should know whom to contact in those situations.

For the established consultant, frustration can occur when the staff attempts to over utilize the consultant’s services or refers patients for basic care that does not warrant the specialty nurse’s services. To minimize unnecessary referrals, educational programs that address common needs and written guidelines, protocols, and sample care plans can be developed to share with consulter. A satisfying aspect of the consultant’s role is seeing consulter grow and become more confident in managing problems. A primary goal of a consultant is for the consulter to manage future, similar problems independently. For example, after a consultation with a WOC nurse, the staff nurse in a subsequent situation is able to identify the presence of redness on a heel as a stage 1 pressure ulcer and initiate proper pressure redistribution and appropriate skin care. To enhance the learning and development of skills by consulter, discussion and evaluation of the consultation process are very important.

To determine the overall effectiveness of the consultation role, the WOC nurse needs to conduct an ongoing evaluation of the consultation services and processes. To assess the consultation role, a WOC nurse might consider the following questions:

- Are you reconsulted after the initial consultation?
- Are requests becoming more sophisticated over time?
- Were you able to respond to all requests for consultation?
- Are there needs that seem to be going unaddressed?
- Are there patterns in terms of theme, number, or location of consultations?

**Collaboration**

The WOC nurse often works in collaboration with a physician. The establishment of a collaborative practice between a physician and a specialty nurse can improve quality, continuity, and cost-effectiveness of care (Waters, 1998). Collaboration is also believed to improve patient satisfaction, and personal and professional satisfaction for clinicians.

Collaboration involves 2 or more individuals interacting constructively and learning from each other to solve problems and accomplish goals, purposes, and outcomes. Good interpersonal skills and behaviors are important for successful collaboration in which responsibility and expertise are shared. Clinicians can derive many positive benefits from effective collaboration.
including improved communications, enhanced trust and respect, and avoidance of duplication or gaps in service, which can lead to improved patient outcomes.

Failure to communicate and collaborate has deleterious effects on patients and staff satisfaction and becomes a source of stress for nurses. Job satisfaction and staff’s attitudes are negatively impacted when territoriality and competitiveness occur, and this usually causes a negative impact on patient care. WOC nurses, physicians, and other providers share a common purpose in providing good patient care. Each group has unique, complementary, and overlapping skills, which benefit patients. Comprehensive and complex care plans to meet patients’ needs can be developed more effectively by combining the skill sets of various providers.

Clinical competence is also essential for successful collaboration. Clinicians must be able to rely on each other through mutual trust. A respect for each other’s practice enhances shared decision making. Nurses must appreciate the knowledge, skills, and abilities that they bring to the table as valuable members of the health care team.

Another aspect of collaboration to consider is the use of “appropriate” humor to provide a setting that is positive and nonthreatening. Properly used and timed, humor can help decrease defensiveness, invite openness, relieve tension, and deflect anger. It can set the tone for trust and acceptance so that difficult situations can be reframed.

Consulting Relationships and Potential for Conflict: Multiple Relationships

Consulting relationships should remain ethical and professional. Contractual/consultant arrangements can lead to areas of conflict from actual or perceived bias, concerns over undue influence or favoritism, access to insider knowledge, ethical concerns, etc. There are potential conflicts if a consultant has multiple contractual agreements with competitive organizations.

Also, ethical dilemmas occur if consultants mix professional and personal roles. “When nurse consultants blend a professional and nonprofessional relationship or assume professional roles that conflict, they have entered a multiple relationship in nursing consultation” (Wilson, 2008, p. 63). Personal involvement in the consulting relationship can be problematic, because the consultant can become overinvolved and unable to separate personal from professional issues. Blurring of boundaries and roles results in decreased efficacy of the consultation practice and can lead to exploitation or harm to the consulter and/or consultant. Particularly problematic relationships involve bartering for goods or services, accepting gifts, entering into a purely social relationship, or becoming emotionally or sexually involved with a consulter.

Additionally, there can be difficulties from serving in combined, dual roles such as a consultant and supervisor, which can interfere with the nurse consultant functioning effectively as a supervisor. The roles and responsibilities and relationships in a dual role can be blurred and confusing to subordinate employees who are also consultants (Wilson, 2008). To avoid potentially conflicting relationships, Wilson suggests that nurse consultants should:

- Be knowledgeable about standards of practice and codes of conduct.
- Identify alternatives for patients/clients to obtain services when a potential conflict arises.
- Network with colleagues to avoid professional isolation.
- Acknowledge potential multiple conflicting relationships and any harm that might result to the patient/client.
- Know their strengths and weaknesses and refer when necessary.
Ethical Standards

Nurse consultants are expected to follow the Nursing Scope and Standards of Practice put forth by American Nurses Association (2010) and Wilson (2008). However, the standards and codes for implementing a consultant’s role are not well defined. WOC nurses are expected to apply the code of ethics of the nursing profession and the standard for ethics presented in the Wound, Ostomy and Continence Nursing Scope & Standards of Practice (WOCN Society, 2010).

Legal Implications of Consultation

Although the consulter remains clinically responsible for the patient, WOC nurses are also responsible for their own practice related to the problem for which they were consulted. Responsibilities of the consultant include gathering accurate data about the problem, documentation of data, making reasonable recommendations, and giving competent and reliable advice. Consultants working in the same place where they are employed might be considered to have more accountability than a consultant from outside the organization.

WOC nurses within their organization may be expected to identify and follow through on urgent concerns and problematic situations for which outside consultants would not be responsible. Knowledge of the organizational structure and job responsibilities is important. Adherence to standards of practice for the WOC nursing specialty is vital. When making a direct patient consultation visit, documentation in the patient’s record is appropriate and necessary. Assessment of the problem and recommendations should be clearly stated. When the patient is not seen directly, the WOC nurse should consider if documentation in the patient’s chart is appropriate. If the consultation involves only education of the consulter in relation to a problem, documentation on the patient’s chart is not necessary. For example, a staff nurse asks if a foam dressing is a good choice for a heavily draining leg wound and the consultant only provides information about the dressing to the nurse and does not see the patient.

Consultants should maintain their own records of their consultations, outlining the issues, assessment data, and recommendations (maintaining compliance with the Health Insurance Portability and Accountability Act of 1996). When an informal consultation seems inadequate for the problem (ie, if in the previous example, the patient also had multiple draining leg ulcers with odor, pain, and infection and was admitted for cellulitis), advise the consulter that more information is needed and suggest that a formal consult be done.

The increased responsibilities of the WOC nurse also bring increased liabilities, and specialists may be held to higher standards than generalist nurses. If the consultant finds that the patient is in a dangerous situation and at risk for harm, but the consulter is unable or unwilling to intervene, the consultant should then follow the organization’s process for assuring that the patient’s safety needs are met (eg, reporting up the chain of command to a supervisor, director, or chief of the service that requested the consultation). Additional information about legal implications for WOC nurses is included in Chapter 3.

Legal Nurse Consultation

Due to the increase in health care lawsuits, especially those in cases related to skin and wound care, the WOC nurse/certified wound care nurse has increased opportunities to participate in the legal process. Determination of the merits of a potential lawsuit requires a complete review of the medical records, conferences with lawyers, possible depositions, and testifying in court (Milazzo, 2007a). As an expert witness, the WOC nurse/certified wound care nurse will be asked
to speak to deviations from the standard of care related to prevention and care of wounds and pressure ulcers. While these activities may be required of any nurse, if the WOC nurse’s employer is involved in a lawsuit or he or she is serving as a legal consultant or expert witness, the WOC nurse needs to have the following information in place (Milazzo, 2007b):

- An employer identification number.
- A fee schedule.
- A record keeping system for billing purposes.
- A current curriculum vitae.
- Access to documents related to the standards of care that are relevant to the case(s) in which he or she is involved.

**Contracting for Services**

When seeking to work as an outside or independent consultant, a written contract should be drafted. An employment contract helps identify parameters of the position and should include a clause for ending the professional relationship. The goal of the contract is to protect the WOC nurse by outlining the specific expectations, objectives, and the nature of relationship. The nurse must always follow certification/licensing requirements in the specialty area of practice and in the state where he or she practices, respectively. Elements that should be clarified and addressed in the written contract include the following (Dyck, 2002):

- **Work.** Products and outcomes; scope of the project and boundaries; performance measures; measurement techniques and timing.
- **Client profile.** Stakeholders and people affected by the project who need to be involved.
- **Roles and responsibilities.**
- **Costs and resources.** Fees and billing, budget, materials, and supplies.
- **Schedule for delivery of products and services.**
- **Data collection.** Sources and methods, confidentiality.
- **Constraints.** Ethical, legal political.
- **Feedback to the consultant.**

**Reimbursement**

WOC nurses often consult in the institution where they are employed as part of their role expectation. Consultation might be a daily activity for many WOC nurses and in some cases issues and questions regarding reimbursement arise. The WOCN Society has developed some informational documents regarding reimbursement for services that are available to members (Member Library, http://www.wocn.org/MemberLibrary, Public Policy section), including the following:


Other revenue-generating activities can be developed to increase awareness of a WOC nurse’s services and exposure to the WOC nurse consultant. These activities could include speaking engagements for educational activities, or the development of informational tapes and books about topics that are relevant to WOC issues/needs. Exchanging consultative services with another network of providers is another option to gain exposure and access to opportunities for increased reimbursement.
References


Chapter 5: Educator Role

Educating others is an integral part of a professional practice. Orientation and ongoing education and development of staff are critical components in an effective WOC care program. This chapter presents guidelines for staff orientation and developing continuing educational programs and describes how to develop measurable learning objectives and educational plans (i.e., objectives, content outline, teaching methods, and evaluation methods). Also, utilization of resource teams to enhance the WOC nurse’s role is discussed.

Guidelines for Staff Orientation

Orientation of staff to the role of the WOC specialty nurse and the responsibilities of staff nurses for WOC care is a key responsibility of the WOC nurse. Orienting staff and new employees to the WOC nurse’s role and consultative procedures should be included in the orientation program for all new employees. To ensure that the orientation achieves the intended learning outcomes, the WOC nurse establishes minimal learning and skills objectives to be met during the orientation and these can be fashioned into a skills checklist. The learning objectives may be met by providing new employees with structured learning opportunities, such as making rounds with the WOC nurse, or by using skills-based lab activities. Other simulated experiences are also beneficial to the learner. For example, if the minimal objectives for ostomy care include sizing a stoma and applying a pouch, using a simulated stoma that is available commercially or can be fashioned from modeling clay and cardboard is effective. Similarly, if the minimal objectives for wound care include accurate documentation of wound characteristics and selection of an appropriate dressing, pictures, slides, or simulated wounds made of clay and paint can be used. Appendix O provides a sample structured orientation plan that can be adapted for a skills checklist.

Guidelines for Developing Educational Programs

Often WOC nurses are asked to help plan an educational program or be a speaker. Educational programs include short in-services (≤1 hour), seminars (6-8 hours), or conferences (several days). Some programs that are provided can be eligible for continuing education (CE) contact hours. Awarding CE credit for a program requires applying to an accredited CE approver who will review the program according to certain criteria.

According to the South Carolina Nurses Association (SCNA), which is an accredited CE approver by the American Nurses Credentialing Center’s Commission on Accreditation, continuing nursing education, for which contact hours can be awarded, is defined as planned, organized learning experiences that are designed to improve the knowledge, skills, and attitudes of nurses (SCNA Continuing Education Approver Committee, 2009). Continuing nursing education enhances practice, promotes professional development, and improves overall health care (SCNA Continuing Education Approver Committee, 2009). In-service education is defined as planned instruction or training to help nurses perform in a specific work setting (SCNA Continuing Education Approver Committee, 2009). In-service is designed to orient to duties, maintain or increase competency, promote compliance with an employer’s policies/procedures, demonstrate the use of facility-specific equipment, or provide practice for previously learned skills. Such in-service activities are not eligible for CE contact hours (SCNA Continuing Education Approver Committee, 2009).
Planning for Educational Programs

The key to success in presenting an educational program is advanced preparation and developing an educational plan. The components of the plan include measurable learning objectives, a content outline, identification of speakers (e.g., the planner and speakers can be different), teaching methods, and the plans for evaluating the learning.

**Writing educational objectives.** When planning a nursing educational program, specific learning objectives are required for the overall educational activity as well as for any individual sessions. Writing objectives can seem intimidating and threatening, but they are integral to a well-designed educational program. Well-written objectives help to:

- Organize what will be taught.
- Determine which instructional methods will be most effective.
- Formulate the evaluative materials.
- Make measuring the outcomes easier.
- Help learners understand what they can expect to achieve upon completion of the course.

When writing instructional objectives, using a frame of reference that clarifies the type of learning outcome that is desired is advantageous to guide the selection and writing of objectives (Gronlund & Brookhart, 2009). A classification system known as the *Taxonomy of Educational Objectives* was developed by Bloom and others, who identified 3 domains of educational outcomes: cognitive, affective, and psychomotor (Bloom, Englehard, Furst, Hill, & Kratwohl, 1956; Gronlund & Brookhart, 2009; Krathwohl, Bloom, & Masia, 1964; Simpson, 1972). These domains as described by Gronlund and Brookhard (2009) are commonly recognized and utilized by educators when preparing objectives:

1. **Cognitive domain.** Intellectual learning outcomes; includes the categories of knowledge, comprehension, application, analysis, synthesis, and evaluation.
2. **Affective domain.** Outcomes related to interests, attitudes, appreciation, values; includes categories of receiving, responding, valuing, organization, and characterization by values.
3. **Psychomotor domain.** Motor skills; includes categories ranging from simple to complex motor skills (i.e., performance skills).

In this structured approach to developing objectives, the learning objectives are hierarchically organized from simple to complex. Gronlund and Brookhard (2009) point out that the level of complexity does not necessarily mean the level of difficulty and that higher-level learning outcomes can be achieved by learners at different age levels and with varying educational backgrounds.

**General definitions.** The following are definitions of important terms related to developing objectives:

- **Course description.** A brief overview of the content in the educational program.
- **Goal.** A general statement of purpose or intent.
- **Objective.** A specific statement of the desired outcome by the learner that is descriptive and measurable.
- **Behavioral verb.** Denotes a measurable action by the learner.

**Developing measurable objectives.** Measurable learning objectives are written by carefully selecting a verb that matches the domain of learning and the level of complexity desired in the outcome. When writing objectives, avoid using verbs such as *understand, realize, know, appreciate, is aware of,* and *comprehend*, that identify achievements that are difficult to measure. Instead, use verbs that can measure behavior or performance. Table 5.1 includes a sample of
verbs that can be used to identify objectives for different levels of learning within the categories of knowledge, application, comprehension, and analysis (Wound, Ostomy and Continence Nurses Society [WOCN], 2005). The following 3 questions developed by Mager (1962) will help test the objectives, and if the answer is yes to all 3 questions, the learners will know exactly what is expected of them:

1. Does the objective describe what the learner will do to demonstrate achievement of the objective?
2. Does the objective describe the conditions under which the learner will demonstrate achievement of the objective?
3. Does the objective indicate how the learner’s achievement will be evaluated? Does it describe at least the minimum acceptable performance?

Table 5.1. Sample: Verbs for Writing Educational Objectives

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<th>Application</th>
<th>Comprehension</th>
<th>Analysis</th>
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<td>Apply</td>
<td>Associate</td>
<td>Analyze</td>
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Guidelines: Seminar and Conference Planning and Development

Planning for educational offerings and programs involves several steps, which includes identifying the need for the education, determining the goal based on the need, developing a brief description of the course, and developing an educational plan that includes the learning objectives, content, teaching methods, and evaluation methods.

The following example demonstrates program planning and development of a sample educational plan for a basic ostomy care class.
1. Program planning and development:
   a. Identify the need: Several nursing supervisors have indicated that they have new nursing personnel who have not had experience in caring for patients with ostomies.
   b. Determine the goal: Assist new nursing personnel in providing quality care for the patients with ostomies on their units.
   c. Develop a course description: Two 1-hour classes (parts I and II) will be developed to provide the following instruction about basic ostomy care:
      - Review of causative factors that may necessitate ostomy surgery.
      - Review the different types of ostomies.
      - Discuss the criteria for a well-constructed stoma.
      - Discuss postoperative care of ostomies.
      - Demonstrate techniques for care of the skin and pouching system.
      - Discuss colostomy irrigation.
      - Explore the psychological needs of patients with ostomies.
      - Discuss discharge planning needs and resources.

2. Develop the educational plan:
   - Based on consideration of the need, goal, and course description, develop an educational plan to include the specific measurable learning objectives, content, teaching methods, and evaluation methods. The components of the plan should be congruent so that the content, objectives, and evaluations are clearly related.
   - Table 5.2 provides an overview of a sample educational plan for providing a basic ostomy care class.

Table 5.2. Sample Educational Plan for Basic Ostomy Care

<table>
<thead>
<tr>
<th>Learner Objectives</th>
<th>Content (Topics)</th>
<th>Teaching Method</th>
<th>Time</th>
<th>Evaluation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I.A.</td>
<td>I.A. Overview of ostomy</td>
<td>Lecture Slides</td>
<td>10 min</td>
<td>Posttest: List 5 reasons why patients have ostomy surgery</td>
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<tr>
<td></td>
<td>Prevalence and incidence</td>
<td>Discussion</td>
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<td></td>
<td>Common factors leading to ostomy surgery</td>
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<td></td>
<td>o Cancer</td>
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<td></td>
<td>o Trauma</td>
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<td></td>
<td>o Inflammatory diseases</td>
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<tr>
<td></td>
<td>o Infectious disease; other</td>
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<tr>
<td>Part I.B.</td>
<td>I.B. Anatomy and physiology of ostomy</td>
<td>Lecture Slides</td>
<td>20 min</td>
<td>Posttest: List 3 types of ostomies and the type of effluent expected from each</td>
</tr>
<tr>
<td></td>
<td>Types of common ostomies and the type of effluent expected: structure/function</td>
<td>Discussion</td>
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<tr>
<td></td>
<td>o Colostomy</td>
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<td></td>
<td>o Urostomy</td>
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<tr>
<td></td>
<td>o Ileostomy</td>
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</tr>
<tr>
<td>Learner Objectives</td>
<td>Content (Topics)</td>
<td>Teaching Method</td>
<td>Time</td>
<td>Evaluation Method</td>
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<tr>
<td>Part I.C. Participate will list 3 characteristics of healthy stomas.</td>
<td>I.C. characteristics of healthy stomas  - Red, round, and budded  - Signs of stomal complications to report</td>
<td>Lecture Slides Discussion</td>
<td>10 min</td>
<td>Posttest: List 3 criteria of a good, healthy stoma</td>
</tr>
<tr>
<td>Part I.D. Participants will demonstrate proper application of a 2-piece, drainable ostomy pouching system.</td>
<td>I.D. Postoperative care and management: Care of the pouching system.  - Types of pouches: 1-piece, 2-piece; drainable, nondrainable  - Criteria for selecting a pouching system for the patient  - Technique to apply a 2-piece, drainable pouching system: Measuring/sizing; peristomal skin care; application of skin barrier flange; attachment of the pouch and pouch clamp; use of support tape/belts, if needed.  - Recommended frequency for changing skin barrier flange and pouch</td>
<td>Lecture Slides Discussion Video</td>
<td>20 minutes</td>
<td>Skills Demonstration: Demonstration of the application of a 2-piece drainable, pouching system in a simulated experience</td>
</tr>
<tr>
<td>Part II.A. Demonstrate proper emptying, rinsing, and deodorizing of the pouching system.</td>
<td>II.A. Routine Care.  - Technique for emptying, rinsing, and deodorizing the pouch  - Frequency to empty pouch  - Procedure to rinse pouch  - Types of pouch deodorants and how to use</td>
<td>Lecture Slides Review handouts Video</td>
<td>10 min</td>
<td>Skills Demonstration: Demonstration of how to empty, rinse, and deodorize the pouching system in a simulated experience</td>
</tr>
<tr>
<td>Part II.B. Participant will identify indications for a colostomy irrigation.</td>
<td>II.B. Colostomy irrigation  - Purpose/indications  - Contraindications  - Patient assessment  - Type of ostomy suitable for management with irrigation</td>
<td>Lecture Slides Review handouts</td>
<td>10 min</td>
<td>Posttest: Name the type of ostomy that can be regulated with irrigation</td>
</tr>
<tr>
<td>Learner Objectives</td>
<td>Content (Topics)</td>
<td>Teaching Method</td>
<td>Time</td>
<td>Evaluation Method</td>
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<tr>
<td>Part II.C. Participant will demonstrate the proper colostomy irrigation technique, using a cone-tip irrigator.</td>
<td>II.C. Colostomy irrigation guideline  • Supplies/equipment  • Irrigation procedure with cone-tip irrigator/advantage of using a cone-tip  • Complications</td>
<td>Lecture Slides Discussion Video</td>
<td>20 min</td>
<td>Skills Demonstration: Demonstration of a colostomy irrigation using a cone-tip irrigator in a simulated experience</td>
</tr>
<tr>
<td>II.D. Participant will discuss effective methods of dealing with possible emotional responses related to ostomy surgery.</td>
<td>II.D. Possible psychological implications of ostomy surgery  • Body image  • Social isolation  • Sexual issues  • Work/recreation concerns</td>
<td>Lecture Slides Discussion</td>
<td>10 min</td>
<td>Posttest: Describe 3 possible emotional responses related to ostomy surgery and how you would meet them</td>
</tr>
<tr>
<td>II.E. Participant will discuss discharge information needed by ostomy patients including the United Ostomy Associations of America information, supplies, diet, resumption of activities, and return appointment.</td>
<td>II.E. Discharge planning, resources and instructions:  • Resources: United Ostomy Associations of America  • Supplies needed  • Source of supplies  • Diet  • Resumption of activities  • Return appointment</td>
<td>Lecture Slides Discussion Review handouts</td>
<td>10 min</td>
<td>Posttest: Describe needed resources and discharge instructions for the ostomy patient</td>
</tr>
</tbody>
</table>

Appendix P provides a suggested conference planning timeline for developing an annual seminar or conference. Appendix Q provides sample forms that may assist in conference planning: sample conference budget planning form, application for exhibit space, exhibitor evaluation form, and conference evaluation form.

**Developing Resource Teams**

Across the care continuum, the health care industry is focused on efficient delivery of quality care. Often this means that utilization of the WOC nurse is better accomplished when a WOC nurse is a member of a resource team rather than the primary (or sole) provider of expert WOC care. As a key contributor to a resource team, a WOC nurse may:

- Identify other resource team members.
- Assess educational needs of the team.
- Provide necessary, ongoing education for the team.

Some examples of collaborative projects addressed by resource teams include the following:
- Creation of a wound product formulary.
- Identification of systemwide multidisciplinary policies and procedures.
- Role clarification of members of the resource team.
- Consensus regarding treatment protocols based on principles of wound healing.
- Policy development regarding a basic vascular examination and subsequent treatment of lower-extremity ulcers.
- Establishment of a communication pathway between departments and the medical staff.

The document *Role of the Wound, Ostomy Continence Nurse or Continence Care Nurse in Continence Care* (WOCN Society, 2009) is provided in Appendix R as an example and guide for defining a role for the WOC nurse on a resource team.

### References


Chapter 6: Leader/Manager Role

In addition to demonstrating strong clinical skills, establishing a successful WOC nursing practice requires that the nurse utilize business skills to market and manage the practice. This chapter addresses how to market professional services, introduces how to develop a proposal, provides suggestions for data collection, outcomes reporting, and establishing quality improvement programs, presents a few tips on organizing and conducting a meeting, and offers suggestions for maintaining a positive work atmosphere and attitude.

Marketing Professional Services

Health care in the United States is charged with containing cost, improving quality, and expanding access to high-quality care (Institute of Medicine [IOM], 2001; Owens, Qaseem, Chou, & Shekelle, 2011). The nursing profession has an opportunity to help transform the health care system to address these issues as a result of the passage of the Affordable Care Act in 2010, and the Robert Wood Johnson Foundation’s initiative on the Future of Nursing (Hinkle, Sullivan, Villanueva, & Hickey, 2012; IOM, 2011; Robert Wood Johnson Foundation, 2012; Tomajan, 2012; Wilson, Whitaker, & Whitford, 2012).

Nurses have a long history of contributing to patient welfare by providing quality care in a cost-effective manner, but these contributions remain largely invisible to the public and policy makers (Mass, 1998; Tomajan, 2012). It is, therefore, critical that nurses identify and demonstrate the effectiveness of nursing interventions to improve patient care outcomes (Ellerbe & Regen, 2012; Mass, 1998; Needleman, Kurtzman, & Kizer, 2007; Tomajan, 2012; Wilson, Kane, & Falkenstein, 2008).

Marketing the WOC nursing specialty has the potential to effect changes in “…public and institutional policies at the national, state, and local levels” (IOM, 2011, p. S–2). WOC nurses can provide leadership within an organization to guide the delivery of care by providing straightforward advice to decision makers. However, to serve in leadership roles that positively impact patient care, WOC nurses must inform others about their experience, educational preparation, and clinical expertise and explain the value and benefits of WOC nursing services. Recently, the American Nurses Association (2010) provided formal recognition of WOC nursing as a specialty practice for the delivery of expert care to persons with wounds, ostomies and continence conditions. Marketing is a way to educate employers and the public about the WOC nursing specialty and what it has to offer.

What Is “Marketing”?  

The American Association of Marketing defines marketing as “the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational objectives” (Bennett, 1995). The consumer and their satisfaction are key elements in marketing. The consumer may be an individual patient, physician, or organization (Berkowitz, 2011).

Five Steps in Successful Marketing

The following 5 steps may be used as a guide to help design a comprehensive marketing plan. Prior to marketing the services of a WOC nursing specialty practice, it is important to gather information and identify the “customers,” define the “product” or service (eg, price, place),
determine/develop marketing strategies, develop and present a marketing plan, and continually reevaluate and revise the marketing plan.

**Step 1: Identify the customers and gather information.** A decision about which customers to target is a key consideration when planning the marketing strategy. Using a mix of strategies, you can target everyone, a single market segment, or multiple market segments. Market segmentation is a way of grouping customers with similar needs into clusters to provide tailored marketing strategies to meet their needs (Berkowitz, 2011).

**Market segmentation.** A market can be described as a group of prospective customers that has unmet wants and/or needs. According to Berkowitz (2011), markets may be segmented in 1 or more of the following ways:

- **Sociodemographic.** Identify the common characteristics of the potential markets (clients). Age, gender, and ethnicity of individuals are pertinent factors to consider in health care environments. The target market of individuals could be segmented by age, diagnosis, income, or insurance coverage. Facilities could be segmented according to frequency of ostomy surgeries, prevalence or incidence of pressure ulcers, the number of surgeons/colorectal surgeons on staff, the number of beds or visits, length of patient stays per admission, average costs, equipment and supply usage, etc. For example, health care facilities that have a colorectal surgeon on staff might represent a certain segment of the market.

- **Geographic.** Where are the potential markets (clients) located? A target market could be the general population in a city or cities, counties, townships, states, or divisions of each. The market could be segmented to include health care facilities in cities within 100 miles, or it could be as small as the facility where the WOC nurse currently works.

- **Psychographic.** What are the common behaviors of the prospective clients? For instance, what do they know about the type of service WOC nurses provide (ie, wound, ostomy, and/or continence nursing)?, what is their attitude toward the service (eg, too costly, not effective, high quality)?, how do the prospects use the service (eg, often, seldom, by contract, by consult)?, and what benefits are they seeking (eg, lower cost, higher quality, shorter length of stay)? For example, facilities that are familiar with WOC nurses and believe it is a cost-effective service could prove to be a lucrative segment.

- **Usage.** Grouping people based on needs or usage of a particular product or service is another way to segment the market. In this approach, the marketing strategy is directly related to the use of the product and needs of the group. When considering the extent and use of a service by a particular group, it is important to also assess customer loyalty and identify what services or benefits the members in the group want or need but are not currently receiving (ie, gaps in service or underserved segments of the group).

**Determine the target markets.** The specific target markets are those segments of the entire market that have been identified as needing or wanting a particular service. They can range from the entire market (ie, anyone needing or wanting the service), to a portion (eg, health care facilities in a given city), or to a very small segment (eg, a single hospital). After determining the target market, decide what type of services will be offered to which segment. The following 3 categories help break the marketing of services into manageable components:

- **Undifferentiated.** Market one type of service to all market segments. For example, design one wound care protocol and market it to all types of health care facilities.

- **Differentiated.** Offer different types of the same service to many segments of the market. For example, several different wound care protocols can be designed to meet the specific needs of a market segment (eg, acute care, home care).
• **Concentrated.** Provide a specific service to a single market segment. For example, specialize in providing wound care in the home setting.

*Get to know your customers.* After conducting a thorough market analysis and pinpointing your market segment, you can begin to identify the customers who would benefit most from your services. This can be accomplished through phone surveys, interviews, networking, and personal experience. Getting answers from prospects to the following questions can help determine how to obtain the best position in the marketplace:

- What do your prospects hope to gain from the type of service(s) you are offering?
- How often do they need the service?
- What is most important to them when considering this type of service (eg, cost, quality, timeliness)?
- How are they getting the service now?
- Do they know your service exists?
- What are they willing to pay?
- Who makes the decision to use the service?
- How would they like to receive the service (eg, employee, contract, consult)?

*Identify and analyze your competitors.* Competition is a normal part of marketing. When beginners develop a marketing plan and strategy, they often overlook the competition. Also, competitors are not always as recognizable as most inexperienced marketers might think. They can come in any of the following forms:

- **Desire competitors.** The consumer has identified a need and has any number of choices to make that will lead to the purchase of a product or service in order to meet the need. For example, a home care agency wants to start a continence clinic. The managers could train current staff, hire a consultant to set up the clinic, or hire a master’s prepared nurse to set up and run the clinic. In this scenario, that the organization’s managers decide the master’s prepared nurse is the best idea.

- **Generic competitors.** Now the question for the home care managers is: What type of master’s prepared nurse should we hire? They could choose a nurse educator, a nurse administrator, a nurse practitioner, or a clinical nurse specialist (CNS). For the purpose of this scenario, suppose that they choose a CNS.

- **Product competitors.** Once the organization decides what the need is, they then determine the hours and employment status required to fulfill the role. For example, the organization could choose a full-time or part-time employee or contract with the CNS. For this scenario, the organization decides to hire a full-time CNS to set up and run the clinic.

- **Brand competitors.** Finally, the managers must choose which type of CNS they want. They might choose a clinical specialist in medical-surgical, OB/GYN, or continence disorders. In this case, the organization chooses a CNS specializing in continence disorders.

As described earlier, there are many different competitors to consider. To assess your competition, there are a few simple questions you can ask yourself:

- How many competitors do I have? Keep in mind that there are different types of competitors, not just other WOC nurses.
- Is this number increasing or decreasing?
- Who are my principal competitors?
- Is competition based on price, quality, service, or experience?
- Where does the competition appear to be heading?
• Were my competitors first in the market?
• Do my competitors have a specialty niche?

Conduct a SWOT (strengths, weaknesses, opportunities, and threats) analysis. Once you have analyzed the market and clearly understand where and how to best position yourself, you should identify your major SWOT. A SWOT analysis will help you define what you will need to address in your marketing plan (Pearce, 2007):

• **Strengths and weaknesses.** This is an internal analysis of your business’s strong and weak points. What do you have to offer that is new, different, or in a better form than your competitors? Are you certified to train others? What areas need development? Where can you improve?

• **Opportunities and threats.** This refers to outside factors that impact your service product. What opportunities are present in the current market? Is there an open niche you can fill? Is there an area that you could be first on the scene? Are customers asking for a new or different service? Are there new facilities moving into the area? On the other hand, consider what might be threats to your success such as a lack of data about outcomes or knowledge of the costs of services; or having other competitors in the area, such as in the following examples:
  o Case-managed companies are requesting information about valid outcomes and you do not have that data.
  o A major hospital in the area is negotiating for services and is basing its choice on a price/cost comparison.
  o Several physical therapists have moved into your area, and they are opening a wound clinic.

The results of the SWOT analysis should be prioritized and can serve as a guideline for identifying the issues that you will address in the completed marketing plan. For instance, developing outcomes, deciding how to compete with the new physical therapy group, or determining whether you are able to be the first to offer a wound care protocol, all might be issues that you should address.

Conducting market research. The market research process can be simple or quite technical and complex. The most important thing at the outset is to be clear about what information you seek and what questions you want answered. To benefit from the results, be sure to keep an open mind. If you need help deciding what research techniques will be most effective in getting the information needed that is within your budget and time lines, ask for advice and use available resources (Stern, 2001). There are several options available to you for conducting marketing research as described in the following examples:

1. **Options for gathering market research information:**
   a. Ask around. It is not the most scientific method, but sometimes a few well-placed telephone calls or interviews can set you on the right track. You may choose to take what you learn at face value or test the feedback with a wider audience.
   b. Look close to home. If your questions have to do with customer satisfaction, you can learn from the people you already know:
      • Regularly invite your customers or participants to recommend/suggest ways you can improve.
      • Follow up with people who show initial interest in your programs or services but do not follow through.
• Conduct exit interviews with people who discontinued your services or severed their relationship with you.
• Ask others who work with you for their observations.

c. Check with known data collectors. There are many organizations that collect and report on varied kinds of data. These organizations include the following:
  • The United Way.
  • The Census Bureau.
  • Research centers and institutes.
  • Universities.
  • Research departments of advertising agencies.
  • Many government agencies.

d. Conduct surveys. Written, telephone, and in-person surveys can provide information about your customers’ opinions and attitudes. For a survey to produce reliable information, however, it must be well-designed. There are many commercial research firms. Check your Yellow Pages and references for assistance in designing or conducting a survey. Also, input and assistance are often available at no charge from the following sources:
  • Advertising and public relations agencies.
  • Business administration graduate students.
  • Corporate marketing departments.
  • Government agencies.

e. Hold focus groups. A representative sample of a target audience (ie, 10-12 people) is brought together to participate in a discussion. Generally, these sessions last no longer than 1 hour. The session is designed to generate responses to a predetermined set of important questions and is facilitated by an outsider or a staff member not intimately involved in the subject. The format is carefully structured to elicit straightforward impressions, reactions, and opinions.
  • Information obtained in focus groups include the following:
    o What the customer values and why.
    o Specific barriers to “buying” your service.
    o Ideas for changes to remove barriers.
    o Product marketing ideas.
    o How to speak in the language of your audience, which can sometimes provide exact wording for promotional messages.
  • Drawbacks to focus group research:
    o The relatively small number of people included and the wholly subjective approach.
    o Focus groups lack the statistical reliability of larger samples. They may tell you quite a bit about what your customers want, but reveal nothing about size of the market.
  • Advantages of focus groups:
    o The major attraction of focus group research is that it puts you directly in touch with your customers in a way that allows the subtleties in their thoughts to be heard and you can establish a face-to-face relationship.
Focus groups are neither time-consuming nor costly. Facilitation of services is quite easily obtained free of charge from students in graduate communication programs or as pro bono contributions from advertising agencies and corporations. Even when you hire a professional, a modest focus group program is relatively affordable.

2. **Side benefits of market research:**
   a. There are additional benefits to market research. Surveying the community is an opportunity to engage people in a positive way and build relationships. Most people enjoy expressing their opinions and will think well of you for asking.
   b. It also may add to their interest or enthusiasm for your product or service.

3. **Tips to maximize the opportunities associated with market research:**
   a. Be well-prepared, gracious, and professional.
   b. Make the ultimate findings of the research available to all participants, and follow up on any individual questions or concerns.
   c. Provide additional opportunities, when appropriate, for research participants to be involved.
   d. Be sure to give research participants the opportunity to buy the product or use the service when it becomes available.
   e. Thank and acknowledge research participants directly and, when warranted, publicly recognize their contributions (ie, if consistent with confidentiality agreements) through newsletters, annual reports, or announcements to your board and staff.

**Step 2: Define the product or service, price, and place.** WOC nursing is a trispecialty practice, which is multifaceted and evidence-based. WOC nurses provide preventive care, health maintenance, therapeutic interventions, and rehabilitation for persons with disorders of the gastrointestinal, genitourinary, and integumentary systems. *The Wound, Ostomy and Continence Nursing Scope & Standards of Practice* (Wound, Ostomy and Continence Nurses Society [WOCN], 2010) is an excellent resource when defining and describing the role and practice of WOC nurses.

**Clinical proficiencies.** Table 6.1 lists common clinical proficiencies of WOC nurses that can be used to describe and promote your services. You may add other areas of expertise that are unique to your practice.

<table>
<thead>
<tr>
<th>Wound</th>
<th>Ostomy</th>
<th>Continence</th>
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<tbody>
<tr>
<td>Debridement</td>
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<td>Bowel training</td>
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<td>Chemical cauterization</td>
<td>Complex prosthetic fitting</td>
<td>Intermittent/self-catheterization</td>
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<tr>
<td>Complex fistula/tube care</td>
<td>Pre- and postoperative management and education</td>
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<td>Product selection</td>
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<tr>
<td>Topical treatments</td>
<td>Dietary counseling</td>
<td>Behavioral training</td>
</tr>
<tr>
<td>Nutritional assessment</td>
<td>Vocational counseling</td>
<td>Complex skin care</td>
</tr>
</tbody>
</table>
Benefits of WOC nursing. Use the benefits of WOC nursing to promote and position your services. Table 6.2 provides a list of benefits that WOC nurses can offer to clients that are common to all settings. Add other benefits unique to your practice. Compare your service line portfolio with the benefits in the table to design a customized package of your services for individual customers.

Table 6.2. Benefits of WOC Nursing (WOCN Society, 2005)

<table>
<thead>
<tr>
<th>Reduced Costs</th>
<th>Increased Revenue</th>
<th>Compliance With Regulations</th>
<th>Improved Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply management</td>
<td>Facilitation of reimbursement</td>
<td>Improved documentation</td>
<td>Consistent positive outcomes</td>
</tr>
<tr>
<td>Risk management</td>
<td>New revenue-producing programs</td>
<td>Staff education</td>
<td>Continuity across settings</td>
</tr>
<tr>
<td>Increased staff productivity</td>
<td>Potential for contracting services</td>
<td>Meet quality assurance/continuous quality improvement</td>
<td>Patient/family satisfaction</td>
</tr>
<tr>
<td>Reduced recidivism</td>
<td>Keeping client in system</td>
<td>standards</td>
<td>Coordinated patient/family education</td>
</tr>
<tr>
<td>Prevention of complications</td>
<td>Marketing advantage/competitive edge</td>
<td>Established protocol</td>
<td></td>
</tr>
</tbody>
</table>

Develop a service portfolio. A service portfolio is an important part of an effective marketing plan. The portfolio should include a full description of the product and services and the charges for the services.

1. What is the primary product? This is not always clear when marketing a service. The 2 obvious choices are the service itself (eg, wound care) or the provider of the service (eg, the nurse). If the nurse is well known, respected, and sought after, then the nurse is the primary product and the service is secondary. Most often, it is the service that the customer is seeking to purchase, and the nurse is perceived as the vehicle (ie, secondary) for providing the service. This does not imply that the nurse is not important in the overall product or critical to the customer’s final decision. Without the service, it is unlikely that the nurse will be retained.

2. How is the product defined or described? The clearest way to define your service product is to analyze its components. Not all customers will want everything you have to offer, nor will all competitors offer the same portfolio of services. In addition, it is frequently necessary, when marketing services, to customize them to individual clients. Categorizing individual aspects or components of the service makes customization easier. Finally, services, unlike tangible products, cannot be seen, touched, or examined. A well-defined service portfolio makes it easier for you to clearly present the specific service(s) to your customer.

Position the service product. Positioning is not what you actually do to a service product; it is what you do to the mind of the customer (Berkowitz, 2011). In other words, you must develop strategies to position the product in the customer’s mind. Strategies that are especially pertinent to WOC nursing services are as follows (Reis & Trout, 1993):

1. The law of leadership. It is better to be the first in the customer’s mind. If you can be the first provider of services that the customer has experience with, it is much easier to market and maintain the account. That does not mean that you were actually the first provider on the scene; it means that you were the first one in the customer’s mind. For
example, Kleenex was not the very first tissue on the market, but it was certainly the one that positioned itself in the minds of consumers.

2. *The law of category.* If you cannot be first in one category, set up a new category in which you can be first. If someone else is already providing wound care services and is well established in customers’ minds, then develop a new service category. For example, be the first to offer in-services to the staff, the first to have wound protocols, or the first to offer the service on a contractual basis instead of as an employee. Your service categories are limited only by your imagination and ingenuity.

3. *The law of exclusivity.* Two competitors cannot own the same word in the customer’s mind. The word might be “quality,” “cost savings,” or “premier,” to name a few. You must decide what concept you want to position in the customer’s mind for your service. A fatal error is when you use a competitor’s word and try to position your service as the same—but better. If you have no competitors, so much the better; pick your word and run with it.

4. *The law of success.* As you experience success with a service product, the tendency is to want to expand and do more, to capitalize on the success. For instance, if the ostomy and wound care services are doing very well, you might want to expand into continence care. Perhaps your staff in-services are sought after and very successful, so why not go on the lecture circuit? Although these strategies may prove to be successful, they also can be a road to failure. Using the past success of one service product to launch another frequently ends in disaster. If you want to expand into a new area, you should treat it as a new service product, not an extension of the old one. Go back to step 1 and work through the entire process. The position that the new service takes in the customer’s mind may be entirely different from the old successful service.

5. *The law of failure.* Some degree of failure is expected and accepted. Whether you are an experienced marketer or a novice, you are going to make mistakes. The secret to turning failure into success is to know when you have made a mistake, admit it, and move on. It is terminal to continue to try to fix something rather than to admit it just did not work and then try a new approach. Whatever position you choose to take in the customer’s mind, be prepared to explain what the benefits (Table 6.2) of using your services will be for the customer.

*Determine the price for your services.* This is often where many nurses have difficulty and fall short in completing their marketing strategies. Money and professional services seem to be at opposite ends of the ethical spectrum. However, if you do not pay attention to appropriate pricing strategies, the entire service can fail. If the term price is not palatable, other terms such as fee, rate, retainer, or charge can be used. Even in a setting where a fee is not charged for the service (eg, in an acute care setting), it is still necessary for the WOC nurse to know the cost of the service. In reality, setting a price can be relatively simple by following these steps:

1. *Determine the cost of the service.* The cost of providing a service sets the floor of the price that you can charge. Determining the cost is crucial to long-term success. If terms such as fixed and variable costs, overhead, depreciation, and capital expenditures confuse you, this is the time to get assistance from an accountant.

2. *Determine the demand for the service.* If the demand for a service is high, you can charge more than if the demand is low. Take care, though, not to overprice at this point. Overpricing makes it much easier for a competitor to enter the market and be first in the
customer’s mind as the “reasonably priced” provider. On the other hand, underpricing can indicate to the customer that the service is not high-quality or worthwhile.

3. **Find out what the competition is charging.** If there is competition in the area, determine what they are charging. This should serve only as a guide in determining your fee structure. Do not think that your fee has to be identical or even less than a competitor’s. If you have developed a good marketing strategy for positioning your service in the customer’s mind, you can then develop a fee structure for your uniquely positioned service. If there is no competition, it is still wise to evaluate what others are charging for similar services. Examples might be other nursing services, other professional therapies, home visits, outpatient visits, and hourly rates of other professional services.

4. **Set a pricing objective.** Being the lowest priced service is not always the correct strategy to use. You have to decide what objective you are trying to achieve and what position you have chosen in the customer’s mind. If “quality” is your word, a very low price would be counterproductive to that concept. However, if “cost savings” is your word, a very high price would be contraindicated. Determining the fees for your services is a balancing act between demand and competition while still maintaining the position that you have chosen.

**Step 3: Determine and Develop Marketing Strategies.** After information has been gathered about the customers and the target market, specific marketing strategies must be developed. There are multiple marketing approaches that might be appropriate.

**Design a promotion strategy.** Deciding what promotional tools you will use can be difficult and confusing. Rubright and MacDonald (1981) suggested that promotional tools should have certain characteristics and they should:

- Reflect marketing objectives and strategies.
- Be written for specific target markets.
- Reflect or suggest the service’s benefits.
- Persuade or inform.
- Be concisely written and edited.
- Request or suggest specific action or participation by the customer.

**Learn to negotiate for success.** It is helpful when preparing to sell professional services to think of it as negotiating rather than selling. If you consider negotiating a form of selling, then it is important to prepare yourself to be a good negotiator before you set out to sell your services. Leo Reilly of KCR Communications (Reilly, 2004) identified several rules for negotiating. The fundamental principles are as follows:

1. **Be prepared and organized.** Gather information about the company and/or the person that you will be meeting. Use the premeeting information to develop specific questions to ask in the face-to-face meeting. Get to know the person’s needs, perceptions, and motivations. Never start the meeting with what you can do or what you have to offer until you know more about what the prospect wants or needs. In other words, “Be patient.” The goal at an initial meeting is to test your assumptions, fine tune your information, and send up a few trial balloons. Find out what your prospective client would like most out of the service(s) you are offering. For instance, when do they need the service? Who is the person who will make the final decision? What would their response be to this or that approach? The virtue of patience in this situation will lead to better control of the negotiations and more satisfying and beneficial agreements.
2. Have a strategy for success. When the time comes to begin discussions about the actual provisions of the contract for service, whether it is a contract for employment or consulting, a few final rules will help make the negotiations successful. Never enter into negotiations without knowing your bottom line. What is the most you can offer and what is the least compensation that you are able to accept? If at all possible, get the client to discuss what they are seeking and what they are willing to pay for services. Even more important, ask the client to give you this information first.

3. Know your opening offer beforehand. It goes without saying, never open with your bottom line. The opening offer should be realistic, clear, and concise. Surprisingly, many clients will accept a fair opening offer when it is sincerely presented. Never try to open with outrageous or unfair offers. This will only decrease your credibility and might bring the negotiations to an abrupt close.

4. Follow up. Always follow up with the client after each meeting. If you promised to send information, find an answer, or call back in 2 days; be certain to do just that and do it promptly. This is frequently overlooked so that when you do what you promised, the client will be pleasantly surprised! Negotiation is a learned skill. By following these few simple but powerful rules, your next attempt at negotiating a mutually beneficial agreement is more likely to meet with a successful outcome.

Select promotional techniques. A variety of promotional techniques are at your disposal. Television, radio, newspaper, magazines, outdoor advertising, direct marketing, and Internet advertising are a variety of media from which to choose (Berkowitz, 2011). Choosing the right mix depends on many factors such as knowing who you are targeting, what the message is that you are trying to convey, and how much money you are willing to invest. The following list outlines some of the more popular promotional methods (Stern, 2001):

1. Advertising. Advertising can work well for special events but is generally not considered effective in small quantities (eg, one local TV spot). Conducting a focused advertising campaign requires thorough investigation and budgeting. Some newspapers and magazines make free space available; most TV and radio stations provide free time. Classified advertisements are a more affordable print advertising option in certain cases. Inserting flyers in community newspapers can help you reach a broad audience.

2. Annual reports. Annual reports can be effective promotional tools if you take a smart marketing approach. Annual reports can take the place of a brochure, especially if your organization changes a lot from year to year. Be sure to pay close attention to image, innovative approaches, and distribution channels.

3. Billboards. Billboards are an excellent way to mix your promotional media. Invest in a good design and use no more than 8 words. Individual companies can provide information regarding rates and availability.

4. Brochures. If writing and graphic design are not your areas of expertise, consider using professional services. Pay close attention to image and message. Keep distribution channels in mind. You may find that flyers, fact sheets, or other options may be more beneficial.

5. Celebrity endorsements. These types of endorsements can be fun and worthwhile. Although celebrity endorsements are a great attention-getter, they seldom “make the sale” in and of themselves.

6. Direct mail. Direct mail can be an expensive strategy and has wide variances in effectiveness. If you are considering using this extensively, take a 1-day seminar to learn
the details. It is really a science. Two tips: (1) It works best once someone already
knows who you are and has expressed some interest in you. (2) Good use of mailing lists
is essential. Note: You can rent or buy mailing lists; keep them updated if you maintain
your own.

7. **Direct sales.** Direct sales are one of the best promotional techniques; however, this
strategy can be very labor intensive. It is most applicable when a “personal touch” is
used. Essential ingredients for a successful direct sales approach are a clear message,
good presentation skills, a thorough understanding of the sales process, persistence, and
the time to really develop relationships.

8. **Editorials.** Newspaper editors are remarkably accessible and will consider well-thought-
out, well-documented points of view. Make a phone call first and be prepared to send
information right away if you receive a positive response. Editorials offer high visibility,
they are an excellent positioning tool for your service, and they add to your credibility
and are a real contribution to public debate on important issues.

9. **Electronic media.** Electronic marketing provides an avenue to reach a variety of care
settings and locations. This realm includes e-mails, faxes, Web pages, social media, and
online education. Costs vary and may include telephone lines, Internet access, and a
computer. Consultative advice may be required. Be sure you understand the Federal
Communications Commission rules concerning the use of these media. The Federal
Communications Commission’s “Do Not Call” list has sparked a flurry of restrictions on
the use of “blast” e-mails and broadcast faxes.

10. **Social media.** Social media or social networking sites (SNS) such as Facebook, Twitter,
LinkedIn, YouTube, and others are an innovative and inexpensive, if not free, way to
reach a host of consumers. Facebook alone publicizes a membership of more than 500
million and LinkedIn reports more than 100 million. Professionals and consumers alike
are using social media sites for networking, obtaining clinical information, and locating
needed/desired services (Prinz, 2011). Most hospitals and professional organizations
have some type of SNS. Accurate data for the exact numbers of social media users are
not available, but it is safe to assume that a large portion of most targeted groups use
some type of SNS (Boyd & Ellison, 2011).

   • Consumers today want and look for information to assist them in choosing
     services that meet their health care needs. Social media sites are an inexpensive
     and effective way to reach these consumers. Frequently, consumers use the
     Internet to seek information or to verify the validity or usefulness of a health-
     related service. Cone Communications (2011), a public relations and marketing
     company, reports 40% of survey respondents research a new product or service
     online prior to making a purchase.

   • Setting up a social media outlet for your service(s) can be as simple or as detailed
     as you choose. Hiring a professional information management service can be
     beneficial if a more complex system meets your strategic goals. Time spent
     maintaining the site depends on the type of site you desire and its complexity.
     Social media sites can help meet your strategic goals without adding significant
costs.

   • It is important to set limits on the information posted or provided on social media
sites. Unintentional violations of the Health Insurance Portability and
Accountability Act of 1996 can easily occur from comments/postings made
by yourself, staff, or others on your Web site. New laws have been established in almost every state regarding the use of social media and patient information. It is NEVER advisable to post health care advice due to legal restrictions and liability.

11. **Feature stories.** Reporters are always looking for timely, unique, interesting, or new stories. They like a fresh angle, are not afraid to say no, and may put you off repeatedly for months and then suddenly—on a deadline—want to talk to you at 1 AM. Do not say anything to a reporter that you would not want to hear on the news or read in print tomorrow morning. Think through how to take advantage of this tool for maximum effect. Be prepared for a high-volume, short-lived response.

12. **Letters to the editor.** Timely, well-thought-out, well-written letters to the editor are often published. If you have a strong opinion or if your position is being attacked, undermined, or misrepresented by others, consider expressing your point of view. As with feature coverage, think through how to take advantage of this tool for maximum effect.

13. **Networking.** Who you know can mean everything in terms of access. Ask board members and friends to introduce you, host meetings, and otherwise convey your message to the people whom you want to hear it. People respond best to initial contacts from people they know.

14. **News conferences.** Press conferences should be held only for something very big, controversial, or out of the ordinary. If there is anything you can do to make it visually interesting, it will help extend coverage. Be sure to prepare your message carefully.

15. **News releases.** Press releases can be used for announcements and often will be run if you can get them to the right person in time. It helps develop contacts and know the deadlines of your local newspaper. Check any basic public or media relations textbook for the appropriate professional format. These can be used to announce classes, workshops, conferences, special events, awards, staff acquisitions, or other events or activities that are newsworthy. Costs are limited to paper, envelopes, and stamps or electronic media.

16. **Newsletters.** Well-written newsletters can produce loyal readers and a good response. Publish the newsletter on a regular schedule. Many people scan only newsletters, so use lots of pictures, headlines, subheadlines, pullout quotes, and white space.

17. **Posters.** As with billboards, posters are a great way to mix media. Remember that location is critical and pay close attention to image. A secondary benefit to attractive posters is their staying power. If suitable for framing, they can be around for years.

18. **Public speaking.** Public speaking is a good positioning tool and a great way to mix media. Handouts reinforce your message. Coaching or training may enhance your public speaking skills. Initially, you could consider speaking locally at places such as civic groups, churches, or synagogues to gain experience.

19. **Publishing articles and reports.** Publishing is an excellent positioning tool that is also sometimes a real opportunity to influence professional practice and public policy. When writing for publication, be sure to understand the audience and gear the article accordingly. Self-published reports should have crisp executive summaries, appear readable, and use a good marketing approach.

20. **Radio public service announcements.** This is an excellent way to mix media and costs you nothing but paper, envelopes, and stamps. Again, check a basic public relations text for the correct professional format. Most stations accept only written copy. Provide 30,
15, and 10 seconds worth of copy. There is often a 2-week lag time before the announcement is aired.

21. **Special events.** A good way to renew or maintain personal contacts on a large scale is to plan a special event. When planning, decide the type and purpose of the event, and then coordinate the elements. The invitation is a promotional tool.

22. **Talk shows.** Radio and network and cable television offer many opportunities for everything from offbeat opinions, to live public service announcements, and to serious discussion. Call and ask to talk to the producer of the show for which you have an interest. Think through your sales pitch—why this person should have you on his or her show. Write down ahead of time the 3 things you absolutely want to be sure to say and then, no matter what you are asked, find a way to say them. Depending on the popularity of the show, you can get a significant response (Stern, 2001).

**Step 4: Develop and present the marketing plan.** A marketing plan is a summation of the work and information that was collected in steps 1 to 3. Regardless of the setting or type of practice, a marketing plan should be written. Your marketing plan can be presented to administrators and used to obtain financial backing. The following are components of a marketing plan:

1. **Executive summary.** A brief overview of the marketing plan should explain the reason for the plan, list the major findings of your research, and conclude with recommendations.
2. **Background information.** If you have completed step 1, you should have all the necessary data to write an effective summary of all the work you have done. It should show you have conducted a thorough analysis of the market and that your program will respond to market needs. This section should include an analysis of your target market’s characteristics, your competition, and a summary of your SWOT analysis. A summary of your service product (step 2) also should be included in the background section of your marketing plan.
3. **Objectives and goals.** The objectives and goals section should be a well-prepared report of your operational goals and how you intend to reach them. This is not a “wish list,” but a precise accounting of what you hope to gain from your marketing efforts. What are the intended outcomes of your hard work?
4. **Marketing strategies.** This section, based on the work you did in step 3, should describe the actual strategies that will be implemented, including a rationale for each strategy and the procedures necessary for carrying it out. In other words, how will these outcomes be achieved?
5. **Budget.** The budget is based on goals, objectives, and strategies. The budget should include direct and indirect costs, general and administrative costs, miscellaneous expenses, and estimated revenue from the project or program. Pricing strategy should also be included.
6. **Controls.** This section of your marketing plan should describe the system of controls that have been developed to ensure that the goals and objectives are being met (ie, the process for evaluation and revision as outlined in step 5 later).

**Step 5: Continually reevaluate and revise the marketing plan.** Marketing evaluation is not a single process. There are many things that should be considered when evaluating if your plan is on track and how to revise it. There are 4 distinguishable types of evaluation:
1. **Plan evaluation.** This examines whether the planned results are being achieved. Was service provided to the intended number of patients? Were new client contract goals met? Are clients, patients, customers all responding to the service as planned? The types of data that need to be collected during the year should be based on the objectives. The plan evaluation can then easily be completed quarterly, semiannually, and/or annually.

2. **Profitability evaluation.** This examines where money is being made and lost. Were revenues and profits as projected? Was the cost, length of stay, use of supplies, etc, within projections? What services are the most profitable? Which are the least profitable? Why?

3. **Efficiency evaluation.** This evaluates the efficiency and effect of marketing expenditures. What marketing strategies produced the most profitable response? What strategies did not produce the expected outcome?

4. **Strategic evaluation.** This examines whether the best opportunities are being pursued with respect to target markets, services, and promotion strategies. A periodic review of steps 1 to 4 is necessary to recheck your plan.

   *Revise the plan as needed.* Marketing is a continual process. Developing a plan and expecting it to last forever is a sure road to failure. Marketing efforts must change with changes in the market, changes in your service, and changes in customer demand. Revision of the plan must keep up through continual, well-planned evaluation and revisions.

### Proposal Development

A proposal may be necessary to convince an administrator that additional WOC nurses or support staff is needed to establish an outpatient clinic, support program, or to independently persuade a health care provider to purchase your services. A proposal is best approached from the perspective of trying to encourage another person (or group) to do something. A convincing argument requires clear communication of the following information:

- The current situation.
- The proposal’s credibility relative to the situation.
- The benefits to the customer(s).
- An action plan.
- The resources that are needed.
- A budget.
- An evaluation process.

The proposal should be succinct—5 pages or less because lengthy proposals might not be read. Package the proposal to be aesthetically appealing. By taking the time to complete a well-thought-out proposal, administrators and business professionals will have a clear understanding related to the clinical services and financial implications of the proposal. For more detailed information on developing a proposal, see the WOCN Business Plan Template Workbook in Appendix S.

### Data Collection/Outcomes Reporting

Data collection is an essential component of any successful professional practice. For collected data to be useful, there has to be an understanding of its relevance to outcomes and a perspective on how the data will be analyzed and interpreted. For example, assume that the number of clinic patients seen in a year is reported to be 575. Until this number is compared to the previous 2
years’ clinic census of 300 and 427, respectively, the data are meaningless. These numbers become even more meaningful when converted to statistics and percentages.

Therefore, data collection should be purposeful and outcome oriented. It is no longer valid to attempt to justify a position on volume alone. For example, recording the number (ie, volume) of “specialty beds” that were denied, as a measure of cost savings, is valid only if those patients who did not use the beds did not develop pressure ulcers. The volume must somehow affect an outcome that reflects organizational goals, revenue, or quality. The following are examples of how to use data:

- Identify the number and type of patients.
- Document the number and types of visits or patient interactions.
- Identify trends.
- Justify current and/or new positions.
- Determine staff utilization patterns.
- Profile specific activities and scope of practice.
- Evaluate use of time.
- Demonstrate cost-effectiveness.
- Conduct quality assurance activities.
- Monitor patient follow-up.
- Track referrals and/or monitor utilization of resources.

**Basic concepts for generating monthly reports.** Categorize commonly performed tasks or procedures, and keep a daily record of procedures in each category. Also, keep a record of “nonclinical” procedures and tasks/responsibilities. This information can then be used to generate grafts and charts for a monthly report. Keeping daily records offers a key advantage because it minimizes the time required to generate accurate monthly reports that can be used to track activities and demonstrate key areas of service. Determine who will compile the final departmental data reports (ie, is secretarial support available?). Key components of a daily/monthly report include the following:

- A recording sheet (ie, Excel spreadsheet) that facilitates “tracking” of various activities with a minimal expenditure of time.
- A list of standard/commonly performed procedures and tasks with definitions and the average amount of time or relative value of the units required to complete the various tasks.
- The daily/monthly report form should be organized to reflect the time and/or number of each major encounter and/or procedure.
- The amount of time spent on nonclinical activities and an accounting of what specific nonclinical activities were included.

Commercial data collection tools and generic forms for record keeping are available. The WOCN Society (http://www.wocn.org) has developed templates for WOC nurses to record/collect productivity data in home health care (WOCN Society, n.d.-a) and acute care (WOCN Society, n.d.-b). The sample productivity templates (ie, Excel spreadsheets) are forms that can be used and adapted to record information about the type of clinical services provided (ie, number/type of patients/problems, services/care provided) and other relevant, nonclinical activities.
Continuous Quality Improvement/Total Quality Management Programs

An important aspect of the WOC nurse’s managerial role is the establishment of a continuous quality improvement (CQI) program to measure and document the impact of the WOC nurse’s activities on patient outcomes, staff knowledge and skills, and the organization’s goals. In establishing a quality improvement program, it is usually helpful to collaborate with the CQI/Total Quality Management department in your organization.

**Goals of CQI.** The primary goal for any CQI program/initiative is to objectively assess the selected quality indicators for your practice and to utilize the data to initiate quality improvement. The CQI goals of the WOC nurse’s practice/department should be consistent and compatible with expectations for other departments. A suggested target goal for CQI initiatives would be 2 to 4 studies per year.

**Guidelines.** A CQI initiative does not have to be complicated or time-consuming. Simple studies can provide valuable data and insights. Potential CQI studies relevant to WOC nursing practice include retrospective and prospective studies whenever a major new program or quality improvement project is initiated (eg, pressure ulcer prevalence and incidence study).

**General tips.** In selecting CQI projects, revisit your organizational and departmental goals and objectives for the year, as well as clinical practice areas that are high volume or high priority. The organization’s CQI team can be a valuable resource for designing and implementing a program. Continuous quality improvement initiatives are an important part of marketing and role justification programs.

Organizing and Conducting a Meeting

In today’s health care environment, meetings have become an essential part of nursing practice for the leader/manager. Meetings are held for a variety of reasons, including coordinating the efforts of individuals, collaborating on projects, gaining support for ideas, solving problems collectively, and making consensus-based decisions.

Planning and conducting a successful meeting is an important part of the role of a WOC nurse manager/leader. Skills for planning and conducting a successful meeting are acquired with practice. One of the most important aspects of conducting a successful meeting is to prepare, prepare, and then prepare again! Time is a valuable commodity, and a poorly planned meeting is a waste of everyone’s time.

**Meeting purpose.** When planning a meeting, first determine the purpose for the meeting. What is the reason the meeting is being held? Determine the objectives for the meeting (Hadler, 2006; Rebori, n.d.):

- Why is the meeting being scheduled?
- What are the goals of the meeting?
- What decisions need to be made?
- What information will be shared?
- Who will be attending?

**Meeting agenda.** A specific agenda should be developed and distributed to the participants of the meeting no less than 3 days prior to the meeting. The agenda will clarify the purpose of the meeting. By distributing the agenda prior to the meeting, it allows the participants time to prepare so they can effectively participate in the meeting. The agenda will also allow for
focus and direction during the meeting. See Table 6.3 for a sample meeting agenda. There are many styles of agendas. Effective agendas commonly contain the following elements:

- Title (e.g., evaluation review meeting).
- Time (e.g., 8-10 AM) and date.
- Location.
- Discussion items with the names of persons responsible for covering each item.

Table 6.3. Sample Meeting Agenda (WOCN Society, 2005)

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Topic</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Call to order</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Roll call</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Approval of minutes</td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td>Reports of officers and committee chairs</td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td>Unfinished business</td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td>New business</td>
<td></td>
</tr>
<tr>
<td>G.</td>
<td>Announcements</td>
<td></td>
</tr>
<tr>
<td>H.</td>
<td>Adjournment</td>
<td></td>
</tr>
</tbody>
</table>

Tips for conducting a meeting. Running an effective meeting is equally difficult and important. There are several factors that should be taken into consideration when planning and conducting meetings. Table 6.4 provides a summary of key considerations and tips to help run an effective meeting (Hadler, 2006; Rebori, n.d.):

Table 6.4. Key Considerations and Tips for Conducting a Meeting (WOCN Society, 2005)

<table>
<thead>
<tr>
<th>I. Location of the meeting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Room size and arrangement</td>
<td></td>
</tr>
<tr>
<td>B. Temperature of room</td>
<td></td>
</tr>
<tr>
<td>C. Acoustics</td>
<td></td>
</tr>
<tr>
<td>D. Audiovisual equipment</td>
<td></td>
</tr>
<tr>
<td>E. Lighting</td>
<td></td>
</tr>
<tr>
<td>F. Comfortable chairs and tables</td>
<td></td>
</tr>
<tr>
<td>G. Drinking water/glasses on tables</td>
<td></td>
</tr>
<tr>
<td>II. Meeting time</td>
<td></td>
</tr>
<tr>
<td>A. Convenient to members’ work schedules</td>
<td></td>
</tr>
<tr>
<td>B. Takes into consideration amount of travel required</td>
<td></td>
</tr>
<tr>
<td>III. Presiding at the meeting</td>
<td></td>
</tr>
<tr>
<td>A. Start and finish on time</td>
<td></td>
</tr>
<tr>
<td>B. Establish and use ground rules (i.e., utilize parliamentary procedure)</td>
<td></td>
</tr>
<tr>
<td>C. Follow the agenda</td>
<td></td>
</tr>
<tr>
<td>IV. General guidelines</td>
<td></td>
</tr>
<tr>
<td>A. Stay focused and keep meeting moving</td>
<td></td>
</tr>
<tr>
<td>B. Solicit participation</td>
<td></td>
</tr>
<tr>
<td>C. Chair remains neutral to issues</td>
<td></td>
</tr>
</tbody>
</table>
D. Recommend further study if unable to arrive at a decision
   1. Appoint an ad hoc committee
   2. Appoint a task force
   3. Set goals and objectives
   4. Set deadlines

E. Control dominating individuals

F. Allow a break after 2 hours of meeting

G. Solicit feedback/further comments at the end of meeting

H. Summarize and plan for the next meeting

Parliamentary procedure. Parliamentary procedure may be necessary in certain meeting situations. Formal groups and organizations should determine the rules of order for conducting meetings. In formal organizations, bylaws might specify the rules for conducting meetings or specify that they have adopted a parliamentary authority such as Robert’s Rules of Order, which was first published in 1876 and since has been published in various revised editions. The object of using parliamentary procedure is to assist the assembly in accomplishing—in the best possible manner—the work for which it was designed. Under no circumstances should concern for parliamentary correctness be permitted to impose undue artificiality on a business meeting. A full discussion of parliamentary procedure is beyond the scope of this document and the reader is encouraged to seek other sources for questions about parliamentary procedure. Rulesonline.com contains a full copy of the fourth edition of Robert’s Rules of Order Revised (n.d.), which is available at http://www.rulesonline.com.

Atmosphere and Attitude

As a leader and manager, it is important to determine what type work atmosphere and attitude you want to convey in your practice and relationships with others. Using a parable inspired by the positive attitudes of workers in the Pike Place Fish Market in Seattle, Washington, Lundin, Paul, and Christensen (2000) offer ways to boost morale in the workplace and improve results. The basic tenets of their philosophy are as follows (Camilli, 2003):

1. Choose your attitude. Each day you have an opportunity to choose your own attitude. Who do you want to be while you do your work?
2. Play. Having fun is energizing. No matter where you work, you can still have moments of play and create more energy! Happy people treat others well.
3. Make their day. Engage with your customers; create energy and goodwill. Who are your customers and how can you make their day?
4. Be present. Be focused on both your customers and your coworkers. Take moments to be attentive.

References


Chapter 7: WOC Nurse’s Role in Evidence-Based Practice and Research

Evidence-based care with definable outcomes is the expectation of 21st-century health care consumers. Health care consumers and providers, including agencies such as the Centers for Medicare & Medicaid Services and the health care insurance industry, expect care to be delivered based on the best available research and evidence. Many agencies and groups utilize and publish evidence-based clinical practice guidelines, including the WOCN Society. WOC nurses use all types of research and evidence to influence the quality of patient care that is provided while practicing in the full scope of WOC specialty nursing (ie, direct care, education, research, consultation, and administration). This chapter provides an overview of evidence-based care/practice, discusses the components of evidence-based practice (EBP), describes the process for searching for evidence and how to critically appraise and critique research, discusses how to apply evidence, briefly discusses the role of the WOC nurse in research, and presents information about evidence-based resources available to the WOC nurse.

Development of Evidence-Based Care

There are many roles that a WOC nurse can play in research and EBP, which include the following:

- Consumer and developer of evidence-based guidelines and standards of care.
- Investigator in a scientific research trial.
- Evaluator of products.

The WOC specialty nurse can contribute to the development of evidence-based care in many ways without assuming the role (or responsibility) of a primary investigator such as by participating in the following activities:

- Surveys or polls.
- Clinical trials or product evaluations (see section on product evaluation).
- Data collection for pressure ulcer prevalence and incidence studies or continuous quality improvement projects/studies that relate to WOC care, or foot and nail care.
- Data collection for generation of institutional, regional, or national databases that capture descriptive data, such as the following:
  - The number of visits required for preoperative and postoperative management of the new ostomy patient.
  - The number of visits/cost of supplies necessary to ensure venous ulcer healing in home care patients.
  - Quality outcomes when managing urinary or fecal incontinence via behavioral interventions.
- Poster presentations (eg, case studies, practice innovation, research).

Evidence-Based Practice

Evidence-based practice is the deliberate use of current best evidence in decision making about patient care. Evidence-based practice is a problem-solving approach that answers key clinical questions that guide patient care. By developing and using evidence for making decisions, patient care is enhanced and satisfaction of the WOC nurse is expanded (Melnyk & Fineout-Overholt, 2010). The components of EBP include the following:
• A systematic search and appraisal of evidence to answer the clinical question(s).
• Integration of the expertise and experience of the WOC nurse.
• Consideration of the patient’s preference, values, and concerns.

Evidence-based practice is different from research utilization in that it incorporates the WOC nurse’s experience and the patient’s preferences, values, and concerns (Melnyk & Fine-Overholt, 2010; Polit & Beck, 2008). “Evidence-based practice requires good nursing judgment; it is not finding research evidence and blindly applying it” (Perry & Potter, 2010, p. 3). Although there are many models and theories about the effective use of EBP in nursing and health care, each model or theory incorporates the critical steps essential to EBP (Melnyk & Fine-Overholt, 2010; Perry & Potter, 2010):

1. Formulate the compelling clinical question.
2. Search the literature for the best available, relevant evidence.
3. Critically appraise the evidence.
4. Apply the results to clinical practice or the patient situation.
5. Evaluate the outcomes.

When searching for evidence, it is essential to ask a question that will allow you to find information in a timely fashion. Without a well-formulated question, a search for evidence may lead to an overwhelming amount of information that does not address the clinical question at hand. To search for evidence about a clinical question in the scientific literature, it is suggested to use a PICOT format to state the question (Fineout-Overholt & Stillwell, 2010; Perry & Potter, 2010; Stillwell, Fineout-Overholt, Melnyk, & Williamson, 2010). There are online and print resources that provide education on how to develop PICOT questions such as the article on EBP by Stillwell and colleagues (2010). PICOT is the acronym for the following:

• Patient population of interest.
• Intervention of interest.
• Comparison of interest.
• Outcome of interest.
• Time.

**Reviewing the Literature**

After a problem has been identified and the PICOT question(s) formulated, it is necessary to review the literature for supporting evidence. The WOC nurse must be able to perform a literature search, accurately interpret and synthesize the findings, and then implement these findings into clinical practice. The purpose of the literature review will determine the extent of the literature search required. A WOC nurse in a clinical setting would most commonly complete a literature review to support an evidence-based project such as development of policies and procedures, development of standards of care, or application of research into practice in response to a clinical problem (Wound, Ostomy and Continence Nurses Society [WOCN], 2010).

In a research setting, the WOC nurse would complete an extensive literature review for a research report, proposal, thesis, dissertation, or for a systematic review for development of practice guidelines (Polit & Beck, 2008). The following discussion focuses on performing a basic literature review for an EBP problem or research report. Additional information about conducting literature searches for developing research proposals and writing grants for research funding has been developed by the Center for Clinical Investigation (CCI) of the WOCN Society Foundation and is available at http://www.wocn.org under the Foundation link for research and funding. Additional information about grant writing is available in Chapter 8 and in the sample WOCN Society Member’s Research Grant Proposal (Appendix T).
A current systematic review of high quality might be all that is needed to support an evidence-based change in practice to improve patient care, such as a meta-analysis of existing randomized controlled trials (RCTs) about a relevant topic from the Cochrane Collaboration (http://www.cochrane.org). It is also wise to look for recent studies that were published after the systematic review was completed to further support a practice change.

Systematic reviews of current literature might also be found in white papers, best practice documents, and clinical practice guidelines. A thorough review of several nursing databases will help determine if the guideline or best practice document has reviewed the existing body of knowledge related to the clinical question. It is important to note that clinical practice guidelines are based on systematic literature reviews, with the intent to influence clinical decision making to solve practice problems. Guidelines are generally developed when there are gaps in knowledge, so information in the systematic review may vary in the quality of the evidence.

A basic research report or review is an overview of the published evidence with 2 purposes: to provide an overview of current evidence about a problem and to prepare an argument regarding the need for new research (Polit & Beck, 2008). The individual providing the literature review should demonstrate comprehensive knowledge of the topic and/or problem through a well-documented critical appraisal of the research. A review for a research report should be 2 to 4 pages to provide an overview of the body of evidence.

**Searching for evidence.** When looking for evidence, the strongest scientific evidence is derived from the synthesis and analysis of multiple RCTs. In EBP, weaker evidence is derived from quasi-experimental studies (eg, uncontrolled clinical studies, time series studies), nonexperimental research (eg, descriptive studies such as clinical series, case studies, retrospective chart reviews, observational studies), and published expert opinion. One of the controversies surrounding EBP is determining what evidence is best to support practice. Some advocate using evidence only from RCTs (ie, experimental study designs). Others propose that nurses apply all sources of evidence related to their practice area to develop, implement, and evaluate nursing practice (Waite & Killian, 2008), because using only RCT evidence restricts information about many areas of practice vital to WOC nursing. The WOCN Society (2011) considers multiple levels of evidence in developing clinical practice guidelines and rates research evidence (ie, level I to level VI), according to the criteria provided in Table 7.1.

<table>
<thead>
<tr>
<th>Table. 7.1. Level and Criteria for Rating Research Evidence</th>
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<tbody>
<tr>
<td>Level</td>
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<tr>
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</tr>
<tr>
<td><strong>Level I</strong></td>
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<tr>
<td><strong>Level II</strong></td>
</tr>
<tr>
<td><strong>Level III</strong></td>
</tr>
<tr>
<td><strong>Level IV</strong></td>
</tr>
<tr>
<td><strong>Level V</strong></td>
</tr>
<tr>
<td><strong>Level VI</strong></td>
</tr>
</tbody>
</table>
Choosing databases. Choosing the correct database to obtain information to answer the clinical question is essential. Well-known health care scientific and medical databases are MEDLINE, PubMed, and CINAHL:

- MEDLINE is the National Library of Medicine’s premier database. This can be accessed for free through PubMed.
- PubMed is a free database accessing citations from MEDLINE, life sciences journals, and other online books. It is maintained by the US National Library of Medicine at the National Institutes of Health.
- CINAHL is the Cumulative Index to Nursing & Allied Health Literature. This database is nursing focused and is a membership benefit of the American Nurses Association. It also may be accessed through university libraries and is a good place to start searching for professional nursing standards.

These databases are representative of the scientific knowledge base for health care, medicine, and nursing, but no one database contains all the information of interest to the WOC nurse. There are hundreds of databases available today, many of which are highly specialized (Fineout-Overholt, Berryman, Hofstetter, & Scollenberger, 2010). Therefore, multiple databases should be used for exhaustive literature reviews. A list of Web sites for evidence-based resources is provided in Appendix U.

Critical appraisal. After the literature has been reviewed and the available evidence has been compiled, it is necessary to critique the evidence in a systematic manner. Critical appraisal is a “…systematic process used to identify the strengths and weaknesses of a research article in order to assess the usefulness and validity of research findings” (Young & Solomon, 2009, p. 82). There are several principles of critical appraisal that apply to all types of study designs and various checklists or guidelines are available to assist in the process (Callihan, 2008; Young & Solomon, 2009).

Table 7.2 includes a sample guide that can be used to critically appraise and synthesize individual or multiple research studies (WOCN Society, 2005, pp. 78–79). The guide to performing a research critique is divided into 2 major sections: Title/Abstract and Full Report. You should complete the Title/Abstract section first and then critique the Full Report only if the Title/Abstract section indicates there is adequate value in the report to proceed with a more detailed analysis and synthesis.

<table>
<thead>
<tr>
<th>Table 7.2. Guide to Critique Research</th>
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<tbody>
<tr>
<td><strong>Section</strong></td>
</tr>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Abstract</td>
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<td></td>
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</table>

*Note that these two criteria (4 and 5) do not ask you to agree or disagree with the results or conclusions of the researchers. Instead, the abstract and title should be clear, concise, understandable, and (most important of all) relevant to WOC nursing practice.
<table>
<thead>
<tr>
<th>Section</th>
<th>Criteria</th>
<th>Responses</th>
<th>Comments</th>
</tr>
</thead>
</table>
|                                | Proceed with a critique of the full research report only when the abstract meets the following standard:  
|                               | • You respond yes to all 5 of the criteria, or  
<p>|                               | • You respond yes to numbers 2, 4, and 5                                                                                                                                                                   |           |          |
| Full report critique          | Having decided that this report is worth a more detailed critique, your analysis should now shift from “yes vs no” to the strength of the evidence provided by this study and its potential impact on your practice. The following questions will lead you to the answers to these essential issues. |           |          |
| Research problem              | What clinical problem does this study purport to address?                                                                                                                                                   |           |          |
|                               | What specific research questions or aims are to be answered by the study?                                                                                                                                   |           |          |
| Review of the literature      | Remember that the sole purpose of the literature review is to briefly summarize previous research related to this study.                                                                                      |           |          |
|                               | What are the major 1-3 points summarized in the literature review?                                                                                                                                           |           |          |
|                               | Do the investigators (authors) omit any critical studies in your opinion?                                                                                                                                     | Yes       | No       |
|                               | Does the literature review provide a current synthesis of evidence related to the problem?                                                                                                                   | Yes       | No       |
|                               | Does the literature review cite mainly primary sources?                                                                                                                                                     | Yes       | No       |
| Study methods                 | Who were the subjects (patients) for this study?                                                                                                                                                           |           |          |
|                               | What was the setting for the study?                                                                                                                                                                         |           |          |
|                               | Was the sample size adequate?                                                                                                                                                                              | Yes       | No       |
|                               | Was a power analysis used to determine the sample size needed?                                                                                                                                             | Yes       | No       |
|                               | Are the participants and the setting similar to my patient population and my setting?                                                                                                                      | Yes       | No       |
|                               | Does the research design minimize bias and threats to validity?                                                                                                                                             | Yes       | No       |
| Instruments                   | Instruments are defined as all the equipment used to measure outcomes of the study. They include forms filled out by the patient, nurse, or physician; machines used to measure physiologic parameters such as wound size; and qualitative assessments such as severity of pain or infection in a wound. |           |          |
|                               | What instruments did the researchers use to measure the study outcomes?                                                                                                                                       |           |          |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Criteria</th>
<th>Responses</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Do the investigators provide evidence that their instruments are reliable and valid?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Are you persuaded that the instruments are sufficiently reliable and valid to produce reproducible and accurate results?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td><em>The results section summarizes the outcomes of the researcher’s investigation. Spend time understanding the results as presented. This is the most important section of any research report, but its relevance is sometimes lost because of intimidating tables, figures, and statistical findings. The following questions will allow you to answer basic questions; more experienced research reviewers will focus on statistical analysis.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are the research questions, aims, or hypotheses answered in this section?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Are the results statistically significant?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Does the author describe limitations to the study design?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Are the results clinically relevant to WOC nursing practice?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Did the researchers select the best statistical analysis to answer each research question or aim?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Discussion and conclusion</strong></td>
<td><em>This section should project the relevance of the data reported in the results section. It must not reach beyond the data reported in the results section.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does the discussion focus on the clinically relevant findings of the study?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Do the authors provide implications for further research?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Are the implications for further research clinically relevant?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>What 1-3 “bottom-line” conclusions does this study confirm, challenge, or disprove?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do the authors conclude that an intervention is effective or safe or both?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Remember that safety and efficacy can only be concluded in the context of a randomized clinical trial that is adequately powered and well-designed. A case study or clinical series never proves or disproves safety or efficacy.*
Strength of the evidence. As part of the critical appraisal process, it is necessary to be able to discern the level and quality of the evidence. There is no “gold standard” instrument for critical appraisal (Young & Solomon, 2009). Table 7.1 provided the levels and criteria for rating research evidence utilized by the WOCN Society in developing clinical practice guidelines. To classify the strength of the evidence for the recommendations in the clinical practice guidelines, the Society uses 3 levels (ie, level A, B, or C). Table 7.3 includes the level of evidence ratings used for WOCN Society’s guideline recommendations (WOCN Society, 2011, Appendix E, p. 7).

Table 7.3. Level of Evidence Rating for Strength of the Guideline Recommendations

<table>
<thead>
<tr>
<th>Level of Evidence Rating</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level A</td>
<td>Two or more supporting RCTs of at least 10 humans with the condition under consideration (at level I or II), meta-analysis of RCTs, or Cochrane systematic review of RCTs.</td>
</tr>
<tr>
<td>Level B</td>
<td>One or more supporting controlled trials of at least 10 humans with the condition under consideration or 2 or more supporting nonrandomized trials of at least 10 humans with the condition under consideration (at level III).</td>
</tr>
<tr>
<td>Level C</td>
<td>Two supporting case series of at least 10 humans with the condition under consideration or published, expert opinion.</td>
</tr>
</tbody>
</table>

Applying the evidence. After the WOC nurse has gathered and appraised all the available evidence to answer the PICOT question, the evidence can be applied to clinical practice. There are various models such as the Stetler model (Romp & Kiehl, 2009; Stetler, 2001) and the Iowa model (Titler et al., 2001) to guide the application of evidence into clinical practice (Ciliska et al., 2010). The WOC nurse should choose a model that fits the practice and philosophy of the institution where the practice change will occur. A full exploration of models of EBP and research utilization is beyond the scope of this chapter, and the reader is encouraged to explore the Web sites for EBP resources in Appendix U for more information about this topic.

Product Evaluation

WOC nurses are recognized for their expertise in clinical matters and their knowledge about product selection for patients with WOC needs. Therefore, they may be offered opportunities to participate in product evaluations. Product evaluations are objective evaluations of products that are approved by the US Food and Drug Administration. The purpose of a product evaluation is to obtain objective data to use for deciding which products should be stocked and used in a particular care setting. Indications for conducting a product evaluation include when the product is to be evaluated:

- Has the potential to meet an unmet clinical need (eg, a skin barrier paste that is resistant to urine).
- Offers a significant clinical advantage over the product currently in use (eg, a new silicone-based contact foam has an increased absorptive capacity, has secure adhesion without taping the edges, is atraumatic upon removal, and leaves no dressing residue).
- Offers a significant cost advantage over the product currently in use (eg, a new mattress replacement system has the same therapeutic features as a specialty bed, but at one-third of the cost).
There are also situations in which a product evaluation is not necessary and it would be appropriate for the WOC nurse to decline to conduct an evaluation such as in the following circumstances:

- When the product to be evaluated is not relevant to the WOC nurse’s patient population (e.g., a compression therapy wrap in a nonambulatory care setting where 95% of the wounds are pressure ulcers on the trunk).
- When the product to be evaluated offers no significant therapeutic or cost advantage compared to the product currently in stock (e.g., caregivers and patients are satisfied with the current product line and the competitive product offers similar features at a similar cost, but without any additional significant advantages).

**Role of WOC nurses in product evaluation.** WOC nurses serve as clinical resources for value-driven purchasing and often serve on clinical product evaluation teams. Just identifying good resources to incorporate into practice is not enough in today’s health care climate. Clinical knowledge about the product (e.g., cost, ease of use, outcomes) must also be applied as part of the product evaluation process.

Risks, benefits, and possible contraindications for use of the products must be considered before pilot trials can begin. Each facility may have specific policies in place for implementing product evaluations. A manufacturer/vendor may assist or facilitate education related to their products and the criteria for the product’s use with oversight from the WOC nurse or other designated team members. Professional team members involved in product evaluations should complete an annual disclosure or conflict-of-interest statement to ensure nonbiased evaluations and avoid conflicts.

**A guide for product evaluation.** Prior to conducting a product evaluation, the WOC nurse should consult the organization’s value analysis or purchasing department about the appropriate process/procedures to follow for conducting the evaluation and for obtaining “no charge” products. The following are general guidelines for conducting a product evaluation:

- Select the appropriate unit(s) or patient population(s): For example, when evaluating moisture barrier incontinence cloths, the most appropriate setting would probably be a critical care unit or an extended care unit.
- Establish clear, objective criteria to be used for the evaluation: Create a simple 1-page form (Figure 7.1) for data collection with structured responses that minimize the time required for completion of the form. The facility may have generic or electronic evaluation forms, which can be customized for the evaluation.
- Conduct in-services about the products with nursing and any other departments that will be involved in the evaluation. Include the purpose of the evaluation and the roles and responsibilities of staff for data collection, if applicable. Be sure to include those who may be impacted by the product outside of clinical care (e.g., housekeeping, family members, or maintenance).
- Compile data on a representative number of patients who would benefit from the product being evaluated. Note: Patient permission is not necessarily required for comparative evaluation of the US Food and Drug Administration–approved products. Consult with the facility’s administration and institutional review board for any questions about obtaining patients’ permission.
- Provide a written summary of the results and make recommendations for integration of the findings into nursing clinical practice. Include the clinical observations throughout the trial, discussions with care providers, and the data that were gathered.
- Communicate the trial’s outcomes and recommendations to the staff and companies whose products were studied.

**Figure 7.1. Sample Product Evaluation Form: Evaluation of a 3-in-1 Incontinence Cleansing Cloth**

<table>
<thead>
<tr>
<th>Product Being Evaluated: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Data</strong></td>
</tr>
<tr>
<td>Age: ______  Sex: [ ] M [ ] F</td>
</tr>
<tr>
<td>Diagnosis: __________________________</td>
</tr>
<tr>
<td><strong>Type of Continence:</strong> Fecal Urinary Both</td>
</tr>
<tr>
<td><strong>Average incontinent episodes per day:</strong></td>
</tr>
<tr>
<td>[ ] 1–2  [ ] 3–5  [ ] More than 5</td>
</tr>
<tr>
<td><strong>Data Regarding Product Use:</strong></td>
</tr>
<tr>
<td>On a scale of 1 to 5, with 5 being the best, rate the 3-in-1 cloth’s characteristics:</td>
</tr>
<tr>
<td>Emulsifies stool and ointment/facilitates cleansing: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Deodorizes: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Ease of application: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Degree of skin protection: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Patient comfort: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Would the use of this product benefit patient care? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>Are there any contraindications for using this product? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>Are there any patient populations where this product could not be used? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>If No, where? __________________________</td>
</tr>
<tr>
<td>Overall Rating on Scale of 1 to 5 (5 being best): [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Comments: ____________________________________________</td>
</tr>
</tbody>
</table>

**WOC Nurse Researcher**

In addition to *synthesizing* research findings into EBP and education, the WOC nurse has a responsibility to contribute to the research base through participation in the investigational process whenever feasible. Research is frequently perceived as “impossible” for the average nurse due to the complexity of the process, and limited time and resources. However, roles and opportunities for WOC nurses in research are rapidly growing in health care, academia, and industry settings. The focus of WOC nurse researchers is on advancing the art and science of WOC nursing care (WOCN Society, 2010). Before proceeding with any research endeavor, it is essential to review the institution’s policy for conducting research and obtaining informed consent from research participants, and submit the proposal to the institutional review board for approval.
As experts committed to lifelong learning, it is important for WOC nurses to share and improve the current knowledge base in all practice settings. Dissemination of research findings can occur through publication or presentation in a variety of media or formats such as professional journals, poster presentations, Web-based education, or bedside clinical education.

**Research and EBP Resources for the WOC Nurse**

There are a variety of evidence-based resources provided by the WOCN Society and its CCI of the WOCN Society Foundation that are available online and can be accessed on the WOCN Web site (http://www.wocn.org) in the Member Library (http://www.wocn.org/MemberLibrary), WOCN Bookstore (http://www.wocn.org/Bookstore), and under the Foundation, Research & Funding section of the WOCN Web site (http://www.wocn.org/ResearchFunding). Some of the resources to support EBP and research by WOC nurses include the following:

- Spotlight on Research section in each publication of the *Journal of Wound, Ostomy and Continence Nursing (JWOCN)*.
- WOCN Foundation Small Grant Program: Annually, offers research funding to a member of the WOCN Society. The CCI administers the grant and provides mentorship and assistance with designing proposals (http://www.wocn.org/ResearchFunding).
- Electronic Database Links to aid in exploring current evidence for practice (Appendix U).
- Regular publication of research studies in the *JWOCN*: Print and online access to *JWOCN* is a benefit to WOCN Society members.
- WOCN Society evidence-based clinical practice guidelines, best practice documents, etc. (see Table 7.4).

**Table 7.4. WOCN Society Publications and Documents to Support Research and Evidence-Based Practice by the WOC Nurse**

<table>
<thead>
<tr>
<th>Product</th>
<th>Description</th>
<th>Type of Evidence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Best Practice Documents</td>
<td>Describes best practices used to address a variety of clinically relevant problems.</td>
<td>Based primarily on expert opinion or nonexperimental research. Content validation is completed to ensure that the content reflects consensus among a national panel of clinical experts.</td>
<td>Developed by WOCN Society committees or task forces.</td>
</tr>
<tr>
<td>Clinical Practice Guidelines</td>
<td>Addresses prevalent and clinically relevant areas of clinical practice using a systematic literature review and a qualitative assessment of the strength of the evidence.</td>
<td>Randomized clinical trials and quasi-experimental studies (excludes expert opinion and single case studies).</td>
<td>Developed by WOCN Society committees or task forces.</td>
</tr>
<tr>
<td>Evidence-Based Report Cards</td>
<td>Highly focused questions are addressed using a systematic literature review and a qualitative assessment of the strength of the evidence.</td>
<td>Randomized clinical trials and quasi-experimental studies (excludes expert opinion and single case studies).</td>
<td>Developed by the <em>JWOCN</em> editor and published in the <em>JWOCN</em>.</td>
</tr>
</tbody>
</table>
The Wound, Ostomy and Continence Nursing Certification Board, in collaboration with the *JWOCN*, publishes an annual EBP literature review supplement that provides a valuable research update and quick reference for busy WOC nurses. The supplement provides a synopsis of current research and trends relevant to WOC nursing, foot care, advanced practice, and advancements in industry and technology. The synopsis includes a brief statement about the clinical practice implications of the study’s findings (ie, what does this mean to me and my practice?). The reviews also serve as valuable resources for identifying areas where further research or technologic advancements are needed (Wound, Ostomy and Continence Nursing Certification Board, 2011). Other collaborative or professional resources available to support research and EBPs include but are not limited to the following:

- Schools of nursing.
- Other professionals within your health care team.
- University or college librarians.
- Organizational research committees.
- Research collaboration with colleagues.
- Other professional organizations.
- Journal or research groups (ie, groups of clinicians who meet to share, discuss, and critique research).
- Sigma Theta Tau.

**References**


Chapter 8: Grant Writing

This chapter provides basic information that is integral to successful grant writing. On first glance, the grant-writing process may seem daunting. However, grants can be successfully completed by novices who follow an organized process and develop an understanding of the basic principles for writing grants (Karsh & Fox, 2009). The ability to write clearly, concisely, and directly is essential to success in writing grants. Of equal importance is the ability to speak knowledgeably and confidently about content that is relevant to a particular grant topic of interest (Johnson, 2011).

What Is a Grant?

A grant is money given to an individual or a nonprofit organization which does not have to be repaid, as long as the terms of agreement for the grant are followed. There are a variety of ways to apply for a grant. The most common avenue is by submitting a proposal or request for funding. Organizations are often required to have a federal nonprofit status, known as 501(c) 3, per the Internal Revenue code, to be eligible for grants (Karsh & Fox, 2009).

The most important caveat in grant writing is to apply only for funds that the individual or organization is qualified to receive that corresponds with the goals of the grant-funding organization. Many falsely believe if they write an excellent grant or can demonstrate the worthiness of their project to the funder, it will not matter if the project does not meet the goals of the funding organization. A better way to view the process is to realize that funders seek applicants whose projects match their mission. When the mission of a funder matches the mission of the project, the result is a symbiotic relationship that benefits both entities (Johnson, 2011). Therefore, grant proposals must be consistent with the grant funder’s objectives and mission to be successful (Wason, 2004).

What Are Typical Grant Funding Sources?

Grants come from 3 main sources: governments, foundations, and corporations. Government grants are available through local, state, or federal governments. Government grants often provide the largest amounts of funding and present the highest level of competition. They are typically the most difficult grants to obtain and tend to be pursued by those with previous grant-writing experience. Government grants often require a complicated grant-writing process with extensive requirements, which can be intimidating to a novice grant writer. When applying for a government grant, it is wise to consider obtaining the assistance of an experienced grant writer, which provides a great learning opportunity for the novice (Wason, 2004).

Foundation grants are established solely with the objective of giving funds to organizations or individuals as a means to promote and achieve the foundation’s goals and priorities. While funding amounts vary widely, foundation grants are generally focused on a mission or a commonly shared issue that is of interest to its members (Wason, 2004). The process and format for submitting grant proposals to foundations and corporations are generally well defined and clear cut, providing a user-friendly experience for the grant-writing novice (Wason, 2004).

Corporate grants come directly from corporations and businesses. Corporations may also provide grant funding through an established foundation within the corporation. Corporation grants are generally designated to benefit the communities where the corporation is located, or to promote research regarding a product they manufacture or represent (Wason, 2004).
**WOCN Society grant resources.** The Center for Clinical Investigation (CCI) of the WOCN Society Foundation has developed a Research Grant Proposal Submission Toolkit (http://www.wocn.org/SubmissionToolkit), which is located under the WOCN Web site, Foundation, Research & Funding section of the WOCN Web site: http://www.wocn.org/ResearchFunding (CCI, WOCN Society Foundation, n.d.-a). The toolkit provides a guide to help applicants work through the elements of the grant-writing process. The toolkit is organized into 3 main sections that provide guidance about the overall process from first determining whether to develop and submit a research proposal to finally starting the study after funding is received. The toolkit is designed so the applicant can use individual sections or all of the sections, depending on the need and interest. After each section there is a flow chart of key tasks, and a final checklist at the end to ensure that all components are completed for that section. Suggestions are included throughout the toolkit to facilitate the success of the proposal. A sample research grant application/proposal is also available in the Foundation, Research & Funding section of the WOCN Web site (http://www.wocn.org/ResearchProposalApp), and a copy included in Appendix T (CCI, WOCN Society Foundation, n.d.-b). WOC nurses who plan to apply for a grant should visit the Research & Funding section of the WOCN Web site for information about the WOCN Society’s grants program and application process, and additional resources for research and funding.

**References**


Health care reimbursement has a direct effect on the amount and type of care provided to patients by all health care providers, including WOC nurses. To understand the current status of the reimbursement for services provided by WOC nurses, it is helpful to first have an understanding related to the history of health care reimbursement, which is discussed briefly in this chapter. Also, this chapter discusses briefly the impact of WOC nursing on health care delivery and the implications of reimbursement on role justification and marketing of WOC nursing.

History of Health Care Reimbursement

Prior to the 1900s, most Americans paid the provider directly for any medical care. In 1908, Workers’ Compensation was introduced to reimburse for the medical care of certain federal employees injured when performing specific “hazardous jobs” (Preskitt, 2008). Throughout the early 1900s, many legislative acts were introduced to provide a national health care plan to reimburse medical care for Americans, but these legislative efforts failed (Preskitt, 2008). During World War II, employers began to offer group health insurance plans to attract employees, and, by 1950, major medical insurance was available to most Americans employed by large businesses and corporations (Preskitt, 2008). As early as 1950, the need for medical payment coverage for the elderly and poor was recognized and Medicare and Medicaid legislation was passed into law in 1966. Later in 1973, Medicare benefits were expanded to include individuals with end-stage renal disease and all railroad retirees (Casto & Layman, 2006).

With the passing of the Medicare Act, the American Medical Association commented that the act would lead to “out-of-control spending” (Preskitt, 2008). Yet, the act remained essentially unchanged for nearly 40 years. Initially, Medicare reimbursement was based on a fee-for-service plan. When medical services were provided and billed, the Medicare payment amount was based on the fee schedule.

As health care costs escalated, managed care was developed to replace the fee-for-service reimbursement model. The first managed care insurance options emerged as health maintenance organizations. This was the first effort to maintain the quality of care while controlling cost. Prevention of disease/disease management was also integrated into this system under a fee-for-service plan (Preskitt, 2008). In this type of reimbursement, one payment is made as the reimbursement for an entire episode of care (Casto & Layman, 2006).

Medicare followed managed care’s lead in prospective payment with the advent of the diagnosis related group (DRG) payment system in 1983. If a patient was admitted to the hospital, the payment for service was based on the admitting diagnosis and one payment covered all the care that was provided (Preskitt, 2008). While these efforts were initiated in all acute and long-term care areas, payment was based on the cost of service. The goal was to reduce the overutilization of service while providing necessary quality care (Casto & Layman, 2006).

Health Care in the 21st Century

In today’s health care environment, efforts continue to control cost and improve the quality of care that is provided. An emerging payment plan that is currently being investigated by the Agency for Healthcare Research and Quality (AHRQ) is called a “Value-Based Insurance
Design" (AHRQ, n.d.; Fendrick, Smith, & Chernew, 2010). Both government-based and private insurance companies are expanding research efforts to explore the cost of health care and determine if quality care is being provided in the appropriate setting (AHRQ, n.d., 2011). Currently, most acute care hospital services are reimbursed by a pay-for-performance plan, which uses quality measures to determine the payment amount.

Other payment alternatives, such as “bundled payments,” are also being investigated. Bundled payment is a method of payment to health care providers based on the predetermined expected costs of an episode of care (AHRQ, 2011). The bundles can be defined in varying ways, cover different periods of time, and include single or multiple health care providers, which might include some or all of the following options:

- All services needed for care of the patient, across health care settings.
- The time needed for the care of the illness.
- A guarantee that the treatment provided will produce positive patient outcomes.

The intent of bundled payments is to decrease spending while increasing the quality of care. It is believed that bundled payments would create a financial incentive for providers to reduce the number and cost of services contained in the bundle (AHRQ, 2011). For example, in a bundled payment system, payments would be made to a group of providers for the care and treatment of a specified patient population throughout the course of an illness and providers would have discretion over how they utilized resources to treat the patient most effectively (AHRQ, 2011). If the services or therapy did not result in positive health care outcomes in a timely manner, the service provider would be motivated to reevaluate the services or therapy provided.

The health care environment of the 21st century is ripe for WOC nurses to explore opportunities to enhance their practice and gain recognition for their value as clinical experts. Although there are associated costs for the services provided by WOC nurses, an increase in positive patient outcomes will justify the cost of the services. Harris and Shannon (2008) demonstrated that the involvement of nurses with advanced wound and ostomy skills in community-level, chronic and acute wound care was associated with lower overall costs due to a reduction in the amount of time required for 100% closure of wounds and fewer nursing visits.

**Impact of WOC Nursing on Health Care Delivery Systems**

Achieving effective clinical patient outcomes and reducing financial outlays are critical factors in the delivery of health care that directly affect justification for the utilization of WOC nurses. Turbyville, Saunders, Tirodkar, Scholle, and Pawlson (2011) propose that health plans and practice can create higher value by increasing the quality of care, without large increases in the use of resources, or by maintaining the same level of quality with decreased resources. Therefore, when the focus is to optimize the effectiveness of clinical services and the staff, the WOC nurse must be able to prove effectiveness by obtaining the desired outcomes in a timely and cost-effective manner (eg, patient independence in ostomy care, documentable progress in wound healing, or correction and/or effective management of continence disorders). Recent research has demonstrated that patients in home health care agencies who were cared for by WOC nurses, compared to agencies without WOC nurses, had better outcomes for pressure ulcers, lower extremity ulcers, surgical wounds, urinary incontinence, bowel incontinence, and urinary tract infection (Westra, Bliss, Savik, Hou, & Borchert, 2013). Also, research has shown that despite caring for patients with the most severe wound and continence problems, WOC
nurses are effective in achieving positive health outcomes for these patients (Bliss, Westra, Savik, & Hou, 2013).

In addition, WOC nurses must create collaborative work environments with case managers and other decision makers within health care delivery systems. To optimize clinical outcomes, WOC nurses are well prepared for a shift to capitation or value-based payment systems, because their care is focused on the following:

- Prevention of complications related to WOC conditions.
- Management of complex rehabilitative care needs.
- Attention to health maintenance concerns.
- Efficient management of chronic WOC conditions.

**Role justification and marketing of WOC nursing.** To justify and market themselves effectively, WOC nurses first need to understand the current payment mix within their facilities and agencies. For example, home health care may be capitated in terms of the number of visits and payment per visit or by a capped dollar amount paid per episode of illness. Also, WOC nurses need to know if the capitated payment includes the costs of supplies or if the supply costs are billed/reimbursed separately (Fendrick et al., 2010).

In today’s health care environment, the goal is to maintain health and/or to manage illness as cost-effectively as possible. For example, the goal in managing a patient with a pressure ulcer would be to heal the ulcer while minimizing visits and supply costs. An important question is: “How can we improve the bottom line?” An organization’s financial bottom line is determined by comparing its expenses to its revenue. The bottom line can be enhanced either by increasing revenues or by decreasing costs.

There are 3 key steps that WOC nurses can follow for effective role justification and marketing in a capitated or value-based system. The first step in effective role justification and marketing within a capitated or value-based system is asking the right questions to learn about the payment of services.

**Step 1: Knowing the right questions to ask.** Suggested questions include the following:

- What is the specific payer mix within the facility or organization? How is this percentage expected to change over the next year and over 5 years?
- What are the specifics regarding payment strategies of capitated or value-based systems?
- Is there a fixed payment based on the patient’s diagnosis, as in the acute care “DRG” system?
- Is there a “cap” on the units of service provided (eg, home health visits or skilled nursing days)? If so, what guidelines or criteria are utilized to determine the cap? Is there a capped payment per unit of service, and, if so, are supply costs included in the capped payment?
- Are access to care and the extent of coverage (ie, units of service such as home health visits) controlled by a case manager rather than a fixed system? If so, what is the process for obtaining approval for services?
- Is the organization involved in a risk-sharing approach to capitation? With this approach, payment is fixed based on the total enrollment in the health plan. For example, a per-member-per-month payment is made: In exchange for the fixed payment, the organization contracts to provide the agreed-upon services to all members in the health plan requiring these services. In this type of system, an increased demand for services represents increased cost rather than increased revenue.
**Step 2: Improve outcomes and reduce costs.** The second step in justifying the WOC nurse’s role in a managed care or value-based system is to determine specific methods to contribute to both positive patient outcomes and reduced costs. Addressing the potential to increase revenue is an important attribute of WOC nursing care.

**Step 3: Collect outcomes data.** The third step in justifying and marketing the WOC nurse’s role is to collect data regarding patient outcomes and cost of care. Sample data may include the following:

- Duration of the wound prior to the WOC nurse’s involvement.
- Etiology of the wound.
- Wound status upon admission.
- The number of visits until healing.
- Healing time.
- Cost and utilization of supplies.
- Average total cost per visit including supplies and visit costs.
- The number of visits required to instruct an ostomy patient in self-care.
- The incidence of wound- or ostomy-related complications.
- Average monthly utilization and cost of wound or ostomy supplies.

In summary, to effectively market the WOC nurse’s role in a managed care or value-based health care system, the WOC nurse must:

- Assemble data regarding the applicable payment systems.
- Determine and market ways to positively contribute to the organization’s “bottom line” by providing quality care resulting in positive patient outcomes.
- Collect and report outcomes data.

**Future Issues**

It remains unknown what the full impact will be of the Patient Protection and Affordable Care Act of 2010 on the delivery and reimbursement of health care services. The goal of the act is to provide quality, affordable care to all Americans. It is anticipated that if no further changes are made to the act, this coverage will expand to cover the currently, uninsured population and that the trend to pay-for-performance and value-based reimbursement will continue (Sherman, 2012). WOC nurses need to continue to monitor the changes in coverage and reimbursement and can play an important role in helping to reduce costs while ensuring high-quality care.

On behalf of its members, the WOCN Society is committed to advancing legislative activity that promotes the benefits of WOC nursing for individuals with WOC care needs. The WOCN Society advocates public policy positions, which advance access to care for people with WOC disorders. On an ongoing basis, the WOCN Society’s National Public Policy Committee, along with the Society’s legislative consultants in Washington, works to inform members of Congress about WOC issues. The WOCN Public Policy & Advocacy Health Care Agenda is available on the Society’s Web site under the Advocacy & Policy News section (http://www.wocn.org/AdvocacyPolicyNews). Also, the WOCN Society has prepared the WOCN Advocacy and Grassroots Toolkit as a resource for its members to enhance their own, individual efforts at public policy/advocacy. A copy of the toolkit is provided in Appendix V and is available on the Web site: http://www.wocn.org/GrassrootsToolkit.
References


Chapter 10: Medicare and Medicaid

Payment for health care in the United States involves several mechanisms, including self-pay by the consumers, insurance companies, and government agencies. The federal government is the single largest payer through Medicare, Medicaid, and the Department of Veterans Affairs (Sherman, 2012). This chapter presents a brief description of Medicare and Medicaid. To view the structure of Medicare/Medicaid in relationship to the rest of the government branches for establishing and implementing policy, see the figures in Appendices W to X.

What Is Medicare?

Medicare is a federally provided health insurance program that is administered by the US Department of Health and Human Services through the Centers for Medicare & Medicaid Services (CMS). Medicare provides coverage for the following individuals (CMS, n.d.-a, n.d.-b):

1. People 65 years or older.
2. People younger than 65 years with disabilities.
3. People of any age with end-stage renal disease.

Some people are automatically enrolled and get Medicare Part A and Part B when they turn 65 years of age, while there are others who must sign up for Part A and/or Part B as described later (CMS, n.d.-c). Automatic enrollment occurs if one of the following applies:

1. Individuals are already receiving benefits from Social Security (SS) or the Railroad Retirement Board (RRB) and have reached 65 years of age.
2. Individuals are younger than 65 years and disabled, after receiving disability benefits from SS or the RRB for 24 months. Note. If individuals live in Puerto Rico, they automatically get Part A but have to sign up for Part B.

Other individuals must sign up for Part A and Part B if:

1. Individuals are not getting SS or RRB benefits because they are still working.
2. Individuals qualify for Medicare because they have end-stage renal disease.
3. Individuals live in Puerto Rico and want Part B.

**Medicare Part A (hospital insurance).** Part A helps with inpatient hospital care, hospice, some home health care, as well as a skilled nursing facility (SNF; CMS, n.d.-d). Most people do not pay for this coverage because they have paid for it through Medicare payroll taxes while working. It is often referred to as “premium free.” Those people who do not qualify for “premium free” coverage may elect to purchase coverage if they meet specific criteria (CMS, n.d.-d).

**Medicare Part B (medical insurance).** Part B usually covers 80% of medically necessary doctor services, outpatient services, durable medical equipment, and some home health care. Some preventive services are also included (CMS, n.d.-b). There is a monthly premium required for the Medicare Part B coverage.

**Medicare Part C (Medicare advantage plans like HMO or PPO).** Part C insurance is provided by private-run insurance companies approved by Medicare. This type of plan will provide all of Part A coverage and Part B coverage (CMS, n.d.-e). Additionally, these plans may provide additional coverage not available through Part A or B such as vision, hearing, and dental coverage. Most advantage plans also include Medicare prescription drug coverage. With these types of plan, Medicare pays the provider a fixed monthly amount for every member. While these plans must follow Medicare rules regarding coverage, they may charge different out-of-
pocket costs and have different rules for coverage, such as a referral might be needed (CMS, n.d.-e).

**Medicare Part D (prescription drug coverage).** Part D is available to everyone who qualifies for Medicare (CMS, n.d.-f). It helps cover the cost of prescriptions, helps lower prescription costs, and/or helps maintain prescription costs in the future. To obtain this coverage, individuals must join a plan run by an insurance company or other company approved by Medicare. Each plan varies in cost and in the drugs that are covered, and there is a premium for each plan (CMS, n.d.-f).

### Special Coverage Considerations for Medicare

**Skilled nursing.** Medicare does not cover long-term care (CMS, n.d.-g). Most long-term care is considered custodial and can be provided in various settings such as private homes, assisted living facilities, or nursing homes. Medicare will pay for medically necessary care in an SNF when rehabilitation or skilled nursing care is required. SNF coverage is provided for up to 100 days, when there has been a preceding qualifying hospital stay of 3 days or more and there is a continued need for skilled care (CMS, n.d.-h).

**Home health care.** Criteria for Medicare coverage of home health care include the following (CMS, 2010):

1. The home health agency (HHA) must be approved by Medicare (i.e., Medicare certified).
2. The patient is under the care of a doctor, and the services are provided under a plan of care established and reviewed regularly by a doctor.
3. The patient must be homebound, and a doctor must certify that the patient is homebound.
4. The patient must need 1 or more of the following services and a doctor must certify the need for the services:
   - Intermittent skilled nursing care: Care provided by an RN (or licensed practical nurse supervised by an RN) and needed or given less than 7 days per week, less than 8 hours per day, and over a period of 21 days or less.
   - Physical therapy.
   - Speech--language pathology services.
   - Continued occupational therapy.

**Reimbursement of home care service.** Reimbursement for home care is based on the prospective payment system (PPS). Under the PPS, agencies are paid a predetermined base payment (CMS, n.d.-i). This amount can be adjusted based upon the following:

1. Geographical differences across the country.
2. The health condition, clinical characteristics, and service needs of the beneficiary, which is referred to as the case-mix adjustment.
3. An outlier provision exists to ensure that appropriate payment for those beneficiaries who have the most expensive care needs.

Reimbursement for each patient is made based upon a 60-day episode of care. One-half of the estimated base payment for the full 60 days is paid to the organization as soon as the fiscal intermediary (FI) receives the initial claim. The remaining half of the payment will be sent at the close of the 60-day episode unless there is an applicable adjustment to that amount. This split percentage payment approach provides a reasonable and balanced cash flow for HHAs. Another 60-day episode can be initiated for longer-stay patients.
Case-mix determination. Agencies assess the patient’s condition and needs for skilled nursing care, therapy, medical social services, and/or home health aide service at the beginning of the episode of care. A nurse or therapist uses the Outcome and Assessment Information Set (OASIS) instrument to assess and document the patient’s condition. All expected therapy needs are used to determine the case-mix adjustment to a standard payment rate. This case-mix adjustment is the amount of money an HHA is paid to provide care to the individual for 60 days. For every 60 days that a patient remains on service with the HHA, a new assessment must be completed (CMS, n.d.-i).

Consolidated billing. Under the PPS, an HHA must bill for all home health services including the following (CMS, n.d.-i):
1. Nursing and therapy services.
2. Home health aide and medical social services.
3. Routine and nonroutine medical supplies, including wound, ostomy, and urological supplies.

What Are Medicare Administrative Contractors?
The Medicare Modernization Act of 2003 (MMA) enabled the CMS to make significant changes to the Medicare fee-for-service program’s administrative structure (CMS, n.d.-j). These changes provide for contracting that is dynamic, competitive, and performance-based.

Under section 911 of the MMA (CMS, n.d.-j), Congress requires that the CMS replace the current FI and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation with new entities called Medicare administrative contractors (MACs). This operational integration centralizes information once held separately, creating a platform for advances in the delivery of comprehensive care to Medicare beneficiaries.

The new MACs will perform claims processing and related functions for the Medicare program, but they will do so more efficiently. Central to the implementation of the contracting reform is the creation of new jurisdictions to be administered by the MACs. The new MAC jurisdictions have been designed to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors (CMS, n.d.-k).

The MACs will serve as the providers’ primary point of contact for enrollment; training on Medicare coverage and billing requirements; and the receipt, processing, and payment of Medicare fee-for-service claims within their respective jurisdictions. In their capacity as the face of Medicare to the providers, practitioners, and suppliers, MACs will need to maintain a staff of experts knowledgeable in all aspects of the fee-for-service program.

The investment for the implementation of Medicare contracting reform helps ensure that the program remains an important and secure health plan for beneficiaries and generates significant trust fund and administrative savings over time. The following improvements to services for beneficiaries and providers can be expected (CMS, n.d.-k):
1. Improved beneficiary services.
   - Most beneficiaries will have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize.
   - Medicare Part A and Medicare Part B (A/B) MACs will be required to develop an integrated and consistent approach to medical coverage across their service area, which benefits both beneficiaries and providers.
• Beneficiaries will be able to have their questions on claims answered by calling 1-800-MEDICARE, their single point of contact.

2. Improved provider services.
• A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers.
• Competition will encourage MACs to deliver better service to providers.
• Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

In addition to MACs that process claims for Part A and Part B for Medicare, there are specialty MACs that process claims for durable medical equipment (DME), home health, and hospice. There are 4 MACs that process claims for DME while the CMS is in the process of integrating home health and hospice into one of the A/B MACs. There are 4 DME MAC jurisdictions (CMS, n.d.-l):


What Is the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Competitive Bidding Program?

Section 302 of the MMA established requirements for a Competitive Bidding Program for certain DME, prosthetics/orthotics, and supplies (DMEPOS; CMS, n.d.-m). Under the program, suppliers compete to become Medicare contract suppliers. This is done by submitting bids to furnish certain items in competitive bidding areas. The CMS awards contracts to enough suppliers to meet the beneficiary demand for the bid items. This results in lower payment amounts that replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules. They must be licensed and accredited and meet certain financial standards. The goal of the program is to set appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services. This program is thought to result in the following benefits:

1. Reduced out-of-pocket expenses for beneficiaries.
2. Savings to taxpayers.
3. Savings to the Medicare program.

Under the MMA, the DMEPOS competitive bidding program was to be phased in during 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program, but it was eventually instituted in 2009 (CMS, n.d.-m). On January 1, 2011,
the CMS launched the first phase of Medicare’s competitive bidding program in 9 different areas of the country for 9 product categories. The MIPPA required the competition for round 2 to occur in 2011 in 70 additional metropolitan statistical areas (MSAs) and authorized competition for national mail order items and services after 2010. The Affordable Care Act of 2010 expands the number of round 2 MSAs from 70 to 91 areas and mandates that all areas of the country are subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016 (CMS, n.d.-m).

In essence, Medicare has suppliers enter competitive bids for predetermined supplies and equipment. The prices must be lower than current purchase prices. After the bidding is complete, Medicare analyzes the bids and selects the suppliers with which it will do business.

**What Is Pricing, Data Analysis, and Coding?**

The pricing, data analysis, and coding (PDAC) performs the following activities for CMS (Noridian Administrative Services, n.d.-a):

- Receives, evaluates, and processes coding verification applications for DMEPOS.
- Establishes, maintains, and updates all coding verification decisions on the Product Classification List that is available on the DME Coding System (Noridian Administrative Services, n.d.-b).
- Provides coding guidance for manufacturers and suppliers on the proper use of the Health Care Common Procedure Coding System (HCPCS).
- Maintains and publishes the National Drug Codes (NDC)/HCPCS Crosswalk and oral anticancer drug pricing files (Noridian Administrative Services, n.d.-c).
- Conducts DMEPOS data analysis.

Coding verification allows manufacturers/distributors to request a coding decision on a DMEPOS item. It is the responsibility of the PDAC to review DMEPOS products available for Medicare beneficiaries to determine the appropriate HCPCS code for Medicare billing.

**What Is Medicaid?**

Medicaid is a joint state and federal health insurance program for low-income individuals. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain “mandatory benefits” and can choose to provide other “optional benefits” through the Medicaid program (CMS, n.d.-n). Services in a specific area can be viewed at the Web site: http://www.medicaid.gov. Medicaid provides health coverage to pregnant women, seniors and individuals with disabilities, and nonelderly, low-income parents or caretaker relatives (CMS, n.d.-o).

**Nondisabled adults.** Eligibility levels for parents or caretaker relatives vary across the country, and there is currently no federal requirement that states provide coverage to nonpregnant adults without dependent children. Many states have optional programs called “medically needy programs” (CMS, n.d.-p). They cover individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups. Individuals can still become eligible by “spending down” the amount of income that is above a particular state’s medically needy income standard (CMS, n.d.-p).
What Is Managed Care for Medicaid?

Medicaid in the past has been provided using a fee-for-service system. However, more recently, states have implemented a mandatory managed care delivery system of services. In this system, people receive services from the managed care organizations (MCOs) that are contracted with the state. Managed care programs can either be joined voluntarily or more commonly have mandatory enrollment. There are 3 common types of managed care programs (CMS, n.d.-q):

1. **Managed care organizations.** These companies provide most of the Medicaid benefits in exchange for a monthly payment from the state.

2. **Limited benefit plans.** Unlike MCOs, they provide only 1 or 2 benefits such as mental and/or dental.

3. **Primary care case managers.** These can be either an individual or a group of providers that act as the primary care provider. They receive monthly compensation for their services.

States must comply with the federal regulations that govern managed care delivery systems. These regulations include requirements for a managed care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed care plans.

Reimbursement and WOC Nursing

The Wound, Ostomy and Continence Nurses Society (WOCN) has developed 2 fact sheets about reimbursement that are available on the Web site (http://www.wocn.org) for members in the Public Policy section. The fact sheet, *Reimbursement of Advanced Practice Registered Nurse Services*, provides information about reimbursement opportunities and challenges for the advanced practice RN (APRN; WOCN Society, 2011a). In addition, the fact sheet, *Understanding Medicare Part B Incident to Billing*, provides some insight into cases where a nonadvanced practice/WOC nurse might bill in the outpatient setting. “Incident to” is a billing mechanism for Medicare that allows services provided in an outpatient setting to be delivered by auxiliary personnel and billed under the provider’s national provider identification (NPI). For example, under the incident to provision, a physician or APRN could develop the plan of care and a non-APRN could provide the care and bill under the provider’s NPI (WOCN Society, 2011b).

As previously mentioned in Chapter 10, it is unknown how the new health care law will impact the eligibility and coverage by Medicare and Medicaid services in the future. WOC nurses, as all health care providers, must continue to monitor these changes to identify opportunities or threats that arise to their services.

References


Chapter 11: Writing for Publication

Writers and potential authors may sometimes perceive many obstacles to writing for publication. Such obstacles include a lack of time, fear of rejection, not being sure where to start, or the overall length of the process. However, writing for publication can be a very rewarding experience. There are several reasons to consider writing for publication because it provides opportunities to:

- Contribute to the knowledge base to improve the delivery of patient care.
- Share knowledge with a worldwide professional community.
- Advance the practice of WOC nursing and the overall nursing profession.
- Provide pilot information for larger studies and product development.
- Disseminate research findings to a global audience.
- Advance an individual WOC nurse’s career.
- Create a permanent record of WOC nursing practice.
- Gain professional and personal recognition and credit for ideas and contributions.

This chapter discusses the planning, preparation, and process for submitting a manuscript for publication. Also, the common types of articles that WOC nurses might consider writing are described.

Planning for Success

Writing starts with an idea, and every journal values original data. Preparation and planning are keys to developing a successful publication (Gray, 2010). When writing for publication, it is important to determine the type of article and the purpose and make a brief outline of the key content areas to include. To choose the appropriate journal for the article, consider the target audience that will have an interest in your information (eg, general nursing audience, WOC nurses, home health care, acute care). After you have a general idea of the content and purpose of the article, choose a journal that is the best match for your information and check the guidelines and instructions for authors of that particular journal.

Novice writers. New authors can gain helpful information to assist them in writing by reviewing articles, such as those by Moos (2011) and Redmond (2002), about writing for publication and how to simplify the writing process. Also, seeking a mentor or coach for guidance can help make writing for publication a reality for the novice (Moos, 2011; Redmond, 2002).

For the WOC nurse who is a novice at writing for publication, a good place to start is with the Journal of Wound, Ostomy and Continence Nursing (JWOCN). The JWOCN is the professional journal of the Wound, Ostomy and Continence Nurses Society (WOCN), which seeks contributions from its members and has several types of articles that it publishes on a regular basis from experienced authors as well as novices. The JWOCN seeks clinically based and professional practice manuscripts related to WOC nursing practice, administration, and education. Original research reports, review articles, clinical series, and case presentations are welcome.

Author guidelines. “Information for Authors” is included in most journals or on their Web sites. For example, the JWOCN provides information for authors in each print issue and online (JWOCN, 2012). Some journals publish this information once or twice per year. It is
important to meticulously follow the reference style specified in the author instructions as well as other guidelines including:

- Preferred topics.
- Overall format for the title page, abstract, and manuscript.
- Page limits.
- Specific instructions for research reports, case studies, and literature reviews.
- Format for spacing, tables, figures, legends, and style of references.
- Submission process: the number of copies to be submitted and options for electronic submissions.
- Process for editing and review of the manuscript.

**Preparation.** Before preparing and submitting a manuscript to a professional journal, it is helpful to consider the following questions regarding your topic and manuscript:

- Does the manuscript topic match the stated goals of this publication?
- Does the writing style of the manuscript match articles published in recent issues of the journal? (Many journals, including the *JWOCN*, have special features that offer an alternative format for novice authors or for persons seeking unique formats to share information and knowledge.)
- Has the journal recently published a similar manuscript related to the topic?
- Is this a professional journal or magazine?
- Will the manuscript be reviewed by experts in the field? (All professional journals should be peer reviewed.)
- Does the publication intersperse advertisements throughout the content pages? (A professional journal does not allow placement of advertisements within its content pages.)

**Query letter.** A query letter can be sent to a journal’s editor if the author is unsure of the appropriateness of a manuscript for that journal or if the journal has recently published a manuscript with a similar topic. A query letter should contain an abstract, summary, or outline of the proposed (or completed) manuscript. The grammar, style, and appearance of the query letter are important because they are the editor’s first impression of the author.

**Types of Articles**

There are many different types of articles, and journals vary in what they accept. WOC nurses should consider developing the type of article that best meets their interests and abilities.

Some nurses are able to successfully convert an academic paper to an article. This could be from a paper that was developed for an advanced degree, thesis, or dissertation. The paper could be a review article or a research report. It is not always easy to turn a student paper into a journal article. A journal article is often different from a student paper in terms of length and detail, depth of methodological discussion, language and style, interest value of the topic, and the target audience (Webb, 2009). Therefore, as previously mentioned, it is important to review the publisher’s guidelines in advance and query the journal’s editor if there are questions about the suitability of the planned manuscript for publication. The following discussion provides an overview of common types of articles (Gray, 2010; *JWOCN*, 2012).

**Clinical challenge articles/case studies.** Ideas can come from posters presented at conferences, discussion on a forum, or day-to-day practice; it does not need to be research based. You can base your article on your own clinical experiences and everyday observations. Write it
up as a single case study or series of cases. Readers like to hear about everyday clinical issues. The content outline for this type of feature includes the following elements:

- **Structured abstract.** Introduce the problem in 3 to 6 sentences, telling the reader why this is a problem and why this is clinically relevant; give the background (1-2 sentences), describing the clinical issue or technique; describe the case (2-4 sentences); and provide a conclusion (1-2 sentences), describing the main points.

- **Introduction.** Include the problem or need with the approach or technique that was used to solve the problem or meet the need. Tell the readers why you found the approach or technique useful and include a reference if needed.

- **Case.** Describe 1 or more cases that illustrate the point of your article. This can be 3 to 5 paragraphs or 5 pages or more. Be sure to describe the WOC nursing interventions in detail, list products, and tell readers how each case contributed to your point. This does not need to include an extensive, comprehensive literature review.

- **Discussion.** Begin with a brief discussion of the underlying problem and then explain how your innovation or approach compares to “traditional” or “typical” care. Include other published examples (if available) of the approach that you used. Figures are highly encouraged. If including images, use the highest-resolution possible and save the images as tiff files, not jpgs. The length should be about 1 to 3 pages.

- **Conclusion.** In a single paragraph (2-3 sentences), state the most important points readers should remember.

- **References.** Use the reference citation style specified for the journal.

**Review articles.** Literature review articles are useful resources for readers because they summarize existing knowledge and research about a topic and help identify knowledge gaps to stimulate future research (Webb, 2009). A review article can be an integrative review or a systematic review.

**Integrative review.** A narrative or integrative review is less systematic and inclusive and might include qualitative as well as quantitative studies. A traditional review paper includes an unstructured abstract, 2 to 3 sentences introducing the topic, 1 to 2 sentences providing a rationale/why the topic is important, and concludes with a final sentence beginning with “This article will review....” The remainder of the article is structured as Introduction, subheads, and Conclusion. The inclusion of tables, figures, and boxes is encouraged to enhance the text.

**Systematic review.** A systematic review uses a highly structured format and process. It is a type of research project and most often focuses on quantitative studies (Webb, 2009). It is important to put the words “systematic review” in your title. The format for a systematic review includes the following content:

- **Unstructured abstract.** Three to 6 sentences that state the question and tell the readers why you are doing the review. Describe your methods of review in 1 to 2 sentences and state the major findings in 1 to 2 sentences.

- **Introduction.** About 3 paragraphs describing the underlying condition/disorder. End this section with a statement about why this review is needed. Include a review of literature, which includes recent articles and latest editions of core textbooks.

- **Methods.** This is a critical element. List the specific databases that were searched and the methods (ie, search terms) used, the years searched, and the inclusion and exclusion criteria for selecting studies for the review. Describe the review process and how the evidence was ranked. There are several systems used to grade the strength of scientific evidence. In a project by the Agency for Healthcare Research and Quality, 26 systems
were identified and described for rating the strength of scientific evidence (West et al., 2002).

- **Study narrative.** Consider using the *Evidence Based Report Cards* published in *JWOCN* as a template for this portion of the manuscript. Include a table summarizing the studies that were included.
- **Evidence ranking.** The evidence rankings can be bulleted or placed in a box.
- **Clinical implications.** A statement recommending how practice should be maintained or changed based on this evidence.
- **Conclusion.** A single paragraph, 2 to 3 sentences, restating the most important points readers should remember.
- **References.** Follow the style for reference citations as specified by the journal.

**Research reports.** Articles reporting data from original research studies receive the highest priority for publication. IMRAD is a standard format for presenting research reports: Introduction, Methods, Results, and Discussion (American Psychological Association [APA], 2010). The article also includes an abstract, a conclusion, references, tables, and appendices, as needed. Follow the IMRAD formula and write in the following order:

- **Introduction.** Three to 5 paragraphs addressing the underlying problem. The last paragraph should state the research aims you addressed: It should persuade readers to read the article.
- **Materials and methods.** What you did, describe how subjects were chosen, how you collected data, and any instruments used. The study must have been through an institutional review board review.
- **Results.** What happened? What are the findings and results? Briefly present the data analysis (eg, 1 paragraph); seek assistance from your statistician as needed to write this section.
- **Discussion.** What did it mean? Summarize findings in a single paragraph. Compare your findings to that of others. References to other published literature are essential. Include 1 to 2 paragraphs describing the clinical implications. Insert a single paragraph addressing the study’s limitations.
- **Conclusion.** A single paragraph, 2 to 3 sentences, restating the most important points readers should remember.
- **References.** Follow the style for reference citations as specified by the journal.
- **Structured abstract.** Check the word-limit requirements for abstracts of the journal to which you are submitting the article. While the abstract will be placed at the beginning of the manuscript, it is often written last to ensure consistency with the final content. The basic components of the abstract for a research report include the following content:
  - **Purpose:** One to 2 sentences why you conducted the study.
  - **Subjects and setting:** Two to 3 sentences describing the research participants and the setting.
  - **Methods:** One sentence summarizing the design; 3 to 5 sentences describing what you did.
  - **Results:** Three to 5 sentences describing the most important findings.
  - **Conclusions:** One to 2 sentences telling readers the take-home message of your study.

Some journals, including the *JWOCN*, specify that reports of research trials follow the Consolidated Standards of Reporting Trials (CONSORT) Statement, which is used worldwide to
improve the reporting of randomized controlled trials (RCTs; Schulz, Altman, & Moher, 2010). The CONSORT Statement is an evidence-based set of recommendations for reporting RCTs. It provides a standard way for authors to prepare reports of RCT results to facilitate complete and transparent reporting. It also aids in critical appraisal and interpretation of results. Additional information about the CONSORT Statement can be accessed at the Web site: http://www.consort-statement.org.

**Submitting a Manuscript**

Authors should format and organize the manuscript to enhance clarity and readability, peer review, editing, and final printing (APA, 2010). Most journals have specific criteria for the preferred structure or format including typeface and font size, spacing, margins, placement of tables or figures, etc. It is the responsibility of the author(s) to adhere to ethical and legal standards for scholarly publications and to comply with policies established by the publisher. These standards include ethical conduct of research, avoiding conflict of interest and bias in publication, properly citing references, and obtaining permission for using materials from other sources to avoid plagiarism or copyright violations (APA, 2010).

A title page is generally required to accompany the manuscript. The title page commonly includes the complete title of the manuscript, author(s) names, credentials, and affiliations, name and address for the key contact for correspondence, address for reprints, and acknowledgement of all sources of funding or support that require disclosure. Some thought and attention should be given when choosing the final title of the manuscript. The title should be clear, descriptive, and informative. The title should also contain the essential key words that readers might use as search terms when looking for information about a specific topic (Webb, 2009).

Some journals also request that the authors develop a separate list of 3 to 5 key learning points that readers should derive from the article. The list of the key points is generally placed before the reference list in the manuscript (JWOCN, 2012).

**Final touches.** Before final submission of the manuscript, check the accuracy of spelling, page numbers and running heads, and references. The references in the final reference list should be the same as those cited in the article, and, conversely, you should not have citations in the body of the article that are not in the final reference list (Webb, 2009).

Check the publisher’s preferred method for submission of the manuscript (eg, print copy by regular mail, e-mail, or online submission to a Web site). In the final submission, include a cover letter to the publisher to provide the following information:

- A list of authors and credentials.
- Contact information for future correspondence.
- A brief overview of the manuscript.
- A statement that the manuscript is original, has not been previously published, and is not under current consideration by another journal.
- Inform the editor of any similar publications by the author(s).
- Copies of permissions if reprinting or adapting the work of others.

**General Publishing Tips**

Publication is important for WOC nurses to share knowledge and build the evidence that can benefit others and improve practice. Following is a list of general tips for preparing and writing for publication (Brink & Wood, 2001; Webb, 2009; WOCN Society, 2005):
• Start your publishing career with a report of a single case study or case series for a “challenges in practice” article. These manuscript styles are often less demanding than that for an original research report or a literature review and help the novice author gain experience and confidence.

• Decide on the manuscript style and outline your work before beginning the manuscript. Follow a conventional format for the article as recommended in author guidelines for the journal.

• Use language that is easily understood; write with the active voice unless reviewing the previous work completed by others.

• Ask a colleague to review the manuscript (eg, looking for style, grammar).

• If writing for the first time, contact the editorial office of the journal where you plan to submit your manuscript for questions about development of the manuscript. As previously mentioned, most journals provide author guidelines. For example, JWOCN (2012) provides extensive information (eg, instructions for authors, author tutorial, revision guidelines) on its Web site to assist authors in preparing and submitting manuscripts.

• Obtain any needed permissions to reprint reproduce tables, figures, photos, protocols, or large amounts of information from other sources.

• Submit your article to only one journal at a time. If that journal refuses, you may then submit to another.

• Be prepared to revise your manuscript. Most journals request revision for more than 90% of the papers submitted for publication. Revision is a normal part of the publication process.

• Do not interpret critique of your manuscript as a personal attack. Journals vary widely in their approach to manuscript revision, and some critiques can appear harsh. JWOCN and other peer-reviewed journals provide authors with a summary of comments from the reviewers and work with authors to develop manuscripts that positively reflect authors’ knowledge and expertise in the published word.

• Respond promptly to page proofs from the editorial office of the journal and read the page proofs very carefully for content and accuracy. All revisions must be completed prior to the final review and preparation of the galley proof, immediately prior to publication.

Conclusion

It is important that WOC nurses share their knowledge and expertise with other WOC nurses and other health care providers to advance the science and art of practice. There are multiple opportunities for WOC nurses to publish and present about their practice or research. For experienced as well as novice authors, the key to success in publishing is planning and preparation, which includes careful attention to the author guidelines from the journal or publisher where they plan to submit the manuscript.

References

Gray, M. (2010, June 14). *Turn your idea into a successful article: How to get published*. The WOCN/ WCET Joint Conference, Phoenix, AZ.


Appendix A: Sample WOC Nurse Position Description: Hospital (Acute Care)

Position Title: WOC Nurse  
Department: Division of Nursing or Department of Patient Services

General Description
The hospital-based WOC nurse serves as a clinical resource and consultant for the acute and rehabilitative care of patients with selected disorders of the gastrointestinal, genitourinary, and integumentary systems such as acute and chronic wounds (eg, complex draining wounds, fistulae, pressure ulcers, vascular ulcers), ostomies, percutaneous tubes, and continence disorders. Professional responsibilities are carried out through direct patient care, clinical consultation, education, research, and administration.

Qualifications
1. Education and experience  
   a. BSN (required) or MS (preferred).  
   b. Two to four years of recent, relevant nursing experience (preferred).  
   c. Graduation from a WOCN-accredited wound, ostomy and continence (WOC) nursing education program, or satisfactory completion of an accredited program within 6 months after assuming the position.

2. License and certification  
   a. Current RN licensure.  
   b. Current certification in tri-specialty (CWOCN) by the Wound, Ostomy and Continence Nursing Certification Board.  
   c. Current certification in cardiopulmonary resuscitation.

General Duties and Responsibilities (this list is representative rather than inclusive)
1. General duties/responsibilities  
   a. Utilizes the nursing process when directing or delivering care to patients with WOC needs including assessment, diagnosis, outcomes identification, planning and implementation (eg, coordination of care delivery, health teaching and promotion, consultation), and evaluation.  
   b. Utilizes and maintains current physical, psychosocial, clinical assessment, and therapeutic communication skills to determine individual patient needs and expected outcomes.  
   c. Participates in committees or task forces related to wound, ostomy, and continence issues.

2. Wound/skin care  
   a. Provides consultation for individuals with altered skin integrity (eg, pressure ulcers, draining wounds, fistulae) to develop individualized plans of care and attain expected outcomes.
b. Provides guidance to staff in implementing protocols to identify, control, or eliminate etiologic factors for skin breakdown, including selection of appropriate support surfaces.

c. With a physician’s order, provides appropriate debridement of devitalized tissue (eg, conservative sharp debridement, silver nitrate [AgNO₃] cauterization of nonproliferative wound edges, hypergranulation tissue, or to control minor bleeding).

d. Provides appropriate education to patients, caregivers, and staff regarding skin care, wound management, care of percutaneous tubes, and draining wound/fistulae management.

e. Validates pressure ulcer data collection for nursing quality indicators (eg, pressure ulcers and restraint use).

3. Ostomy care
   a. Provides pre- and postoperative education to patients (and their families) who are undergoing ostomy surgery, with consideration of the need for physical and psychological adaptation.

   b. Marks the stoma site preoperatively by determining the appropriate site for stoma placement with consideration of the patient’s anatomical markings, physical capabilities, and lifestyle.

   c. Assesses the stoma and stoma functioning and initiates appropriate procedures for stoma care (eg, removes rod/sutures, measures/fits a pouching system, teaches care of stoma/peristomal skin and pouch).

   d. Provides appropriate educational information to patients, including postoperative and discharge instructions about care, referrals, and supply needs.

   e. Serves as a resource for patients after discharge through telephone consultation or outpatient services.

4. Continence care
   a. Identifies risk factors for urinary or fecal continence disorders.

   b. Assesses patients with urinary and/or fecal continence disorders.

   c. Establishes an appropriate management program to include dietary and fluid management; bowel training or stimulated defecation program; bladder retraining, prompted voiding, or a scheduled voiding program; pelvic muscle reeducation without biofeedback; indwelling catheter management; recommendations regarding containment/absorptive products and devices and skin care; and education and counseling for patients/caregivers.

   d. Identifies patients requiring referral for assessment/management of complex urinary or fecal continence disorders.

5. Education
   a. Participates in developing and implementing procedures and protocols, based on current national guidelines, to deliver care to patients with the following:
      - Urinary or intestinal disorders resulting in the need for an ostomy.
      - Conditions requiring wound management.
      - Impaired or altered skin integrity.
      - Urinary and/or fecal continence issues.

   b. Assists the nursing and medical staff in maintaining current knowledge and competence in WOC care by providing the following:
• Formal or informal continuing education programs.
• Clinical rounds.
• Lunch and learn sessions.
• Orientation sessions.
• Collaborative practice committees.
• Nursing councils.

c. Attends continuing education programs related to WOC nursing to maintain current knowledge and skills.

6. **Research**
   a. Collaborates with leadership and multidisciplinary clinical practice teams to establish protocols, which support best practices to achieve optimal clinical benefits for patients needing WOC care.

7. **Administrative duties**
   a. Maintains and submits required activity and statistical reports to the appropriate department supervisor.
   b. Contributes to the selection of cost-effective supplies and equipment related to WOC care, which might need to be individualized for different units/departments.
Appendix B: Sample WOC Nurse Consultant/Clinical Expert Position Description: Hospital (Acute Care)

**Position Title:** WOC Nurse Consultant/Clinical Expert  
**Department:** WOC Nursing  
**Clinical Ladder:** Level IV  
**Supervisor:** VP of Nursing and Clinical Services  
**Supervision Exercised:** Autonomous

### General Description

The WOC nurse functions as a consultant and expert clinical nurse to assess, plan, implement, evaluate, and reassess (as indicated) the care of patients with abdominal stomas, acute or chronic wounds (eg, draining wounds, fistulae, pressure ulcers), and/or continence disorders.

### Qualifications

1. **Education and experience**  
   a. BSN (required) or MS (preferred).  
   b. Graduation from a WOCN-accredited wound, ostomy and continence (WOC) nursing education program or satisfactory completion of an accredited program within 6 months after assuming the position.

2. **License and certification**  
   a. Current RN licensure.  
   b. Current certification in tri-specialty (CWOCN) by the Wound, Ostomy and Continence Nursing Certification Board.  
   c. Current certification in cardiopulmonary resuscitation.

### General Work Requirements

1. **Normal work hours per day.**  
   a. Normally works 32 to 40 hours per week.  
   b. Normal work hours are 8 AM to 4:30 PM, Monday to Friday, excluding recognized holidays.

2. **Mental demands**  
   a. Exceptional mental alertness is required.  
   b. Must be able to make clinical decisions regarding individualized patient care plans and establish priorities to provide effective, efficient care.

3. **Working conditions**  
   a. Frequent use of body substance isolation and contact precautions.  
   b. Contact with patients under a wide variety of circumstances.  
   c. There is a high probability that unexpected situations will occur.

4. **Physical demands**  
   a. Must be able to meet basic physical requirements: frequent walking, standing, lifting, or bending.

**Primary Duties and Responsibilities:** The following statements describe the principal functions and duties of the job and are not to be considered a detailed description of all requirements inherent in the position.
1. Demonstrates competence and knowledge in the assessment, diagnosis, planning, implementation, and evaluation of care for patients of all ages with WOC needs.

2. Provides consultation for individuals with altered skin integrity (i.e., pressure ulcers, draining wounds, fistulae) to develop an individualized plan of care and attain expected outcomes.
   a. Provides guidance to staff in implementing protocols to identify, control, or eliminate etiologic factors for skin breakdown, including selection of appropriate support surfaces.
   b. With a physician’s order, provides appropriate debridement of devitalized tissue (e.g., conservative sharp debridement, silver nitrate [AgNO₃] cauterization of nonproliferative wound edges, hypergranulation tissue, or to control minor bleeding).
   c. Provides appropriate education to patients, caregivers, and staff regarding skin care, wound management, care of percutaneous tubes, and draining wound/fistulae management.

3. Provides pre- and postoperative education to patients (and their families) who are undergoing ostomy surgery, with consideration of the need for physical and psychological adaptation.
   a. Marks the stoma site preoperatively by determining the appropriate site for stoma placement, with consideration of the patient’s anatomical markings, physical capabilities, and lifestyle.
   b. Assesses the stoma and stoma functioning and recommends appropriate procedures for stoma care (e.g., measures/fits a pouching system, teaches care of stoma/peristomal skin and pouch).

4. Assesses patients with urinary and/or fecal continence disorders.
   a. Recommends an appropriate management program to include dietary and fluid management; bowel training or stimulated defecation program; bladder retraining, prompted voiding, or a scheduled voiding program; pelvic muscle reeducation without biofeedback; indwelling catheter management; and recommendations regarding containment/absorptive products and devices and skin care.
   b. Provides education and counseling for patients/caregivers.

5. Develops expected outcomes that reflect realistic, measurable, and patient-centered goals.

6. Communicates the individualized plan of care to the interdisciplinary health care team and establishes criteria requiring reassessment or follow-up education.

7. Participates in interdisciplinary collaboration to provide safe and therapeutically effective interventions across the continuum.

8. Evaluates individual patient/family outcomes in response to the plan of care and the WOC nurse’s clinical interventions.

9. Provides outpatient services within the scope of WOC nursing practice (e.g., stoma clinic, wound centers).

10. Manages the WOC nurse’s office and its operations.

11. Provides guidance for the use of specialty support surfaces (e.g., rental beds, chairs, lifts) and monitors for their appropriate use.

12. Provides educational opportunities to update other health care professionals about current guidelines/standards of care for patients/populations with WOC needs or risks.
Additional Responsibilities/Duties

1. Seeks opportunities for professional growth.
2. Demonstrates and supports the organization’s mission, values, and goals.
3. Contributes to professional or consumer publications.
4. Collaborates with community resources and organizations.
5. Complies with reasonable requests to perform other duties.
6. Maintains/demonstrates knowledge and skills to perform competently as required by the employer or state board of nursing (eg, conservative sharp debridement).
Appendix C: Sample WOC Nurse Consultant/Clinical Expert Position Description: Home Health

Position Title: WOC Nurse Consultant/Clinical Expert
Department: Home Care
Responsible to: Director of Nursing

General Description
The WOC nurse provides care in the home care setting to patients with acute or chronic wounds (eg, draining wounds, fistulae, pressure ulcers), ostomies, and continence disorders. Utilizing the nursing process, the WOC nurse provides hands-on care and educates clinicians, patients, and their families. The WOC nurse collaborates/coordinates care with nurses, the physician, and other health care team members to implement the plan of care and meet the rehabilitation needs for patients with WOC needs. Additionally, the WOC nurse performs other related tasks for documentation and supply management.

Qualifications
1. Education and experience
   a. BSN (required).
   b. Graduation from a WOCN-accredited WOC nursing education program or satisfactory completion of an accredited program within 6 months after assuming the position.
   c. Two to 4 years of RN experience (preferred).
2. License and certification
   a. Current RN licensure.
   b. Current certification in tri-specialty (CWOCN) by the Wound, Ostomy and Continence Nursing Certification Board.
   c. Current certification in cardiopulmonary resuscitation.

General Duties and Responsibilities (this list is representative rather than inclusive)
1. Direct care
   a. Assists in caring for patients with stomas (eg, stoma site marking), acute or chronic wounds (eg, draining wounds, fistulas, pressure ulcers), and continence disorders.
   b. Initiates assessment, planning, and implementation of care for patients with WOC needs.
   c. Provides comprehensive postoperative care and education to patients with fecal or urinary diversions and their families.
   d. Evaluates, selects, and recommends supplies and equipment for patients with ostomies, acute or chronic wounds, and continence disorders.
2. Consultation
   a. Serves as a consultant to the nursing staff, physicians, and other members of the health care team.
b. Attends patient care conferences and staff meetings as needed and communicates patients’ special needs to appropriate members of the health care team.

3. **Education**
   a. Instructs nursing personnel in the care of patients with ostomies and acute or chronic wounds (e.g., draining wounds, fistulas, pressure ulcers).
   b. Provides in-service educational programs as needed to staff, physicians, and other health care team members, in cooperation with the education coordinator to influence organizational best practices related to WOC nursing care.
   c. Maintains current knowledge and competence in WOC specialty nursing by participating in professional programs and organizations.
   d. Orient new nursing personnel and selected nursing students to the role of the WOC nurse.

4. **Research**
   a. Develops and monitors standards of care and assists in the formulation and evaluation of procedures, protocols, and policies to maintain best practice.
   b. Engages in research, measurement of quality outcomes, and safety projects, as appropriate.

5. **Administration**
   a. Evaluates, selects, and recommends supplies and equipment for patients with ostomies, draining wounds, fistulae, pressure ulcers, acute or chronic wounds, and continence disorders.
   b. Documents patient care in accordance with home health and nursing department policy.
   c. Performs other appropriately assigned duties, as required.
Appendix D: Sample WOC Nurse Position Description: Clinical Nurse Specialist

Position Title: WOC Clinical Nurse Specialist (AP-CNS)
Department: Nursing
Responsible to: Assistant Administrator for Nursing Services

General Description
The WOC clinical nurse specialist (CNS) demonstrates WOC professional activities that contribute to advancing the evidence and art of WOC specialty practice. The WOC CNS serves as a clinical resource for patients with wounds, ostomies, and continence disorders. Professional responsibilities are carried out through direct patient care, education, consultation, research, and administration.

Qualifications
1. Education and experience
   a. Master's degree in nursing required.
   b. Graduation from a WOCN-accredited WOC nursing education program or satisfactory completion of an accredited program within 6 months after assuming the position.
   c. Three years of nursing practice.

2. License and certification
   a. Current state license as an advance practice nurse (CNS, NP).
   b. Current certification in tri-specialty (CWOCN) by the Wound, Ostomy and Continence Nursing Certification Board.
   c. Current AP-CNS certification by American Nurses Credentialing Center.

General Duties and Responsibilities (this list is representative rather than inclusive)

1. Clinical practice
   a. Provides comprehensive assessment of patients/situations.
   b. Initiates and interprets diagnostic tests and procedures as indicated.
   c. Provides direct care to selected patients.
   d. Determines diagnosis or nature of the problem.
   e. Identifies expected outcomes and plans individualized care to promote continuity across the continuum.
   f. Implements and coordinates plans for integrating systems and community resources.
   g. Assists in solving complex problems.
   h. Provides health education to selected patients and caregivers.
   i. Responds to changes in health care and safety initiatives.

2. Consultation
   a. Integrates current evidence, clinical data, and information within theoretical frameworks when providing consultation.
   b. Evaluates the need for repeated consultations.
c. Responds to identified needs of the health care team to enhance the work of others and effect change.
d. Facilitates involvement of individuals and groups that have a direct interest in the situation or plan.
e. Serves as a clinical consultant to committees (e.g., safety, safe patient handling, infection control).

3. **Education**
   a. Develops and implements educational programs for the health care team.
b. Incorporates principles of teaching and learning in the planning, implementation, and evaluation of educational programs.
c. Assists staff to identify learning needs.
d. Participates in health education activities for the community.
e. Serves as a role model to promote excellence by critical analysis of current research to expand clinical knowledge.

4. **Research**
   a. Interprets, communicates, and incorporates current research findings and evidence-based guidelines into clinical practice.
b. Conducts or contributes to nursing research.
c. Identifies opportunities to mentor others in best practices to improve care processes.

5. **Administrator**
   a. Provides leadership in the coordination and delivery of health care services across the continuum of care.
b. Innovatively designs solutions to improve patient care, health services, and health outcomes related to WOC nursing care.
c. Provides leadership in the development of care models for chronic issues related to WOC nursing care.
d. Promotes clinical best practice standards as the basis for nursing practice.
Appendix E: Sample WOC Nurse Position Description: Nurse Practitioner in Adult Health

Position Title: WOC Nurse Practitioner in Adult Health (ANP)
Department: Patient Services
Responsible to: Director of Nursing Education, Director of Clinical Practice, or Medical Director of Primary Care

General Description

The WOC ANP functions as a generalist provider to the adult patient population with wounds, ostomies, or continence disorders, and functions in accordance with his/her State Nurse Practice Act. The WOC ANP has expert skills and is a leader in coordination of resources to facilitate achievement of health and wellness at an optimum level for each patient.

Qualifications

1. Education and experience
   a. Successful completion of a recognized nurse practitioner program with a master’s or doctor of nursing practice degree.
   b. Additional education in WOC nursing (required); graduation from a WOCN-accredited WOC nursing education program or satisfactory completion of an accredited program within 6 months after assuming the position (preferred).
   c. Minimum 2 years as an RN and 1 to 2 years as a nurse practitioner (preferred).

2. License and certification
   a. Current state license as a nurse practitioner advance practice nurse.
   b. Current certification in tri-specialty (CWOCN) by the Wound, Ostomy and Continence Nursing Certification Board.
   c. Current NP certification by the appropriate national certifying body (eg, ANCC, AANP).
   d. Eligibility and acquisition of prescriptive privileges within 1 year (if required by practice).

Physical Requirements

1. Physical requirements include those necessary to provide or influence patient care in the clinical setting (eg, ability to lift and/or move objects within job requirements, ability to stand for prolonged periods of time).
2. Sensory requirements include the ability to articulate and comprehend the spoken and written English language (eg, acceptable vision and hearing).

General Duties and Responsibilities (this list is representative rather than inclusive)

1. Assesses the physical and psychosocial status of clients via interview, health history, physical examination, and diagnostic tests.
2. Interprets data, develops and implements therapeutic plans, and follows through on a continuum of client care across the health-illness spectrum and life span.
3. Performs in accordance with organizational and work role performance standards. Tables 1 and 2 provide performance standards and related measurement criteria to meet organizational and work role requirements, respectively.

### Table 1. Organizational Standards and Related Measurement Criteria

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Measurement Criteria</th>
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| **A. Responsibility:** Acts responsibly as a member of the organization. | 1. Works independently, requesting assistance of the organization when needed.  
2. Anticipates problems and works to solve them.  
3. Performs duties willingly.  
4. Demonstrates appearance and hygiene appropriate to the delivery of quality service.  
5. Actively participates in all efforts to maintain a safe, clean environment.  
6. Recognizes that fulfilling the organization’s mission involves successfully managing financial and other resources.  
7. Actively creates innovative, cost-effective systems throughout the organization to continuously improve the management of all resources. |
| **B. Sensitivity:** Demonstrates sensitivity to customers’ needs. | 1. Works collaboratively with other team members; treats other team members with consideration, courtesy, and respect, even in stressful situations.  
2. Continuously improves communication within the organization and with patients, visitors, and colleagues.  
3. Cooperates with other hospital departments.  
4. Encourages people to express ideas; encourages personal growth and learning for all; considers suggestions from other members of the team.  
5. Responds to patients, family members, hospital team members, and everyone else in a manner that indicates a desire to meet their needs and exceed their expectations. |
| **C. Accuracy:** Demonstrates knowledge and attention to detail to ensure proper service to customers. | 1. Completes work in an accurate and thorough manner to ensure proper service to customers. Attention to detail is evident.  
2. Seeks information necessary for accurately completing job duties.  
3. Maintains current knowledge and skills necessary to perform competently. |
| **D. Timeliness:** Recognizes time as the individual's most valuable resource. | 1. Responds promptly to customers’ needs.  
2. Carries out work assignments within the allotted time. |
| **E. Ethics:** Demonstrates a commitment to protecting the rights of customers. | 1. Discusses patient- and staff-related issues only in a confidential manner and setting, and only with those who have a right to know. |
### Performance Standards | Measurement Criteria
--- | ---
F. Attendance: Maintains a satisfactory attendance record. | 1. Individual is in the disciplinary process with a minimum of a written warning.  
2. Individual has satisfactory attendance.  
3. Individual has perfect attendance.

### Table 2. Work Role Performance Standards and Related Measurement Criteria

<table>
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<tr>
<th>Performance Standards</th>
<th>Measurement Criteria</th>
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| **A.** The ANP functions as an expert clinician in assessing, planning, evaluating, and revising care for the adult population. | 1. Provides direct care consistent with standards of practice by identifying, managing, or referring actual or potential problems of patients.  
2. Orders diagnostic and therapeutic interventions consistent with standards of practice.  
3. Demonstrates the ability to incorporate complex biopsychosocial dimensions into the nursing process at an advanced level.  
4. Demonstrates the knowledge and ability required to incorporate life span milestones into the nursing process (ie, age appropriateness, growth and development, aging).  
5. Collaborates with members of the health care team to facilitate coordinated delivery of care across the continuum.  
6. Requests consultation when specialized needs are identified.  
7. Utilizes prescriptive authority in a manner consistent with standards of practice. |
| **B.** The ANP assumes a leadership role in implementing nursing practices to promote continuous quality improvement and desirable patient outcomes. | 1. Practices in accordance with current standards and research.  
2. Demonstrates continuous quality improvement in individual practice.  
3. Provides leadership to other nurses on the health care team in the use of research findings in current practice (eg, development of institutional standards and staff education).  
4. Participates in departmental and hospital efforts to continuously improve systems. |
| **C.** The ANP demonstrates leadership in the development, implementation, and evaluation of community and patient education programs. | 1. Demonstrates an ability to provide individualized patient and family education related to health maintenance, illness, wellness, and prevention.  
2. Demonstrates knowledge of community needs and interests and develops creative, innovative mechanisms for meeting those needs.  
3. Provides leadership to other nurses on the health care team in the use of educational techniques. |
<table>
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<tr>
<th>Performance Standards</th>
<th>Measurement Criteria</th>
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| **D.** The ANP continually improves clinical avenues to provide optimal care while maximizing the use of resources. | 1. Participates in the attainment of budget objectives.  
2. Uses all information available to monitor use of resources, identify trends, and develop plans of action to ensure efficient practice.  
3. Maintains current knowledge of reimbursement issues as they apply to the ANP’s individual practice.  
4. Seeks avenues for revenue generation in a creative, innovative, manner. |
| **E.** The ANP creates an atmosphere for positive communication across all departments that plays a role in the continuum of care. | 1. Initiates or participates in team-building activities.  
2. Facilitates communication and collaboration among all members of the health care team. |
| **F.** The ANP adheres to the policies and procedures outlined in the exposure-control plan regarding universal precautions; blood-borne pathogens; disposal of needles, syringes, and sharps; cleanup procedures for blood and body fluid spills; and storage, handling, and disposal of medical waste. | 1. Demonstrates knowledge and understanding in the policies and procedures outlined in the exposure-control plan.  
2. Practices safe work techniques and utilizes proper engineering controls to minimize the risk of blood-borne pathogen exposure. |
| **G.** The ANP utilizes appropriate personal protective equipment when performing a task that presents a risk of exposure to blood-borne pathogens. | 1. Demonstrates knowledge of the appropriate level of personal protective equipment to be used in relation to a specific task.  
2. Degree of compliance is measured by personal observation by the immediate supervisor and managers and feedback from other supervisors and managers. |
| **H.** The ANP adheres to hospital policies and procedures related to mandatory continuing education and annual health assessment. | 1. Completes annual records on mandatory continuing education assessment requirements and submits them to the human resources department.  
2. Completes annual health assessment form as required; maintains current inoculations.  
3. Submits the department-/state-required current license upon issuance or renewal to human resources. |
Appendix F: Sample WOC Nurse Position Description: Independent Practice

Position Title: WOC Nurse Consultant

General Description

The independent WOC nurse, working under a contractual agreement between the nurse and the contracting organization, functions as a consultant for patients with complex draining wounds, fistulae, pressure ulcers, vascular ulcers, ostomies, and skin problems related to fecal and/or urinary continence disorders. The nurse is responsible and accountable for assessing, planning, implementing, and evaluating the care related to the aforementioned conditions.

Qualifications

1. Education and experience
   a. BSN required or MSN (preferred).
   b. Graduation from a WOCN-accredited WOC nursing education program.
   c. Two to four years of relevant and recent experience as an RN (preferred).

2. License and certification
   a. Current licensure as an RN.
   b. Current certification by the Wound, Ostomy and Continence Nursing Certification Board in one or more areas of WOC specialty nursing practice for the services to be provided (ie, tri-specialty [CWOCN], wound care nurse [CWCN], ostomy care nurse [COCN], continence care nurse [CCCN], or foot care nurse [CFCN]).

General Duties/Responsibilities (this list is representative rather than inclusive)

When developing a contract for independent practice, the WOC nurse should consider the following duties/responsibilities and specifically determine which services will be provided by the WOC nurse, and these should be delineated in the contract.

1. Direct patient care: Serves as the primary patient educator for patients undergoing ostomy surgery who are referred to the WOC nurse.
   a. Provides preoperative visits and stoma site selection for elective procedures.
   b. Assesses, develops a plan of care for complicated pouching issues, and evaluates the outcomes.
   c. Provides education to patients and significant others regarding the care of the stoma and peristomal skin, and any special considerations that should be reported to the physician or the WOC nurse.
   d. Assists with selection and instruction of patients in the use of an appropriate pouching system and accessories, including where and how to obtain supplies.
   e. Determines if alterations in the pouching system are needed due to abdominal features, activity, adherence problems, diet, odor, or flatus and instructs patients/families and staff of those alterations.
   f. Coordinates discharge plans including follow-up visits with the WOC nurse as necessary and makes referrals for home health services if needed.
2. **Consultation**
   a. Provides consultation for patients referred with complex draining wounds or fistulae.
      - Selects and applies or recommends an appropriate system to contain drainage, recommends interventions to protect the surrounding skin, and provides the necessary instructions to the staff and the patient.
   b. Provides consultation for patients referred with or at risk for impaired skin integrity (eg, pressure ulcers, vascular ulcers, patients needing pressure redistribution devices).
      - Recommends local wound care management.
      - Recommends modalities to relieve or eliminate the cause(s) of the skin breakdown.
      - Evaluates the progress or lack of progress toward wound healing and recommends changes in procedure or products as indicated.
   c. Provides consultation to patients referred with fecal and/or urinary continence disorder.
      - Assesses the patient for the cause and type of continence disorders.
      - Collaborates with the physician regarding the plan of care to control or manage continence disorders.
      - Evaluates the patient’s response to therapy and recommends alternative approaches as needed.
      - Provides required instruction/education to the patient, family, and staff regarding concepts of bowel/bladder control.
   d. Provides in-service education to staff of the contracting facility.
      - Provides education to staff regarding WOC care as agreed upon.
      - Obtains CE approval for educational programs, when indicated and agreed upon.
Appendix G: Sample WOC Nurse Position Description: Industry

Position Title: Director of Professional Services
Responsible to: President, CEO, or Senior Vice President

General Description
The director of professional services shall assume responsibility for assisting the corporation in providing products and services in accordance with the corporate mission statement and philosophy. The director implements quality standards, develops educational programs and materials, and offers consultation to other members of the team in the area of clinical expertise.

Qualifications
1. Education and experience
   a. BSN; master’s degree from an accredited school of nursing preferred.
   b. Graduation from a WOCN-accredited WOC nursing education program.
   c. Minimum of 2 to 4 years of experience as an RN preferred.
   d. Prior teaching, management, and leadership experience preferred.
   e. Working knowledge of quality management.
2. License and certification
   a. Current RN licensure.
   b. Current certification by the Wound, Ostomy and Continence Nursing Certification Board in one or more areas of WOC specialty nursing practice for the services to be provided.

General Duties and Responsibilities (this list is representative rather than inclusive)
1. Develops, implements, and directs the corporation’s quality assurance program in conjunction with input from senior operations personnel and develops a plan to introduce the program to the field.
2. Defines the quality standards.
3. Establishes a patient advocacy hotline and a patient evaluation response system.
4. Develops a business plan that describes the structure, reporting mechanism, financial projections, and expected outcomes.
5. Informs field centers of quality assurance standards as requested.
6. Apprises senior operations personnel and local centers of regulatory guidelines promulgated by professional state practice associations (eg, Food and Drug Association, Department of Transportation, Compressed Gas Association). Establishes a monitoring mechanism to evaluate the center’s regulatory compliance.
7. Develops protocols and other collateral materials for review by senior management for home medical equipment centers to guide professional and patient care practices in home. Provides clinical/patient care consultation about the company’s services, as required.
8. Reviews client care and administrative policies and procedures encompassing the following:
   a. Intake procedures.
b. Follow-up visit standards.
c. Patient grievance procedures.
d. Medical supervision procedures.
e. Infection control guidelines.

9. Monitors all product recall notices that affect field centers and notifies senior operations personnel and centers as appropriate regarding product recalls.

10. Provides guidance to field home medical equipment centers regarding patient incidents. Assists in the investigative process as requested for incidents that may result in litigation. Serves as a liaison between the field centers and the corporate legal staff for all patient-/product-related incidents.

11. Coordinates and networks with corporate and regional offices and departments to promote continuity and the efficient use of resources.

12. Analyzes existing practices and provides recommendations as requested to senior and regional management regarding methods and procedures that facilitate integration of the corporation’s spectrum of services, thus yielding improved service to patients, cost economies, and greater market penetration.

13. Provides guidance to field home medical equipment centers and clinical staff in the provision of professional services. This includes supervision of performance evaluations, continuing education, and development of standardized procedures and practices.

14. Assists senior management in the development of new programs as required, including the following:
   a. Analysis of needs.
   b. Development of a business plan.
   c. Assistance with program implementation.
   d. Production of collateral materials relating to professional and patient care practices for new programs.

15. Provides consultation to field centers as requested regarding clinical and patient care issues and practices.

16. Provides coordination of continuing educational offerings provided by the corporation to the community.
Appendix H: Sample Position Description: Certified Wound Care Nurse

Position Title: Certified Wound Care Nurse (CWCN)
Department: Nursing
Responsible to: Director of Nursing, Nurse Manager, or WOC Nurse Supervisor

General Description
The certified wound care nurse (CWCN) has the responsibility and accountability for utilizing the nursing process in the prevention and treatment of acute and chronic wounds throughout the organization. The CWCN functions primarily as a consultant providing direct patient care and education to selected patients and provides staff development in wound care.

Qualifications
1. Education and experience
   a. BSN required.
   b. Graduation from a WOCN-accredited education program or specialty course, or satisfactory completion of program within 6 months of assuming new position.
   c. Minimum 2 to 4 years of RN experience preferred.
2. License and certification
   a. Current RN licensure.
   b. Current certification in wound care nursing (CWCN) by the Wound, Ostomy and Continence Nursing Certification Board.

General Duties and Responsibilities (this list is representative rather than inclusive)
1. Provides consultation and assistance to staff in developing and implementing protocols used in the identification and management of patients with potential or actual alteration in skin integrity.
2. Provides guidance to staff in implementation of protocols to identify, control, or eliminate etiologic factors for skin breakdown, including selection of appropriate support surfaces.
3. Establishes protocols and guidelines for appropriate and cost-effective use of therapeutic support surfaces.
4. Evaluates the patient’s response to treatment and the progress toward wound healing and makes adjustments and modifications in care as indicated.
5. With a physician’s order, provides appropriate debridement of devitalized tissue (eg, conservative sharp debridement, silver nitrate \([\text{AgNO}_3]\) cauterization of nonproliferative wound edges or hypertrophic granulation tissue, and to control minor bleeding).
6. Provides consultation and assistance to staff in developing a plan of care to manage patients with draining wounds and fistulae (eg, containment of drainage and odor, protection of perifistular skin).
7. Provides consultation and assistance to staff in developing a plan of care for patients with percutaneous tubes (ie, tube stabilization, site care, appropriate drainage collection system).
8. Provides appropriate education to patients, caregivers, and staff regarding skin care, wound management, care of percutaneous tubes, and management of draining wounds/fistulae.
9. Provides follow-up for patients with acute and chronic wounds (eg, draining wounds, fistulas) or percutaneous tubes through outpatient clinic visits and/or phone consultations.
10. Initiates appropriate referrals for medical or surgical interventions.
11. Assists staff to maintain current knowledge and competence in the areas of skin and wound care through orientation, regularly scheduled in-service programs, and by reviewing/updating policies and procedures according to national guidelines.
12. Maintains records and statistics and submits reports to the employer.
13. Analyzes stocked items and recommends appropriate additions and deletions to assure the quality and cost-effectiveness of products used for skin and wound care.
14. Conducts product evaluations or contributes to research studies related to skin and wound care and submits reports and recommendations based on the results.
15. Serves on systemwide committees and participates in systemwide projects as requested.
16. Attends continuing education programs related to wound management.
Appendix I: Sample Position Description: Certified Ostomy Care Nurse

Position Title: Certified Ostomy Care Nurse (COCN)
Department: Nursing
Responsible to: Vice President/Director of Nursing, Nursing Manager or a WOC Nurse Supervisor

General Description

The certified ostomy care nurse has the responsibility and accountability for utilizing the nursing process in the management of patients with fecal and/or urinary ostomies throughout the organization. The certified ostomy care nurse functions primarily as a consultant providing direct patient care and education to selected patients and provides for ongoing staff development in ostomy care.

Qualifications

1. Education and experience
   a. BSN required.
   b. Graduation from a WOCN-accredited WOC nursing education program or specialty course, or satisfactory completion of a program within 6 months of assuming new position.
   c. Minimum 2 to 4 years of RN experience preferred.
2. License and certification
   a. Current RN licensure.
   b. Current certification in ostomy care nursing (COCN) by the Wound, Ostomy and Continence Nursing Certification Board.

General Duties and Responsibilities (this list is representative rather than inclusive)

1. Provides consultation, direct care, and education to patients undergoing ostomy or continent diversion surgery.
2. Visits patients preoperatively who are scheduled to undergo ostomy or continent diversion to provide informational, technical, and psychological support. Explains the surgical procedures and the rehabilitation process, selects and marks a potential stoma site, completes and charts the nursing assessment of the abdomen and psychological status.
3. Initiates appropriate procedures for stoma care.
   a. Assesses the stoma and stoma functioning and alerts the physician to any problems.
   b. Removes sutures and/or the support rod.
   c. Measures and fits the stoma with a pouching system. Selects and provides appropriate products for the patient based on knowledge of the type of stoma, skin sensitivities, body contours, and disease processes. Orders supplies as needed.
d. Instructs and demonstrates to patients and/or significant others the correct procedures to care for the stoma, peristomal skin, pouching system, and intubation and irrigation techniques (if indicated).

e. Explains the availability of supplies/equipment and procedures for reordering.

f. Provides counseling and educational literature to patients and their significant others.

4. Provides consultation and assistance to staff in developing a plan of care to manage patients with an ostomy or continent diversion.

5. Coordinates counseling services for patients and makes appropriate referrals to psychiatry, dietetics, social services, occupational therapy, or others that may be recommended by the physician.

6. Provides follow-up for patients with ostomies or continent diversions through outpatient clinic visits and/or phone consults and initiates appropriate referrals for medical or surgical intervention.

7. Assists staff to maintain current knowledge and competence in the areas of ostomy and continent diversion care through orientation, regularly scheduled in-service programs, and by reviewing/updating policies and procedures according to national guidelines.

8. Maintains records and statistics and submits reports to the employer.

9. Analyzes stocked items and recommends appropriate additions and deletions to assure the quality and cost-effectiveness of the products used for ostomy and continent diversion care.

10. Conducts product evaluations or contributes to research studies related to ostomy care and submits reports and recommendations based on results.

11. Serves on systemwide committees and participates in systemwide projects as requested.

12. Attends continuing education programs related to ostomy and continent diversion care.
Appendix J: Sample Position Description: Certified Continence Care Nurse

Position Title: Certified Continence Care Nurse (CCCN)
Department: Nursing
Responsible to: Vice President/Director of Nursing, Nurse Manager or a WOC Nurse Supervisor

General Description
The certified continence care nurse (CCCN) has the responsibility and accountability for utilizing the nursing process in the management and treatment of patients with fecal and urinary continence disorders throughout the organization. The CCCN functions primarily as a consultant providing direct patient care and education to selected patients and provides staff development in continence care.

Qualifications
1. Education and experience
   a. BSN required.
   b. Graduation from a WOCN-accredited education program or specialty course, or satisfactory completion of program within 6 months of assuming new position.
   c. Minimum 2 to 4 years of experience as an RN, preferred.
2. License and certification
   a. Current RN licensure.
   b. Current certification in continence care nursing (CCCN) by the Wound, Ostomy and Continence Nursing Certification Board.

General Duties and Responsibilities (this list is representative rather than inclusive)
1. Identifies risk factors for urinary and/or fecal continence disorders.
2. Assesses patients with urinary and/or fecal continence disorders. Assessment includes the relevant history, a focused physical examination, a record of bladder and bowel elimination and incontinent episodes, simple bedside cystometry, and identification of complicating factors.
3. Establishes an appropriate management program to include dietary and fluid management; bowel training or stimulated defecation program; bladder retraining, prompted voiding, or a scheduled voiding program; pelvic muscle reeducation without biofeedback; indwelling catheter management; recommendations regarding containment/absorptive devices and skin care; and education and counseling for patients/caregivers.
4. Identifies patients requiring referral for assessment/management of complex urinary or fecal continence disorders.
5. Provides consultation and assistance to staff in developing and implementing plans and protocols to identify and manage patients with potential or actual fecal and/or urinary continence disorders.
6. Evaluates the patient’s response to treatment and the progress of the continence care program and makes adjustments and modifications to care as indicated.

7. Provides follow-up for patients with fecal and/or urinary continence disorders through outpatient clinic visits and/or phone consults and initiates appropriate referrals for medical or surgical intervention as needed.

8. Assists staff to maintain current knowledge and competence in the areas of skin care and continence care through orientation, regularly scheduled in-service programs, and by reviewing/updating policies and procedures according to national guidelines.

9. Maintains records and statistics and submits reports to the employer.

10. Analyzes stocked items and recommends appropriate additions and deletions to assure the quality and cost-effectiveness of the products used for continence management.

11. Conducts product evaluations or contributes to research studies related to continence and submits reports and recommendations based on results.

12. Serves on systemwide committees and participates in systemwide projects as requested.

13. Attends continuing education programs related to continence management.

**Advanced Continence Care Skills:** The following additional care may be provided if the CCCN has advanced continence care skills.

1. A comprehensive assessment that includes performing the following examinations as indicted:
   a. A detailed physical examination and evaluation for prolapse and urethral hypermobility.
   b. Complex multichannel urodynamic studies, with or without fluoroscopic imaging and anorectal manometry studies.

2. Management/interventions including pelvic floor rehabilitation and reeducation via electrical stimulation and biofeedback and fitting and placement of vaginal pessaries.
Appendix K: Sample Position Description: Certified Foot Care Nurse

Position Title: Certified Foot Care Nurse (CFCN)
Department: Nursing
Responsible to: Vice President/Director of Nursing, Nurse Manager, or a WOC-FC Nursing Supervisor

General Description
The certified foot care nurse (CFCN) has the responsibility and accountability for utilizing the nursing process in the management and treatment of patients with selected foot and nail disorders throughout the organization in accordance with licensure and educational preparation. The CFCN functions primarily by providing direct patient care to selected patients with foot/nail care needs and provides staff development in foot, skin, and nail care.

Qualifications
1. Education and experience
   a. BSN preferred.
   b. Graduation from a WOCN-accredited WOC nursing education program or specialty course that includes foot/nail care, didactic and clinical; or completion of a specific foot/nail care continuing education course that includes foot/nail care, didactic/clinical, under the supervision of a foot/nail care expert.
   c. Minimum 2 to 4 years of experience as an RN, preferred.
2. License and certification
   a. Current RN licensure.
   b. Current certification as a foot care nurse (CFCN) by the Wound, Ostomy and Continence Nursing Certification Board.

General Duties and Responsibilities (this list is representative rather than inclusive)
Three levels of foot/nail care have been described as basic, level I; intermediate, level II; and advanced, level III (Kelechi & Luckacs, 1996). The levels of care are based on the level of need of the patient and the qualifications of the staff who provide the care, which can vary according to state licensing laws and specific agency policies. For example, some states require a physician’s order for nail debridement, while others do not (Etnyre, Zarate-Abbott, Roehrick, & Farmer, 2011).
1. Basic foot/nail care, level I & intermediate foot/nail care, level II
   a. Identifies risk factors for foot disorders or ulcerations.
   b. Assesses patients with identified risk factors or actual foot disorders for:
      • Risk of ulceration.
      • Risk of amputation.
      • Mobility and the need for footwear or mobility aids.
      • Quality-of-life issues related to foot pathology.
c. Provides assistance to staff in developing and implementing protocols used in the identification and management of patients with actual/potential disorders of the feet.

d. Provides hygiene, trims toenails, and debrides thick toenails, corns, and calluses of selected at-risk patients.

e. Establishes an appropriate management and education program to include foot assessment, prevention of injuries, hygiene, and skin and nail care.

f. Identifies patients requiring referral to other specialists for assessment/management of complex foot disorders or ulcerations.


g. With a physician’s order, initiates dressings and other therapies such as compression.

h. Evaluates the patient’s response to treatment and the progress of the foot care management program.

i. Provides follow-up for patients with foot disorders through outpatient clinic visits and/or phone consultation.

j. Assists staff to maintain basic current knowledge and competence in the areas of prevention and skin care of the feet and lower extremities.

k. Maintains records and statistics and submits reports to the employer.

l. Analyzes stocked items and recommend appropriate additions and deletions to assure the quality and cost-effectiveness of products used for foot/nail care.

m. Conducts evaluations of the products that are used for foot/nail care.

n. Serves on systemwide committees and participates in systemwide projects as requested.

o. Attends continuing education programs related to foot/nail care.

2. Advanced foot/nail care, level III

If the CFCN has advanced foot/nail care skills based on licensure and educational preparation, in addition to the basic level I and intermediate level II care, the following advanced care can be provided:

a. Provides prompt interventions for specific foot complications.

   • Patient assessment and advanced care are performed and referrals made for diagnostic tests or specialty care.
   
   • Patients are reassessed by the CFCN as indicated for foot complications at least 4 times annually.

b. Makes referrals for patients with complications who need ongoing assessment or care in the community until the condition no longer warrants the services.

c. Pares (ie, sharp debridement) corns and calluses (selected RNs with competency).

d. Prescribes appropriate pharmacological treatments for selected disorders of the feet or lower extremities (APRN with prescriptive authority).

e. Performs digital blocks and excises ingrown toenails (APRN).

References


Appendix L: Sample Position Description: Wound Treatment Associate

Position Title: Wound Treatment Associate
Department: Nursing
Responsible to: Director of Nursing or WOC Nurse Supervisor

General Description
Under the direction of an advanced practice WOC nurse, specialty WOC nurse, and/or MD, the wound treatment associate is responsible for provision of routine skin care, identification of patients at risk for pressure ulcer development, implementation of prevention protocols for patients at risk for pressure ulcer development, and assisting with the provision of comprehensive wound care and monitoring for patients with skin tears, incontinence-associated dermatitis, dehisced incisions, pressure ulcers, and lower extremity ulcers.

Qualifications
1. Education and experience.
   a. Minimum of diploma, associate degree, practical/vocational nurse education, or completed training as a military medic/corpsman.
   b. Two years of clinical experience in nursing.
   c. Strong interpersonal skills.
2. License and certification
   a. Licensed RN, LPN/LVN or military medic/corpsman (no license required).
   b. Certificate of successful completion of a WOCN Society--endorsed Wound Treatment Associate Program.

Duties and Responsibilities
1. Collaborates with other team members to provide routine care that keeps skin healthy.
2. Collaborates with other team members to identify patients at risk for pressure ulcer development and to provide appropriate preventive care using established protocols.
3. Identifies patient at risk for skin tears and for incontinence-associated dermatitis and initiates appropriate preventive care.
4. Collaborates with other team members to identify and address causative and contributing factors to skin breakdown.
5. Collaborates with other team members to assess and address systemic factors affecting wound healing.
6. Collaborates with other team members to provide ongoing and comprehensive assessment and documentation of wound status and progress in wound healing.
7. Collaborates with other team members to select appropriate dressings and to maintain a physiologic environment for wound healing.

* Note: Each nurse is accountable for practicing in accordance with the specific requirements of the licensing boards in the state(s) in which he/she practices. Job titles and specific role functions are determined by the employing organization and should be consistent with state board of nursing licensing regulations and requirements.
8. Identifies patients who require referral to a wound specialist, vascular surgeon, or other specialist for any of the following issues: evaluation for deterioration or failure to progress, management of closed wound edges (epibole), instrumental debridement of necrotic tissue, and differential assessment and management of lower extremity ulcers.

9. Performs the following procedures when ordered and appropriate:
   a. Applies compression wraps.
   b. Measures ankle brachial index.
   c. Obtains swab wound cultures.

10. Provides or assists with appropriate education regarding skin and wound care to patients, families, and staff.

11. Collaborates with other team members to maintain an appropriate inventory of products for skin and wound care.

12. Participates in quality improvement programs.
Appendix M: Sample WOC Nurse Performance Appraisal: Acute Care

Date: ________
Employee Signature: ______________
Manager Signature: _______________

Meets Clinical Nurse IV Maintenance Criteria
☐ Clinical ladder validation criteria submitted.

Knowledge/Education, Leadership/Management, Clinical Practice, Quality/Safety, Research/Innovation.
☐ Certifications current: _________________________

Completes annual required RN education
☐ Documented on in-service record.

Demonstrates maintenance of required annual competencies (if applicable):
☐ Conservative sharp debridement.
☐ Other: ______________________

Assessment Rating Scale: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
(1 = below expectations; 3 = meets expectations; 5 = exceeds expectations)

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
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</table>

Manager/Supervisor Comments: ________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Employee Comments: _________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
Appendix N: Sample WOC Nurse Practitioner Performance Appraisal Form

Job Title: Nurse Practitioner
Department: Patient services

Job Criteria and Performance Standards

Scoring: Each performance standard scored on a scale of 1 to 5 (1 = below expectations; 3 = meets expectations; 5 = exceeds expectations).

Criterion 1: Provides diagnosis and treatment of common acute illnesses, prevention and maintenance health care to patients with stable chronic illnesses, and performs interim physical examinations for healthy patients within practice guidelines.

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Elicits appropriate present and past medical history and reviews systems.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.2. Performs appropriate physical examination and orders appropriate diagnostic studies.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.3. Discriminates between normal and abnormal findings in history and physical.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.4. Establishes appropriate differential diagnosis.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.5. Assesses stability of chronic illness and compliance with present therapy and monitors for complications of disease or therapy.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.6. Establishes appropriate treatment plan. Assesses need for hospitalization or physician intervention.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.7. Determines timing for follow-up and orders appropriate referrals.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>1.8. Counsels regarding health maintenance and disease prevention and provides anticipatory guidance as appropriate.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td><strong>Exceeds Standard</strong></td>
<td></td>
</tr>
<tr>
<td>1.9. Demonstrates high degree of effectiveness in fulfilling standard as observed by supervisor.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
</tbody>
</table>

Comments: ________________________________________________________________________
______________________________________________________________________________
**Criterion 2:** Provides health education to patients about ways to improve, promote, and maintain health status, including but not limited to providing educational information on disease/disease processes, self-care practices, and positive lifestyle choices (e.g., diabetes, safe sex, weight loss, and smoking cessation).

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Assesses learning capabilities and readiness of population or individuals and tailors education to meet age, developmental, and educational needs.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>2.2. Prioritizes learning needs and documents them accordingly.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>2.3. Ensures that time frame and subject matter are appropriate for target audience/individual.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>2.4. Utilizes appropriate teaching materials (e.g., handouts, audiovisuals, demonstration) and documents use and patient outcome.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>2.5. Initiates, designs, and completes educational programs for patients, families, and targeted audiences.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exceeds Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6. Demonstrates high degree of effectiveness in fulfilling standard as observed by supervisor.</td>
</tr>
</tbody>
</table>

**Comments:**

______________________________________________________________________________

**Criterion 3:** Maintains accurate records, medication lists, and documentation of care and follow-up for administrative purposes and reimbursement of services.

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Adheres to agreed-upon format/protocol for documentation of records.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>3.2. Maintains appropriate level of documentation to promote/support level of complexity when compared against/to service fee charges.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>3.3. Reviews and updates problem list at least on annual visit/episodic visit by patient and initiates problem and medication lists for new patients.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>3.4. Documents telephone calls with patients and specialists.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
<tr>
<td>3.5. Documents visit in concise, clear, logical, and legible manner.</td>
<td>☐1 ☐2 ☐3 ☐4 ☐5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exceeds Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.6. Demonstrates high degree of effectiveness in fulfilling standard as observed by supervisor.</td>
</tr>
</tbody>
</table>

**Comments:**

______________________________________________________________________________
Criterion 4: Maintains competence in clinical practice.

4. Performance Standards

<table>
<thead>
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<td>☐ 1</td>
</tr>
</tbody>
</table>

4.1. Identifies the knowledge and skills needed through self-assessment, peer review, and supervisory review.
4.2. Participates in a variety of educational activities in order to maintain and increase competency.
4.3. Maintains licensure/certification.
4.4. Uses continuing education opportunities as a basis for expanding knowledge and improving clinical skills and incorporates these into the daily practice.
4.5. Participates in developing, implementing, and interpreting quality assurance/risk management programs.
4.6. Demonstrates high degree of effectiveness in fulfilling standard as observed by supervisor.

Comments: ___________________________________________________________________
_____________________________________________________________________________

Criterion 5: Supervises and intervenes with clinical issues and supports/directs triage by clinical staff when necessary. Implements clinical education and training of clinical staff when necessary.

5. Performance Standards

<table>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

5.1. Provides constructive feedback as it relates to performance, patient flow, and patient care issues.
5.2. Provides in-services and clinical education for staff members on an “as-needed” basis.
5.3. Is available for feedback on call back and triage issues as needed.
5.4. Identifies barriers to patient care flow or delivery and assists at formulating corrective action.
5.5. Serves as a role model for patient interaction and conflict resolution for clinical staff.
5.6. Works collaboratively with health team members, both in and out of office setting, to ensure continuity of care and complete delivery of prescribed care.
5.7. Demonstrates high degree of effectiveness in fulfilling standard as observed by supervisor.

Comments: ___________________________________________________________________
_____________________________________________________________________________
**Criterion 6:** Adheres to the drug formulary developed by the practice.

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1. Prescribes within the nurse practitioner scope of practice for state/licensing body.</td>
<td>1  2  3  N/A</td>
</tr>
<tr>
<td>6.2. Ensures updated and accurate practice agreement as set forth in rules and regulations for licensing authority.</td>
<td>1  2  3  N/A</td>
</tr>
</tbody>
</table>

Comments: ___________________________________________________________________
_____________________________________________________________________________

**Criterion 7:** Demonstrates regard for the dignity and respect for all patients, families, guests, and representatives of other organizations as well as fellow employees, volunteers, and medical staff in support of the practice’s mission to provide consistent, quality health care services in a professional, caring, and responsive environment.

<table>
<thead>
<tr>
<th>Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1. Maintains confidentiality of patient and of patient/practice information with no infractions.</td>
<td>1  2  3  N/A</td>
</tr>
<tr>
<td>7.2. Consistently displays a caring and responsible attitude, represents the practice in a positive manner, and conducts all activities respecting patient/customer rights and expectations.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td><strong>Exceeds Standard</strong></td>
<td></td>
</tr>
<tr>
<td>7.3. Consistently makes extra efforts to achieve patient/customer expectations while discharging job responsibilities.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.4. Regularly maintains a neat appearance and adheres to department/corporation expectations for dress, including the wearing of appropriate identification.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.5. Interpersonal relations with other health care workers are regularly fostered in a courteous and friendly manner as evidenced by supervisory observation and peer input.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td><strong>Exceeds Standard</strong></td>
<td></td>
</tr>
<tr>
<td>7.6. The employee continuously exhibits self-initiated behaviors as outlined previously.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.7. Resolves conflicts with staff members by following established communication norms with limited involvement by supervisor to initiate resolution.</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.8. Consistently receives and gives suggestions and constructive criticism in a professional manner.</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>

Comments: ___________________________________________________________________
_____________________________________________________________________________
**Criterion 8:** Demonstrates responsibility for individual performance and efficient utilization of products, supplies, equipment, and time to ensure the timely completion of duties and to promote financial viability through provision of services at a reasonable cost.

<table>
<thead>
<tr>
<th>8. Performance Standards</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1. Maintains consistent level of productivity as influenced by impinging factors of access, practice load, and complexity of care.</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>8.2. Performs other support functions to enhance the workflow.</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>8.3. Provides proper notification for all absences or tardiness, scheduled shift, and scheduled time off in accordance with company policy.</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>8.4. Consistently uses products, supplies, and equipment in an efficient manner, keeping waste within practice limits as observed by peers and administration. Exceeds Standard</td>
<td>□1 □2 □3 □N/A</td>
</tr>
<tr>
<td>8.5. Regularly exceeds company standards and regularly suggests more efficient ways to complete tasks.</td>
<td></td>
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</table>

Comments: ____________________________________________________________________________________________

**Criterion 9:** Employee follows established safety precautions and procedures in the performance of all duties to ensure a safe environment.

<table>
<thead>
<tr>
<th>9. Performance Standards</th>
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<tbody>
<tr>
<td>9.1. Regularly performs job tasks in accordance with company policy and procedures, including appropriate use of equipment and machines and appropriate use in wearing of personal protective equipment and safety equipment.</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>9.2. Demonstrates a complete knowledge of body mechanics by consistent use in the work setting as evidenced by no injuries sustained as a result of improper body mechanics in the evaluation period.</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>9.3. Demonstrates a concern for cleanliness of self and work area and practices proper infection control and universal precautions techniques. Exceeds Standard</td>
<td>□1 □2 □3 □4 □5</td>
</tr>
<tr>
<td>9.4. No observable variances during the review period.</td>
<td></td>
</tr>
<tr>
<td>9.5. Responds to codes in accordance with emergency procedures.</td>
<td>□1 □2 □3 □N/A</td>
</tr>
</tbody>
</table>
9. **Performance Standards**

<table>
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<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5</td>
</tr>
</tbody>
</table>

9.6. Regularly maintains work area and equipment in a neat and orderly manner, assists in the cleaning of other work areas, and corrects any malfunctioning equipment or environmental conditions as observed by administration.

Comments: ___________________________________________________________________
____________________________________________________________________________

**Smart Goals**

**Goal and Target Date**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Date</th>
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<tbody>
<tr>
<td>Goal</td>
<td>Date</td>
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<tr>
<td>Goal</td>
<td>Date</td>
</tr>
<tr>
<td>Goal</td>
<td>Date</td>
</tr>
</tbody>
</table>

Employee Name: __________________________________________

Employee Signature: ________________________________

Department Director/Supervisor Name: __________________________

Department Director/Supervisor Signature: __________________________

Date: ______________________

Date Issued/Approved: ______________________
Appendix O: Sample Structured Orientation Plan and Skills Checklist

Overview

The purpose of this form is to document completion of the orientation process and demonstration of skills in the critical components of WOC nursing care. This form can be adapted with areas to place a checkoff or dates when the orientation/skills were completed. Additional skills or content areas can be added to meet the needs of the facility and/or the WOC nurse.

Utilization Guidelines

1. Each nurse hired by the _______________ organization is assigned to receive 1 full day of orientation with the WOC nurse(s).
2. The WOC nurse will utilize the Structured Orientation and Skills Checklist to ensure that:
   - Critical procedures are reviewed and demonstrated to the orienting nurse.
   - The orienting nurse is able to satisfactorily describe/demonstrate the critical skills.
3. Following orientation to the WOC nurse role and the critical procedures, the skills checklist form will be completed by the WOC nurse with the following distribution:
   - One copy to the orienting nurse’s file.
   - One copy to the orienting nurse.
   - One copy to the appropriate supervisor.
4. If the WOC nurse and the orienting nurse are unable to complete all of the components of the structured orientation, the appropriate supervisor will be notified and a follow-up plan will be established to complete the orientation and skills demonstration process.

WOC Care Orientation Guide and Skills Checklist

I. WOC nurse role.
   A. Services provided/indications for referral.
   B. Referral process.
   C. WOC nurse and staff nurse roles and responsibilities.

II. Wound care.
   A. Critical assessment parameters:
      1. Identify location.
      2. Measure dimensions and depth in centimeters: length measured at longest head-to-toe dimension and width measured at widest point (side to side) perpendicular to the length; depth measured straight into wound at deepest point.
      3. Determine presence of sinus tracts and undermined areas: location and depth in centimeters.
      4. Stage pressure ulcers; classify other type of wounds as full/partial thickness.
      5. Assess status/appearance of wound bed (eg, granulating, necrotic, infected).
      6. Assess wound edges (open/closed).
      7. Assess exudate---volume, color, odor.
      8. Assess status of surrounding tissue (eg, intact, macerated, inflamed).
   B. Principles of management/dressing options.
      1. Importance of eliminating causative factors.
2. Importance of providing nutritional support and glucose control.

C. Guidelines for topical therapy.
   1. Options for wound with dry eschar.
   2. Options for superficial wound with minimal amounts of exudate.
   3. Options for superficial wounds with moderate to large amounts of exudate.
   4. Options for deep or tunneled wounds with minimal to moderate amounts of exudate.
   5. Options for deep or tunneled wounds with moderate to large amounts of exudate.
   6. Special considerations for leg ulcers.
   7. Importance of differential assessment and WOC nurse consult when needed.
   8. Venous ulcers: Importance of elevation and compression.

III. Ostomy care.
   A. Pouch emptying.
      1. Indications and frequency.
      2. Guidelines for instruction to patient (eg, removing pouch clip, draining pouch, cleansing tail, reattaching clip).
   B. Pouch change: Fecal diversions.
      2. Guidelines for cleansing and drying skin.
      3. Peristomal skin protection: Guidelines for paste application and use of skin sealants if needed.
      4. Procedure for centering and applying pouch.
         • One-piece.
         • Two-piece.
   C. Pouch change: Urinary diversion.
      2. Guidelines for cleansing and drying skin and for “wicking” the stoma.
      3. Peristomal skin protection: Guidelines for use of skin sealants, if needed.
      4. Procedure for centering and applying pouch.
         • One-piece.
         • Two-piece.
   D. Management of peristomal skin breakdown.
      1. “Crusting” procedure (eg, use of skin barrier powder and skin sealant).
      2. WOC nurse referral for severe or nonresponsive skin breakdown.
   E. Dietary/Fluid modifications (teaching guidelines).
      1. Colostomy: No absolute restrictions, reduction or “timing” of gas-producing foods, fiber/Fluids needed to prevent constipation.
      2. Ileostomy: Importance of increased fluid intake, cautious intake of high-fiber foods to prevent food blockage.

IV. WOC nurse availability for bowel and bladder retraining/assistance with continence issues.
Appendix P: Sample Annual Conference Planning Time line

Suggested Time Frame and Actions to Be Taken: Starting 36 Months Prior to the Date of the Program.

36 Months in Advance

Form the Planning Committee
- For ANCC-accredited programs, the nurse planner coordinator is an RN (minimum BSN or master’s prepared); members hold BSNs.
- Individuals with previous experience in planning seminars/programs are helpful.
- Persons who have expressed an interest in working on the planning committee and can commit to the expectations and responsibilities of a committee member are good choices.
- Meetings may need to be held quarterly the first 2 years and then monthly.
- Establish specific timetables for marketing and arranging convention center space.
- Assign areas of responsibilities to committee members.
- Members should provide general update to committee during regularly scheduled meetings.

30 Months in Advance

Site Selection/Negotiation
- Locale may have been predetermined by rotation schedule or committee selection based on prior sites, the time of year that the program has previously been held, and other activities that were identified as affecting attendance.
- Determine/compile preferred dates/sites.
- Determine/solicit facility availability and capabilities. Conduct site visit.
  - Facility must be able to accommodate program schedule, meeting room needs (e.g., general session vs breakouts), and the required exhibit space.
  - Determine available room blocks and rates quoted (single or double).
  - Determine audiovisual (AV) support, food function capabilities, handicap accessibility, and exhibitor table space, if required.
  - Negotiate waiving meeting room rental based on food functions, complimentary rooms per number of reserved rooms per night, and special rates for faculty or committee members.
  - Negotiate a “set” (confirmed) room rate—same rate housing 1 or 4 persons. Inspect the rooms.
  - Establish method of room reservation and confirm if reservations should be made directly with the hotel or through a group.
  - Present details of facility and contract to committee prior to commitment.
  - Reserve site/dates—submit security deposit if required. Coordinator signs contract.
24 Months in Advance

Topic Selection/Objectives/Program Schedule/Evaluation

- Compile a needs assessment from prior program evaluations, questionnaires, or requests received from potential participants.
- Select theme and topics.
  - Theme should have a central or specific focus.
- Verify target audience.
  - Usually driven by topic selection; could be general health care, nursing, or specialty focus.
- Determine program schedule based on number of topics selected.
  - Will the program all be general sessions or will breakout sessions be included, and on which days?
- Speaker solicitation/outlines.
  - Determine speakers to address the selected topics who have recognized expertise in the field of the specific topic.
  - Speakers who have been recommended or previously heard are preferable.
  - Do not overlook nurses or local speakers, which can help contain costs.

Exhibitors

- Compile a list of exhibitors---consider previous participants. May need to develop criteria for selecting/admitting exhibitors based on topics presented at conference. For example, if a conference is planned only about continence disorders, having a significant number of bed companies will not support the focus of the conference.
- Determine fees---based on the number of days available for exhibitors and the space requirements of individual exhibitors (eg, a bed company usually requires more space than other vendors).
- Identify what the fee covers (ie, number of representatives per space, representatives attending educational/social/food functions) and include this expense in the fee.
- Consider a discount for early registration or a late fee if the registration deadline is missed.
- If the number of exhibit spaces is limited, stress early registration and stick to the deadline.
- At some meeting facilities, the fee for exhibit space is waived based on food and beverage expenses during the meeting.
- Exclusive viewing times for exhibits are recommended to ensure support from the solicited companies. Exhibit times that compete with educational or business sessions or that are scheduled for brief periods of time are usually not well attended and, therefore, are not believed to be beneficial for exhibitors.
- One- to 2-hour exhibit sessions are recommended.
- Serving refreshments in the exhibit hall during the exhibit sessions also helps draw attendees to the exhibit area.
- Early morning exhibit sessions usually are not well attended.
Registration/Budget Projections

- It is recommended that 1 person, ideally the treasurer, be responsible and accountable for all monies.
  - Registrations from attendees should be sent to the designated person(s).
  - Exhibitor’s fees should be forwarded to designated individual/treasurer.
- Develop budgetary needs with input from each committee member regarding expenses that will be incurred from his or her area of responsibility.
  - Determine the speakers’ honoraria and what travel expenses will be reimbursed.
  - Review menu items and determine a cost per person for food and beverage.
- Determine registration fees with committee input:
  - Special rates might be developed for students, retirees, and more than 1 person attending from the same institution.
  - Fees for daily walk-in registration and early or late registration also should be established.
  - In setting the fee, consider the costs of the program for all food functions, costs for room rental, AV expenses, speaker fees, and any expected profit margin.
- Develop a cancellation policy and procedure.

18 Months in Advance

- Identify topic and audience, overview of desired content, honorarium, and expenses (ie, room, travel, meals) offered, length of presentation (consider need for question-and-answer period).
- Develop written behavioral objectives for the program and individual topics.
- Identify and invite possible speakers for selected topics.
- Outline speaker responsibilities, including honorarium and travel expenses.
- Negotiate any fees and confirm all of the speaker’s information in writing. This should include expectations regarding the presentation, handouts, biography, presentation outline, AV needs, arrival and departure information, location of conference, and so forth.
- Request necessary American Nurses Credentialing Center (ANCC) forms from speakers.
- Invite potential exhibitors.
  - Send invitation letters, which should include dates, location, the conference theme, program topics, exhibit times, and the fee structure plus what is included in the fee (eg, number of reps).
  - A registration form should be completed by each company that plans to exhibit. It should include all information exhibitors need to provide, including a company description.
- Confirm receipt of exhibitors’ fees. If you have a late fee structure in place, notify exhibitors if the fee has been received after the deadline.
  - Confirmation letters to exhibitors should include a map or directions to the location of the meeting, instructions regarding shipping of booth materials, and setup and teardown times.
- Develop the brochure to send to potential program attendees.
- Consider layout, type of print, paper color and texture, content, registration information, hotel information (if applicable), map to location, food functions included, and special events.
- Contact printers and determine cost. Determine whether printer can provide mailing services.
- Utilize printer resources for design ideas.
- Determine sources of mailing lists based on the identified target audience.
- Approve the brochure design and confirm content and commence printing.

- Seek sponsorship for conference (usually the responsibility of the conference coordinator).
  - Sponsorship is typically solicited for specific functions or activities such as:
    - Speakers.
    - Receptions.
    - Conference items (eg, attendee bags, hotel key cards).
  - Sponsorship requests should be made in writing, although phone contact is often beneficial because it is more personal and direct. Talking by phone also allows both parties to explore options and determine how the sponsorship can best benefit both parties.
  - Appropriate acknowledgment of all sponsors should be provided in the program booklet along with appropriate signage.
  - Sponsors of special events (either solely or jointly sponsored) should be acknowledged separately from supporters who contribute to the overall program or speakers’ support.

12 Months in Advance
- Provide an outline of the program schedule and objectives, information about the fee structure, and the cancellation policy to the promotional chair/public relations committee for inclusion in the conference/program brochure.
- Procure commitments from speakers.
- Send a reminder to exhibitors who have not responded.
- Confirm sponsors.

6 Months in Advance
- Request the packet to apply for continuing education (CE) contact hours for the program from the accredited body that will approve the program for CE.
- Develop the evaluation tool based on the American Nurses Credentialing Center’s Commission on Accreditation (ANCC) criteria or in accordance with the accredited approver’s guideline. Included the evaluation tool in the conference booklet at the time of registration.
- Secure the needed written information to complete the CE application packet from speakers.
- Mail brochures.
  - Note the early bird deadline (if relevant) and also the deadlines for the hotel registration, which are typically 1 month prior to the actual date of the conference.
- Develop the format for the program booklet to be distributed at registration.
  - Cover might reflect theme or concept used in brochure.
Appendix P – Sample Annual Conference Planning Timeline

- Content should include objectives, speakers’ information, content outlines, bibliographies, schedule at a glance, committee members, posters, recognition of any sponsors/supporters, and so forth.
- Assemble program booklet and send to the printer.
  - Determine and initiate registration strategies and financial records.
  - Finalize program logistics.
    - Arrange for necessary AV equipment, determine room assignments, arrange for moderators/monitors for each presentation, determine setup of rooms to maximize speaker visibility, determine lighting requirements for speakers using slides or overheads, and so forth.
    - Based on information submitted by each speaker, determine the time, location, and type of AV equipment needed; submit requests to the AV company.
    - Assign moderators to introduce speakers and inform them of their duties. Moderators should greet the speaker half an hour prior to the presentation; review introductory remarks (ie, speaker bio---how to introduce the speaker), assist with AV needs; escort the speaker to the room; and check the microphone, pointer, and lighting controls with the room monitor or AV personnel.
  - Determine layout of the exhibit area. Avoid having “like” companies adjacent to one another, especially bed companies, if possible.
    - Determine location for exhibitor registration, have name tags available, and provide each company with a list of preregistered attendees in its registration packet.
    - Have appropriate signage made to indicate exhibitor registration and if desired, signage for each exhibitor at the conference.
    - Be sure that exhibitors are in their designated space in the exhibit area and that they do not extend into adjacent spaces.
  - Determine location for attendee registration and solicit volunteers to assist with registration, if needed.

5 Months in Advance

- Submit the completed application and fee for CE approval to the appropriate association that is an accredited approver of CE (eg, ANCC, State Nurses Associations).
  - This may need to be done earlier based on the time line given to you by the accredited CE approver.

4 Months in Advance

- Monitor financial projections.
- Send confirmation to registrants.

2 Months in Advance

- Contact speakers to confirm dates, time, location, and other details related to presentation, transportation, or lodging.
- Plan the schedule/staff for the registration areas for exhibitors and participants.
- Verify exhibitors and the number of representatives designated to attend.
- Provide exhibitors with a registration packet, program booklet, and rules list for exhibitors.
• Notify the contact person for the exhibitor about the time of the exhibitors’ meeting during conference, if applicable.
• Reconfirm details of the conference with the meeting facility and reconfirm commitments of committees to assist with on-site conference needs.
• Communicate the food and beverage orders directly to the catering manager at the facility.
  o Any changes in food and beverage orders since first reviewed should be discussed.
  o Review the number of anticipated attendees, being mindful of the allocation of space needed for food functions. Coffee by the gallon is more cost-effective than per person. Sodas or bottled waters should be purchased by usage (based on consumption) versus per person, if served during a break.
  o If a food function is being solely funded by a specific sponsor, the caterer should be made aware of billing arrangements.
  o Verify with the catering department all the required food services and the specific date that is required for final confirmation of the number of attendees to be served (i.e., usually 3 days prior to the actual event); review any special food requirements.
• Confirm that all necessary forms and required information for CE, along with required payment, have been completed.

1 Month in Advance
• Prepare “certificate of attendance” forms. Include the approval number or appropriate information from the CE-accrediting body on the certificate.
• A certificate may be given for the total program, which requires the participant to attend the entire program, or separate certificates can be awarded for each day the participant attends. Follow the guidelines for determining and awarding CE, as identified by the accredited approver in the CE application packet.

1 Week Prior
• Finalize food and beverage requirements and your “guaranteed” numbers with the catering manager. Remember, you can always go up in your numbers, but once they have been guaranteed, you cannot reduce them.

At Conference
• Compile registration packets and have name tags made for attendees who have preregistered.
• Have appropriate signage made to indicate attendee registration area.
• Attendees to complete necessary registration information for roster of attendance.
• Greet speakers; confirm AV requirements.
• Provide additional evaluation forms at the conference.
• The conference coordinator should review food and beverage receipts with the caterer each day. Keep a copy of the receipts. You will receive a final bill after conference. Compare your receipts from the conference to the final bill that you receive.
End of Conference

- Collect the final evaluations; distribute certificates of attendance.
- Thank speakers; distribute honorariums.
- Submit bills to the treasurer or the treasurer’s designee.

Postconference

- Collate evaluations and submit to conference coordinator.
- Send written acknowledgment to speakers and include evaluation summaries for individual presentations.
- Treasurer or designee facilitates payments after review of all invoices.
- Submit all necessary postconference information to the accredited CE approver as requested. This typically includes a roster of attendance, program evaluation summaries, and posttest results, if applicable. Check the accredited CE approver’s guidelines for the specific information and deadlines for submitting the postconference information.
Appendix Q: Sample Conference Forms: Budget, Application for Exhibit Space, Exhibitor Evaluation, and Conference Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Budget for Prior Year</th>
<th>Actuals for Prior Year</th>
<th>Current Year Budget</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibits</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Registration</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Event Sponsorship</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Commercially Supported Symposia</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Unrestricted Educational Grant</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Postmeeting List Sales</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstract Management</td>
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<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>CE Administration</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Marketing Annual Conference</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Audiovisual</td>
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<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Audience Response Units</td>
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<td>Awards</td>
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<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>CD ROM</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Commercial Supported Symposia</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Decorator</td>
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<td>$ -</td>
<td>$ -</td>
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<td>Disability Accommodations</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Equipment Rental</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Food and Beverage</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Gratuities</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Gifts/Amenities</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Insurance--Cancellation</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Meeting Space Rental</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
</tbody>
</table>

*This column is important to complete. When you are determining a budget line item, please note how you arrived at that figure.*

ie, registration income – 100 Members at $100 = $ and 50 Nonmembers at $50 = $
<table>
<thead>
<tr>
<th>Item</th>
<th>Budget for Prior Year</th>
<th>Actuals for Prior Year</th>
<th>Current Year Budget</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Booth/Book Store</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Opening/Closing Speaker</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Photography</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Printing</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Registration</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Shuttle Service</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Signs</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Speaker Honoraria</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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<tr>
<td>Speaker Housing</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Speaker Per Diem</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Speaker Web site</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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</tr>
<tr>
<td>Speaker Travel</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Sponsored Items</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Supplies</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
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</tr>
<tr>
<td><strong>Total Direct Expense</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td></td>
</tr>
<tr>
<td>Copies</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Management Fees</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Postage/Shipping</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Staff Travel</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td>Tele/Fax/E-mail</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td></td>
</tr>
<tr>
<td><strong>Total Meeting Management</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Net Income (loss)</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td><strong>$ -</strong></td>
<td></td>
</tr>
</tbody>
</table>
Sample Conference Forms: Application for Exhibit Space

Please Photocopy Form for your Records

CONFERENCE INFORMATION

Conference: ____________________________
Date: ________________________________
Location: _____________________________

Please return this form and your check to:
Name: _______________________________
Address: _____________________________
City, State, Zip: ________________________
Phone: (___) ________ Fax: (___) _________

CONTACT INFORMATION (FOR ALL CORRESPONDENCE)

Firm or company name: ______________________________
Contact person: _______________________________
Title: _______________________________
Address: _____________________________
City, State, Zip: ________________________
Phone: (___) ________ Fax: (___) _________
E-mail: ________________________________

PLEASE INDICATE HERE THE EXACT COPY FOR YOUR COMPANY DESCRIPTION IN THE ON-SITE PROGRAM BOOK:

Firm or company name: ______________________________
Contact person: _______________________________
Address: _____________________________
City, State, Zip: ________________________
Phone: (___) ________ Fax: (___) _________
E-mail: ________________________________

Please indicate your product/service category:
□ Wound □ Ostomy □ Continence

Company or Product Description (maximum 50 words; attach additional sheet if necessary):
________________________________________

Each company will receive 2 complimentary registrations per booth. All representatives must be registered.

Additional registrations are $____ per person. Please submit names on the separate sheet enclosed in prospectus.

Booth Choices

<table>
<thead>
<tr>
<th>Booth Choice</th>
<th>Space No(s):</th>
<th>Indicate Booth Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st choice</td>
<td></td>
<td>Single Booth 10' x 10' = _____</td>
</tr>
<tr>
<td>2nd choice</td>
<td></td>
<td>Multiple In-Line Booth 10' x = _____</td>
</tr>
<tr>
<td>3rd choice</td>
<td></td>
<td>Peninsula Booth x = _____</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Island Booth x = _____</td>
</tr>
</tbody>
</table>

We want to be situated near the following companies:

We do not want to be situated near the following companies:

PAYMENT ENCLOSED

| # of booth(s) | @ $ member | @ $ nonmember | $ |
|---------------|------------|---------------|
| Corner booth fee | @ $ | $ |
| # of additional personnel | @ $ | $ |
| Set(s) Labels | @ $ | $ |

TOTAL ENCLOSED $____

It is agreed that this application and contract resulting from its acceptance and confirmed assignment of space shall be subject to the regulations contained in “Information for Exhibitors” as contained in this brochure. Cancellation requests must be received in writing. If written notice of space cancellation is postmarked before ________, a full refund, less a $50 administrative fee will be made. No refunds will be made after ________. In case of cancellation of the conference for reasons beyond the control of ___________ it is understood that the liability of the association shall be limited to the refund of the amount paid.

Authorizing Signature (required): ____________________________ Date: ___________

Company: ____________________________ Individual Check #: ____________________________ Amount Paid $____ Balance Due: $____

Credit Card: ☐ Visa ☐ Master Card Credit Card #: ____________________________ Expiration Date: ___________

Signature: ____________________________

Appendix Q – Sample Conference Forms: Budget, Application for Exhibit Space, Exhibitor Evaluation, and Conference Evaluation 159
Sample Conference Forms: Exhibitor Evaluation Form

Conference or Seminar Name: 
Date: 
Location: 

In order for __________ to provide optimum arrangements for our exhibitors, we would appreciate your cooperation in completing this questionnaire. Please fill in the circle for rating of your choice.

| 1. Please rate the interest level and quality of conference attendees in the exhibit hall. | Excellent | Good | Fair | Poor |
| 2. How would you rate overall attendance in the exhibit hall? | Excellent | Good | Fair | Poor |
| 3. How would you rate the effectiveness of the following exhibit days? | Excellent | Good | Fair | Poor |
| a. Date — Exhibits Open — time | Excellent | Good | Fair | Poor |
| b. Date — Exhibits Open — time | Excellent | Good | Fair | Poor |
| c. Date — Exhibits Open — time | Excellent | Good | Fair | Poor |
| d. Date — Exhibits Open — time | Excellent | Good | Fair | Poor |
| 4. How would you rate the adequacy of the exhibit hours? | Excellent | Good | Fair | Poor |
| 5. How would you rate the effectiveness of the exhibitor lead program? | Excellent | Good | Fair | Poor |
| 6. Please rate the quality of the following: | Excellent | Good | Fair | Poor |
| a. Exhibitor Registration Process | Excellent | Good | Fair | Poor |
| b. Hotel Accommodations | Excellent | Good | Fair | Poor |
| c. Exhibit Hall Design | Excellent | Good | Fair | Poor |
| d. Booth Location | Excellent | Good | Fair | Poor |
| e. Decorating | Excellent | Good | Fair | Poor |
| f. Cost of Booth | Excellent | Good | Fair | Poor |
| g. Overall Exposure to Attendees | Excellent | Good | Fair | Poor |
Sample Conference Forms: Conference Evaluation Form

Conference or Seminar Name:
Date:
Location:

To assist us in evaluating the effectiveness of this meeting and to make recommendations for the future, please complete this conference evaluation form by filling in the circle for the appropriate rating. Please complete the speaker portion of this form at the conclusion of each lecture. Return this form to the registration desk at the end of the conference along with the white copy of your certificate of attendance and contact hours form. Thank you for attending this meeting!

Section I. Overall Conference Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel the conference achieved the following objectives:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. (List objective)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. (List objective)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. The conference met my personal objectives.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. The program was well organized.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. The exhibits provided an adequate environment for learning.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. The program book was easy to read and helpful.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. The individual sessions were relevant to the conference goals.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. The individual sessions assisted me in achieving my learning goals.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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</table>
### Section II. Evaluation of Conference Quality

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall Conference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Exhibits:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Grand Opening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Quality/Space</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Time Allowed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Location</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Hotel Facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Conference Registration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Special Event</td>
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<tr>
<td>6. Helpfulness of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Planning Committee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Monitors/Moderators</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Registration Personnel</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d. Hotel Staff</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Section III. Content/Speaker Evaluation

N/A = Not at All  1 = Poor  2 = Average  3 = Above Average  4 = Outstanding

<table>
<thead>
<tr>
<th>Session Type – Date – Time</th>
<th>Speakers Effectiveness</th>
<th>Effectiveness of Teaching Method</th>
<th>Relevance of Content to Session’s Objective</th>
<th>Session Met Stated Objectives</th>
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</tbody>
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Title:

Objective:

Speaker Name:
Appendix R: Role of the WOC Nurse or Continence Care Nurse in Continence Care

*Note: This document was approved and adopted by the WOCN Society Board of Directors in 2009 and is available in the WOCN Public Library: http://www.wocn.org/PublicLibrary

Background

Incontinence (ie, loss of bladder and/or bowel control) is a significant health care problem, which affects an individual’s physical and psychosocial life. The social costs of incontinence are high and even mild symptoms affect social, sexual, interpersonal, and professional function. Incontinence creates a burden on families and caregivers and has a significant economic impact on society.

The incidence of incontinence increases with age and is greatly impacted by factors that affect independent living. In 2000, the cost of incontinence was $12.6 billion. With increasing numbers of people who are 65 years of age and older, dealing with issues relating to incontinence will have a major economic impact on society.

Urinary Incontinence

Urinary incontinence is a stigmatized, underreported, underdiagnosed, and undertreated condition that is erroneously thought by many to be a normal part of aging.

- Nocturnal enuresis is the predominant type of incontinence among children.
- The incidence of incontinence among elderly nursing home residents is estimated to be 47% to 70% and is the second leading cause noted by caregivers for seeking nursing home placement.
- Fifty-three percent of homebound, older persons are incontinent or have overactive bladder/urge incontinence.
- One-third of men and women, 30 to 70 years of age, experience loss of bladder or bowel control at some point in their adult lives, one-third get out of bed 2 or more times per night to urinate, 1 in 8 reports losing urine in route to the bathroom, and two-thirds have never discussed bladder health with their doctor.
- Only 1 in 8 Americans who has experienced loss of bladder control has been diagnosed.
- On average, women wait 6.5 years from the first time they experience symptoms until they obtain a diagnosis for their bladder control problem(s).
- Men are less likely to be diagnosed than women.
  - Men are also less likely to discuss incontinence with friends and family and are more likely to be uninformed.
- Two-thirds of individuals who experience loss of bladder control symptoms do not use any treatments or products to manage their incontinence.
- In the elderly population, the need for frequent toileting and/or urgency to void increases the risk of falls by 26% and bone fractures by 34%.
- It is estimated that approximately 80% of persons affected by urinary incontinence can be cured or improved.
- A recent study has shown that pelvic floor muscle training and bladder training resolved urinary incontinence in women as effectively as some anticholinergic drugs and were more effective than other approaches.
Fecal Incontinence

Fecal incontinence is the inability to control the passage of gas and/or liquid or solid stool.

- More than 5.5 million Americans are estimated to experience episodes of fecal incontinence.
- Six percent to ten percent of men and 6% to 15% of women experience fecal incontinence without urinary incontinence.
- More than 2% of all women (2.2%) who have delivered 1 or more children may experience fecal incontinence.
- Seven percent of healthy people, 65 years and older, experience fecal incontinence.
- Twenty-three percent of stroke patients experience fecal incontinence.
- Thirty-three percent of elderly people at home or in a hospital experience bowel control problems.

Combined Urinary and Fecal Incontinence (Dual Incontinence)

Dual incontinence impacts 25% of all US adults during their lives.

Role of the Continence Nurse

The continence nurse provides expert care to patients with urinary and/or fecal incontinence by conducting a focused assessment, performing a limited physical examination, synthesizing data, developing a plan of care, and evaluating interventions. The role includes, but is not limited to, serving as an expert clinician, consultant, educator, and/or administrator/manager in various health care settings.

Continence nursing management is based on an in-depth knowledge of normal voiding and defecation physiology, common alterations in bowel/bladder function and their sequelae, and a basic understanding of common diagnostic studies (eg, urinary analysis, culture and sensitivity, studies of the urinary and lower digestive tract).

Continence Nurse Competencies

Specific competencies of the continence nurse include the following skills and abilities:

- Performs a focused assessment.
- Obtains a relevant history.
- Performs bedside testing of bladder filling and sensation (bedside cystometrogram).
- Measures postvoid residual urine by catheterization or bladder scan.
- Synthesizes data related to incontinence to identify individuals at risk, reversible causes, types of urinary incontinence, and common bowel dysfunctions that contribute to fecal and/or urinary incontinence.
- Makes an appropriate nursing diagnosis of urge, stress, mixed, and/or functional urinary incontinence.
- Uses/recommends appropriate management strategies including the following interventions:
  - Educates and counsels patients, families, and staff regarding:
    - Behavioral therapies such as toileting programs, urge suppression, and pelvic muscle exercises.
    - Bowel training or stimulated defecation programs.
    - Intermittent self-catheterization.
- Care of indwelling urethral and suprapubic catheters.
- Incontinence products.
- Measures to clean, protect, and moisturize the perineal skin.
- Treatments for incontinence-related skin breakdown.
- Fluid and dietary modifications.
  - Monitors therapeutic effects of medication therapy.
  - Provides pelvic floor rehabilitation and reeducation via electrical muscle stimulation and biofeedback, in some settings.
  - Evaluates outcomes of interventions and reports to the primary care provider as appropriate.
  - Makes appropriate referrals for recurrent urinary tract infections, hematuria, pelvic organ prolapse, urinary retention, and pelvic pain syndromes.
  - Monitors overall quality of care to identify needs for improvement.

**Role of the Advanced Practice Continence Nurse**

The advanced practice continence nurse provides expert care to patients with urinary and/or fecal incontinence by conducting a focused assessment, performing a comprehensive physical examination, synthesizing data, developing a plan of care, and evaluating interventions. The role includes, but is not limited to, serving as an expert clinician, consultant, educator, and/or administrator/manager in various health care settings.

**Advanced Practice Nurse Continence Competencies**

The advanced practice continence nurse possesses the competencies of the continence nurse and in addition has the following advanced competencies in accordance with an advanced level of education at the master’s level and in accordance with state practice regulations:

- Performs a comprehensive physical assessment that may include a pelvic examination for masses, prolapse, and urethral hypermobility; a digital rectal examination of the prostate; and a neurologic assessment.
- Synthesizes data.
- Uses/recommends appropriate management strategies including the following interventions:
  - Interprets diagnostic studies such as urodynamic studies and studies of bowel motility and elimination.
  - Prescribes pharmacologic treatment of common conditions of the urinary tract and bowel such as urinary tract infection, overactive bladder, constipation, and diarrhea.
- Provides care for common gynecological conditions such as vaginitis and pelvic organ prolapse (ie, fitting and management of pessaries).
- Performs complex, multichannel urodynamic studies with/or without fluoroscopic imaging.
- Performs anorectal manometry studies.
- Provides pelvic floor rehabilitation and reeducation via electrical muscle stimulation and biofeedback.
**Conclusion**

The continence nurse is in an excellent position to meet the needs of patients with urinary and/or fecal incontinence across all practice settings. The continence nurse is skilled in the collaborative practice approach required for comprehensive patient management in today’s health care environment.

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Adopted by the WOCN Board of Directors: May 6, 2009
References

Appendix S: WOCN Business Plan Template Workbook

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Acknowledgments

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Date Submitted: January 10, 2011
Resubmitted: April 18, 2011
Revised: May 2, 2011
Board Approval: July 26, 2011
Developing a Business Plan

In this section, you will find a business plan template workbook designed to identify the specific components of a business plan and guide you through creating one for an existing or new business/product. As a wound, ostomy and continence (WOC) clinician, managerial leader, consultant, or advanced practice nurse, planning is an integral component of meeting organizational, departmental, and professional practice goals.

The concepts within this template will benefit the WOC nurse across a variety of health care settings. As a WOC nurse clinical leader, you know the advantage you provide in managing resources cost-effectively and affecting improved outcomes related to wound, ostomy, and incontinence care (Wound, Ostomy and Continence Nurses Society [WOCN], 2010). Whether you are a novice or experienced WOC nurse, your expert assessment and individualized plan of care influence long-term clinical outcomes across care systems.

Completion of a professional business plan demonstrates commitment to your goals for implementing best practices, serves as an educational tool that highlights your focus on improved patient outcomes, and provides an instrument for the expression of professional values.

Each part of the business plan template provides brief theoretical background, using questions to help you gather the information that will create a meaningful plan for your business model. You may find that not all content areas will apply to every business plan depending upon your business model as a sole proprietor or in a partnership.

Included in the business plan template are as follows:

- Introduction
- The Cover
- Present Situation
- Goals and Objectives
- Business/Product Description
- Market Analysis/Strategy
- Critical Success Factors/Key Assumptions
- Qualifications
- Budget Process
- Sample Contract

A sample business plan with data follows the workbook template. The information contained in the sample is fictitious and should not be considered valid to your plan. (See **Appendix S–I: Sample Business Plan Template With Data.**)

The business plan table of contents includes:

- Executive Summary
- Present Situation
- Goals and Objectives
- Business/Product Description
- Marketing Analysis and Strategy
- Critical Success Factors/Key Assumptions
- Staffing Structure
- Proposed Budget
- Appendices
The real value of creating a business plan lies in the process of researching and thinking about your goals in a systematic manner, more so than the finished product in hand. The act of planning helps you think through concepts thoroughly, study and research uncertain facts, and look at ideas critically. This takes time on the front end but often avoids costly mistakes later. The entire business plan template may take days and sometimes weeks to complete. Each question should be given serious thought and outside resources should be reviewed before completing most questions. After all the questions are answered, the actual business plan can be written. A formal written business plan will provide the greatest benefit to your process.

Planning a new business/product can be both exciting and intimidating. This business plan template will make the planning process easier. Adequate planning is the foundation of a successful business/product.

**Introduction**

I. “He who fails to plan, plans to fail.” Proverb
   “Success in business is threatened if you can’t see the forest for the trees.” Unknown
   “In the absence of clearly defined goals, we are forced to concentrate on activity and ultimately become enslaved by it.”---Chuck Conradt (Marquis & Huston, 2006)
   • What business endeavor, product, project, or proposal is you creating a business plan for (ie, private practice consultation, a small consulting business, continence or stoma clinics, skin care team, disease management program, etc)?

   • Is this a new or existing business/product or clinical service?

   • Have you started the business plan? Yes □ No □

II. Planning requires time: It typically takes several weeks to complete a good business plan. Most of that time will be utilized in research and rethinking/rewriting your ideas and assumptions. Make time to complete the task thoroughly.

   Be realistic and do not underestimate the time you will need to create a thorough and meaningful business plan or proposal. Whether you strive to improve clinical processes or you are requesting another WOC position to better meet current patient needs, planning will influence accomplishment. After the initial business plan is implemented, revising should be an ongoing process. You should collect information in your day-to-day activities and update the business plan 2 to 3 times a year. Minimally, you should revise your business plan with new goals and strategies at least once a year.

   • How much time do you have to devote to a business or professional plan?

   • When is the business plan due for presentation?

   • How will you ration your time? ______ hours per week for ______ weeks/months.

III. Why develop a business plan?
A business plan is essential because it allows you to:
1. Lay out the master blueprint to show a logical progression of steps needed to reach the established goal. It is a powerful management tool that also helps you consider alternatives or possibly a better way of doing things.

2. Communicate your business plan to your own team. This is important in order to keep everyone on the same track and to be able to measure progress.

3. Communicate your business plan to others to gain their support. This may come in the form of resources, financing, reimbursement, “word of mouth” referrals, or just plain moral support.
   - Who on your team needs to be included in the business plan?
   - Who else needs to receive your business plan?

Example: For a personal business or consulting business plan with an agency, include team members such as business partners, attorney, accountant/banker, and technology/end user consultant. Other recipients of the business plan include your key physicians and/or clinical partners.

If you as the clinical expert are creating a wound care program or an outpatient stoma clinic from within an agency or facility, include administrators, managers, nurses, and WOC nursing peers as appropriate. Depending on the scope of your services or proposal, you may seek guidance from the human resource department, data analyst, or an expert in billing and reimbursement. The knowledge, advice, and support you gain by collaborating with other leaders and thoroughly planning are critical to the business/product’s success.

IV. Keys to convincing others

When others are looking at your business plan, their decision to support it depends heavily on the following areas:

1. **Your understanding of the current environment and your vision of the future: Your team’s expertise**—it is essential to identify the key attributes unique to a WOC nurse: the focused application of nursing science and practice to the care of persons of all ages with wounds, stomas, fistulae, drains, tubes, pressure ulcers, and incontinence (WOCN, 2010). You or your team must demonstrate that you have a balance of expertise in planning, educating, organizing, review/control, and leadership skills to impact patient care across health care systems.

2. **Your business/product**—culturally sensitive and age-appropriate care planning for patients across a variety of delivery systems is essential. Holistic care and guidance for psychosocial, sexual, and body image adaptation promotes optimal client outcomes. You should be able to describe how your business/product is different from others and how it will address current and future health care needs.

   Example: You may provide consultation in a remote service area without a formally educated or certified WOC nurse.

   Refer to http://www.wocn.org and http://www.wocncb.org for more information about the value of board-certified WOC nurses. There are many ways that our training and expertise can influence positive measurable outcomes.
3. **Your marketing plan**---market research is vital to the success of your business/product. There are 2 types of market research: (1) primary (gathering your own data) and (2) secondary (published information). You should have a strategy in place to market your business/product that includes expected growth as a result of marketing strategies. Wound, ostomy and continence nursing is a dynamic specialty that has been influenced by societal and health care needs of communities.

4. **Your projected financial statements**---you should be able to show that support of the business plan will result in an expected financial outcome. This will include forecasted positive financial growth for your business/product and/or cost-effective utilization of resources with improved patient outcomes.

V. **Before you start**

- *Ask yourself:*
  - How much money is available (now)?
  - Where will the money come from?
  - Whom can I depend on for financial support?
  - Will I leave a primary salaried (hourly) position with benefits?
  - If so, will I be able to sustain myself financially until my business/product begins to profit?
  - What outcomes/returns do I expect?
  - What expertise do my team and I have?
  - Will I work out of a home, office, or separate dwelling?
  - How many hours am I/are we willing to invest?

- *Name your business/product:*
  1. Keep it simple and straightforward.
  2. Be descriptive, include specifics.
  3. Make it distinctive.
  - What key words describe your business/product?
o What will you name your business/product?

- Select outside advisors (identify which of the advisor/consultant experts you will utilize and who they are):
  - Attorney or legal council:
  - Management consultant, manager, or administrator:
  - Marketing consultant:
  - Accountant, value analysis manager:
  - Insurance agent:
  - Banker, billing, or reimbursement experts:
  - Other consultants such as information services/technology (IS/T) for Web page design and privacy and safety compliance experts for sharing or storing electronic patient records:

- Determine your “Unique Service Advantage”:
  This is “That single, unique advantage, benefit, or appeal that others don’t offer or do as well as you.”
  You should consider years of experience, special skills or talents, particular areas of expertise, education, and service areas that are unique.
  o What is unique about your business/product?
  o What benefit(s) will your business/product bring that does not exist now?
  o What is unique about you or your team?
VI. Building your business plan

Your business plan should look professional but not glitzy. It should be bound with a cover, printed on quality paper, and be produced with a laser or letter quality printer.

- What paper will you use for your business plan?
- What color will the cover and coordinated paper be for your business plan?
- How will you bind your business plan?
- Will you need a quick print shop?
- Which one?
- How many copies of your business plan will you need?

Consistent color coordination with your business/product logo, business cards, and stationary provides a professional presentation. Create a theme. Establish a Web site (even if it is only 1 page). This will present a professional appearance for yourself/business/product. If you will be presenting your business plan to a prospective client, remember to bring several hard copies of your business plan and always have a copy for your review during your interview.

The Cover

When you design the cover page of your business plan, keep the following in mind:

1. Keep it simple.
2. Clearly identify the business/product.
3. Include address and phone numbers.
4. Always date it.
5. Indicate a contact person.

- What information do you want on your cover sheet?
  - Name of business/product:
  - Address:
  - Phone number:
  - Date:
  - Contact person:
    - Contact person’s credentials:
    - Contact person’s qualifications:
Table of Contents
A table of contents is imperative to facilitate the reader finding critical information with ease. The following is an ordered list of the usual contents of a business plan.

I. Executive Summary
II. Present Situation
III. Objectives
IV. Business/Product Description
V. Market Analysis/Strategy
VI. Operational Plan
VII. Financial Projections
VIII. Appendix

Executive Summary
An executive summary is a critical but frequently overlooked portion of a business plan. It must be designed to capture the intended reader’s interest by summarizing the key points and highlights of the business plan. It is a crystallization of the entire business plan in a brief overview format. Due to the nature of the executive summary, it is always located at the beginning of the business plan; however, it is one of the last portions that you will write.

A few things to remember when writing the executive summary are as follows:
1. **Keep it brief**—1 page, if possible.
2. **Hit the high points**—do not get bogged down in details.
3. **Make it interesting**—you may want to change the summary for each intended reader and concentrate on the areas of most interest to that reader. **Example:** If presenting to a physical therapist, explain how WOC nurse and rehab work together as a team.

Begin with a brief description of your business/product, how you developed it, and what your mission/purpose is. Next, describe the business/product that you will provide and how it will benefit the customer and/or the reader. (These topics should be stated succinctly in a few paragraphs.) One reference guide could be the information from Wound, Ostomy and Continence Nursing Certification Board “Are your Nurses Board Certified?” Do not assume that everyone is knowledgeable about the specific expertise and professional/clinical benefits provided by the WOC nurse.

Next, write a paragraph or two describing the background information including the market analysis, customer characteristics, competitive analysis, critical success factors, and assumptions. Then spend sufficient time explaining your goals and strategies for obtaining them. This will lead easily into a summary of the financial picture and projections.

Close the executive summary with a 1-paragraph conclusion that highlights the points that you want this particular reader to remember.

Present Situation
Explain what factors and information have brought you to the decision to start this business/product. How does your business plan support the facility’s mission statement and organizational goals?

- What changes are occurring in the health care environment, which will actually/potentially affect your business/product?
What future changes or factors will impact your business/product? Include both those types of factors that will have a negative or a positive impact.

I. External analysis

The following factors are important when analyzing the external environment (remember to do your homework and research these areas below):

1. Demographics of the anticipated target patient population.
2. Technology requirements.
3. Regulatory/political.
4. Economic/reimbursement.

What does the average person in your market area demographically look like? (You can usually find this information in the census bureau report; local, state, and federal reports; and other documents located in your local library or online.)

- Average age?
- Fastest growing age group?
- Average income?
- Facility pressure ulcer prevalence and incidence?
- Nonhealing wounds or patients with diabetes, and so forth?
- Colon or bladder cancer incidence?
- Continence or stoma clinics?
- What is the primary industry?

- Top 5 causes of mortality?
  1.
  2.
  3.
  4.
  5.

- Top 5 causes of morbidity?
  1.
  2.
  3.
  4.
  5.
II. Competitive analysis

There are many types of competitors. Some of the most difficult competitors are the least obvious. The following are the 3 most common types:

1. **Input or resource**---competes for the same resources as you.
2. **Process**---provides a business/product that is different than yours but has many of the same results (ie, physical therapist, case managers).
3. **Output**---does the exact same thing as you do.

- **Who would compete for the same resources that you need?** (Resources may include money, space, staff, equipment, etc.)

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<th>What Resource?</th>
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- **Who provides a business/product with the same outcomes as yours or a business/product that makes yours obsolete?**

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<th>Who?</th>
<th>What Business/Product?</th>
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- **Who is doing the exact same thing as you?**

III. Internal analysis

The following areas are the most common areas reviewed in an internal analysis.

1. **Past performance**---can only be done when there is an existing business/product that has data from the past to analyze.
   a. **Cost/profitability**---reviews how profitable the business/product has been in the past. Profitability might be measured in actual revenue or net profit but could also be measured in other forms of benefits brought to an organization.
      **Example:** The business/product has been within budgeted expenses for the last 3 years and has had a net profit of “X” each year, or the business/product has stayed within the break-even projection and as a direct result of the business/product’s activities, visits to the outpatient clinic have increased by 20%.
   b. **Utilization**---can be expressed in whatever units of measurement you prefer. It might be measured in any or all of the following: number of visits, hours, and patients. This is a representation of “volume” of service.
   c. **Quality (customer perceived and technical)**---technical quality is expressed as measurable outcomes and proven benefits. Perceived quality is from the customer’s point of view. Sometimes what makes a customer satisfied is not necessarily technical quality. **Example:** Many patients have a high degree of satisfaction with a health care provider who is friendly and caring, even though his/her clinical skills may be less than adequate.
2. **Strengths and weaknesses**---you must take a close look at what strengths and weaknesses you have. This can include an evaluation of your skills, your team’s skills, financial strength, your support systems, your competitors, and any other factor that will impact your business/product.

- **For EXISTING Businesses/Products Only:**
  How many “units” of service (ie, visits, hours, patients) compared to budget have you provided in the past 3 years?
  - **Unit of Service:**
    - Year 1: Actual: _____ Budget: _____
    - Year 2: Actual: _____ Budget: _____
    - Year 3: Actual: _____ Budget: _____
  - **Unit of Service:**
    - Year 1: Actual: _____ Budget: _____
    - Year 2: Actual: _____ Budget: _____
    - Year 3: Actual: _____ Budget: _____

- **For All Existing and New Businesses/Products:**
  *It is very important to capture this information on an ongoing basis.*
  - What proof do you have that your customers are satisfied or what types of methods will you use to measure your customers’ satisfaction? (This information can include customer/patient satisfaction reports, written statements from patients, physicians, etc)

  - What are your strengths and weaknesses?
    - **Technical skills:**
      - Strengths
      - Weaknesses
    - **Business skills:**
      - Strengths
      - Weaknesses
    - **Other skills/talents:**
      - Strengths
      - Weaknesses

  - What are your team’s strengths?
    - **Technical skills:**
      - Strengths
      - Weaknesses
Business skills:

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Other skills/talents:

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What financial strengths and weaknesses do you have?

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Who supports you? Who does not?

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What can you do better than your competitors?

What can your competitors do better than you?

What other things do you do well?

Goals and Objectives

Formulate a vision of where you want to be in 1 and 2 to 5 years and how you are going to get there. It is fine to be enthusiastic, but you should also be realistic. It is easiest to first set long-term goals and then establish a few objectives for each time period describing how you will achieve the goals. Do not get locked into a yearly time period; monthly time periods are very appropriate, especially for businesses/products.

- What are your goals?
  
  Here are a few things to consider in setting goals.
  
  - When do you want to open or start the business/product? _____
  - Do you want to stay a sole proprietor? _____
  - Have partners? _____
  - When do you want to break even? _____
  - Make a profit? _____
  - What kind of financial growth do you want over the next 5 years?
How many patients/hours/units of service do you want to provide/serve over the next 5 years?

What debts must you incur to start the business/product and when do you want to have your start-up costs paid off? (Normally, it takes 2-3 years to pay off start-up costs for supplies and 5-10 years for equipment.)

What do you need to do to overcome your identified weaknesses?

What other things do you need to consider?

List at least 3 goals you want to achieve over the next 3-5 years:
1. 
2. 
3. 

Fill out the following charts:

- **Goal 1:**

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<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
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- **Goal 2:**

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<th>Resources Needed</th>
<th>Completion Date</th>
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- **Goal 3:**

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<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Business/Product Description**

Develop a clear explanation of what the business/product does and how it benefits your customers. To get support or financing for a business/product and to attract customers, you must show that you have researched and identified the need for the business/product. Moreover, you must be able to clearly describe the business/product and the benefits that it provides.
In a large organization, you cannot assume that others know what you do as a WOC specialty nurse. What is your vision? One of greatest contributions of leaders is having a driving purpose, a vision. This purpose is exhibited through your knowledge, passion, and experiences, and is reflective and empowers the group or culture (Grossman & Valiga, 2005).

The following are specific areas you need to consider:

1. **Service portfolio**---WOC services, direct care, education, research, and standards.
2. **Unique features**---these are specific to your business/product.
3. **Value-added benefits**---program development expertise, disease management.
4. **Pricing strategy**---this is unique to your situation and should reflect the economic environment, health care reform, and regulatory or market demands.

- What are the key features of your business/product?

- How do they differ from similar businesses/products?

- What value-added benefits does your business/product bring to your customers?

- Does your business/product save money for your customers? How?

- Does your business/product improve quality of life? How?

- Does your business/product create a competitive advantage? How?

- How do customers access your business/product?

- What are your hours of availability?

- Are you available for emergencies?

- What geographic area and care settings do you cover?

- How will the business/product evolve in the future?
Market Analysis and Strategy
Through market analysis, you can clearly identify your customers, your competitors, and your business/product’s position in the market. This is the first and most important step in marketing. It is what will drive your marketing strategy and your promotional efforts. It helps you understand the needs of your customers, who your competition is, and where pitfalls lie. Give yourself adequate time to research and analyze this information. Market information can be obtained through analysis of past customer data, written or verbal surveys, and demographic information.

You can define your market in one way by the type of customer. The 3 types of customers are as follows:

1. **Decision maker**---this is the customer who actually makes the decision to obtain your business/product. It may be the patient but also could easily be the physician or managed-care case manager, for example.
2. **Influencer**---this customer influences the decision maker. It could be the patient’s family, another nurse, and so forth.
3. **End user**---this customer is the one who actually uses the business/product. The end user may also be the decision maker, but in health care the patient is frequently only the end user.

- Who are the consumers of your business/product?
  - Who are the “decision makers?”
  - Who are the “influencers?”
  - Who are the “end users?”

- What characteristics and needs do your customers have?
  - “Decision makers”
  - “Influencers”
  - “End users”

Once you have analyzed your market and your customers, you can begin to plan a marketing and promotional strategy. Based on the individual characteristics of each customer group, you can plan a strategy that will appeal to each. Keep in mind that one strategy does not usually apply to all 3 groups. **Example:** A case manager wants to hear how you will save money and achieve the expected outcomes. A patient, however, wants to know specifically what you will do and how available you are for phone calls.
When you plan your strategy, remember your Unique Service Advantage that you identified earlier. Focus strategies to highlight your uniqueness and benefits you bring to customers.

You will also need to decide what media you will use to market your business/product. If it is a business/product within an organization, a well-written, professional-looking business plan is the perfect medium. However, if it is an independent business/product, you will probably want to consider at least business cards, stationery, and perhaps brochures. Other techniques include the Internet, telephone books, human interest stories in the newspaper, speaking engagements, and face-to-face meetings. The key is to not get carried away and blow your budget on advertising and promotion. Start small, see what works, and then expand if you need to. Frequently, the most effective means of marketing a business/product is through word of mouth and networking. Go to where your customers are and talk to them!

- What key points do you want to convey to each customer group?
  - “Decision makers”
  - “Influencers”
  - “End users”

- What media is best for each customer group?
  - “Decision makers”
  - “Influencers”
  - “End users”

**Critical Success Factors and Key Assumptions**

Critical success factors are the conditions that must be met to achieve the success of your business/product. They may be resource related or situation related. **Example:** Your continence clinic will succeed only if there is adequate dedicated space available in the current outpatient setting, or your independent practice will succeed only if you obtain a contract with the local 400-bed hospital.

Assumptions are similar to critical success factors; however, they differ in that the success of the business/product is not dependent on them. Assumptions may also be resource or situation related. Frequently, assumptions are financial or utilization (volume of business---number of patients, hours, visits, etc) related. **Example:** Available space in the outpatient clinic becomes an assumption if there are several other space options available. **Example:** You assume that you will get a contract with the local 400-bed hospital and have based your financial analysis on that assumption. This is not a critical success factor if there are other contract options available.
- What resources are **critical** to the success of your business/product (ie, space, finances, personnel, equipment, etc)?

- What other factors are **critical** to the success of your business/product?

- What **assumptions** are you making as you plan your business/product?

### Qualifications

The success of your business/product depends on the skills that you and your team possess. In addition, gaining support from others for your business/product will also depend on your ability to demonstrate that qualified individuals will be involved. Therefore, as you write your business plan, describe who will be in charge of the different aspects of the business/product and what other expertise you will use. **Example:** If you are the sole proprietor of an independent practice, you will want to describe your abilities, and the outside advisors that you have chosen (ie, attorney, accountant, etc).

For a business/product, it is likely that you will have several members of a team. The skills and responsibilities of each team member need to be clearly defined. Specific guidance documents or training classes may be necessary. It is helpful if several individuals are involved to identify specific responsibilities and explain who will manage each area. **Example:** Areas might be clinical services, reception, intake, billing, scheduling, marketing, quality improvement, purchasing, legal, accounting, and others as needed for your individual plan. Depending on how you are going to be using your business plan, you may want to include full resumes or curriculum vitae of individual team members in the Appendix of the plan.

You should also review the weaknesses of each team member. This is not a negative exercise. We all have areas in which we are less than perfect. Identifying those areas helps avoid putting people into situations in which they are sure to fail.

- Who are the members of your team? (Do not forget yourself!)

### What are the strengths and weaknesses of each?

- **Member:**
  
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Member:**
  
<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Financial Projections

It is critical in any business plan to formulate a pro forma budget that projects the expected revenues and expenses for 3 to 5 years or the length of the business/product and the break-even point. This helps you determine the validity of the business plan prior to starting the business/product and to evaluate progress over the ensuing years or life of the business/product.

Doing a pro forma is nothing more than creating an operating budget for the next 3 to 5 years. It should indicate at what point the business/product will break even and when it will start to show a profit. With businesses/products, the time frame may be in yearly quarters as opposed to entire years depending on the extent of the business/product.

I. Financial fundamentals

There are several fundamental principles that you must understand in order to do a pro forma budget. You will most likely need to employ the services of an accountant to actually do the budget; however, you will still need to understand the concepts and be able to provide certain information to the accountant (See Appendix S–III: A Business Financial Glossary).

The first principle you need to understand is what a balance sheet and an income statement are used for and what information they contain.

1. **Balance sheet**---a financial snapshot of a moment in time. A balance sheet profiles the overall financial condition of an organization. It can be likened to a complete physical assessment. It lets you know how things are at a given moment. The balance sheet specifically addresses a company’s assets (or resources of value) and liabilities (or debts).

2. **Income statement**---shows the results of operating activities. The income statement chronicles how a company got to the given moment in time that the balance sheet portrays. It can be likened to a record of how well or poorly a wound has healed over the past month. The income statement reports the total revenues (resources coming into the company), the expenses (resources going out of the company), and the net profit or net income (what’s left over after expenses are paid). The income statement describes a period in time; it is usually done every month or every quarter.

A pro forma budget is nothing more than an income statement that projects the next 3 to 5 years.
It is not necessary to completely understand all the items on a balance sheet. Refer to an accountant for assistance. A sample balance sheet follows.

**Balance Sheet as of April 30, 2011**

<table>
<thead>
<tr>
<th>Assets</th>
<th>Liabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assets</td>
<td>Current liabilities</td>
</tr>
<tr>
<td>Property/plant/equipment</td>
<td>Long-term debt</td>
</tr>
<tr>
<td>Investments</td>
<td>Owners equity</td>
</tr>
<tr>
<td>Intangibles</td>
<td></td>
</tr>
</tbody>
</table>

It is necessary to have some understanding of an income statement. However, it is not necessary to understand exactly how the numbers are calculated. Again, refer to an accountant for assistance. A sample of an income statement:

**Income Statement for Period Ending April 30, 2011**

**Revenue and Gains**
- Patient care revenues
- Contract fees

**Operating Expenses**
- Salaries
- Supplies
- Administration
- Depreciation
- Utilities
- Occupancy

**Net Income**

II. Financial concepts
There are also several financial concepts that you must understand in order to compile the information that the accountant will need to put together your pro forma budget.

1. Contractual allowances are like discounts. First, you will decide what your charge will be for a particular service. However, instances will occur in which you will need to discount your charge. This frequently happens with managed care contracts. If your charge is $80 but your managed care contract is for $75, the $5 difference is a contractual allowance. This amount will show up on the income statement in a format such as the following:

   Revenue: $80
   Less contractual allowance: $(5)
   Total revenue: $75
You must state your actual charge as revenue and then show your contractual allowances. You cannot just show the difference (ie, $75). This is an accounting rule that only accountants understand!

2. Charity and bad debt are similar to contractual allowances except that they are not planned for as in a contract. Charity is a discount that you determine you will give prior to providing the service. **Example:** You can decide to give a 10% charity write-off to a patient who has limited financial resources. The amount the patient would actually pay of the $80 charge would be $72.

   Bad debts are unplanned write-offs from what you had expected to receive for your services. **Example:** You billed a patient the $80 fee and he or she paid only $40 and never paid any more. After a period of time, you determine that this patient will never pay the remaining amount, and you write it off to bad debt.

   Bad debt and charity write-offs are expressed on the income statement:

   | Revenue (2 visits): | $160 |
   | Less charity of 10% for 1 visit: | $ (8) |
   | Less bad debt: | $ (40) |
   | Total revenue: | $132 |

3. Depreciation is the financial representation of the normal wear and tear on a large piece of equipment or property determined by taking the total value of the equipment or property and dividing it over a given number of years. This is also referred to as amortizing. The number of years is determined in many ways; the best thing to do is ask the accountant how many years to depreciate each piece of equipment you will need. Most organizations choose a specific dollar amount over which they will depreciate an item. **Example:** Anything over $500 or sometimes $1000 will be depreciated.

   **Example:** You will need a biofeedback machine for your incontinence clinic that will cost $10,000. The accountant tells you that it will need to be depreciated over 5 years. The amount that will be “expensed” each year is $2000 ($10,000 divided by 5). The tricky part here is that the actual cash ($10,000) for the equipment will be spent when the equipment is purchased. However, the IRS will only let you recognize $2000 in expenses per year. In your pro forma budget, you will record an expense of $2000 each year for 5 years.

4. When determining the costs that must be considered for your business/product, you will need to decide which are fixed and which are variable costs. Fixed costs are those costs that do not vary with the amount of services you provide. **Example:** Rent and depreciation on equipment are fixed. If your rent is $1000 per month, it does not matter whether you see 5 patients or 50 patients, the rent will not change. Variable costs are those costs that vary with the amount of services provided. **Example:** Patient care staff salaries and supplies will vary with the number of patients. You will use more supplies to see 50 patients than you will to see 5 patients.

5. The importance of understanding fixed and variable costs is that you can control variable costs much more easily than you can control fixed costs. Frequently, you are more valuable to an organization as a variable cost than you are as a fixed cost. If you are a full-time employee with a set salary and benefits, you are a fixed cost. Whether you see 100 patients or 1000 patients, your salary and benefits will cost the
organization the same. However, if you have a contract for a per unit fee, you are a variable cost. If your per unit fee is $75, the total amount the organization pays will vary with the number of units of service you provide. Therefore, if business is slow for your client (e.g., a hospital), they can pay you for just the number of visits or amount of service that they need. When business is better, they are able to pay you for increased amounts of service.

The Budgeting Process

Now that you understand a few of the basic concepts, you are ready to begin collecting data for the pro forma budget. You must determine how much total revenue by source and total expenses by source you expect.

To determine the revenues and expenses, certain exercises are necessary:

I. Statistical forecasting---trending

This is how you can determine the expected revenues for your business/product. If it is an existing business/product, you can use past data to forecast the coming year(s). If it is a new business/product, you will use your situation and market analyses to project the future years. This part of forecasting is based on utilization only. Example: You will determine the number of patients, procedures, visits, hours, and so forth, that you will provide. The unit to use is based on the mechanism by which you are paid. Example: If you are paid for the service by hour, you should project in hours, and so forth.

- Example:

<table>
<thead>
<tr>
<th>Patient Visits</th>
<th>‘10</th>
<th>‘11</th>
<th>‘12</th>
<th>% Forecast</th>
<th>‘13 Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>500</td>
<td>460</td>
<td>440</td>
<td>3%</td>
<td>426</td>
</tr>
<tr>
<td>Wounds</td>
<td>800</td>
<td>1000</td>
<td>1300</td>
<td>20%</td>
<td>1560</td>
</tr>
<tr>
<td>Continence</td>
<td>300</td>
<td>550</td>
<td>700</td>
<td>30%</td>
<td>910</td>
</tr>
<tr>
<td>Total</td>
<td>1600</td>
<td>2010</td>
<td>2440</td>
<td>19%</td>
<td>2896</td>
</tr>
</tbody>
</table>

*The forecast is calculated by averaging the % of increase for each of the past 3 years and then estimating any additional increase or decrease based on market factors.

- Based on your analyses, complete the following chart:

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>For Existing Businesses/Products</th>
<th>For All Businesses/Products</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Year 1</td>
<td>Prior Year 2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. Expense forecasting

Now, you will begin to think in dollar amounts. You will need to list all of your expenses and do the same type of trending that you did in the statistical forecasting.

Expenses that you should consider are as follows:
1. **Salaries/benefits**---of all personnel (including yourself) involved in the business/product. You will need to know how much time will be worked and the salaries and benefits of each individual.

2. **Taxes and other employee expenses**---the accountant can provide this information.

3. **Rent.**

4. **Supplies/equipment**---this includes only the supplies and equipment that will not be depreciated. You can also include your brochures, business cards, and office supplies here. Repairs on equipment can be included here also.

5. **Depreciation**---this is where the $2000 of depreciation for the biofeedback machine in the example would be noted.

6. **Professional fees**---this would include your outside advisors such as accountants, attorneys, and so forth.

7. **Dues/membership**---you can include any professional journal subscriptions or memberships to professional organizations in this category.

8. **Education**---this would include any seminars or conferences that you plan on attending. Expenses in this category include flight, mileage, food, lodging, and so forth, related to the educational event.

9. **Travel**---these are travel costs associated with providing the service.

10. **Postage and shipping.**

11. **Utilities**---this would include phone, electric, gas, and so forth.

12. **Marketing/advertising**---include any media that you will be using. This could be online marketing, telephone book listings, advertising, and other expenses associated with marketing. If you did not include your business cards and/or brochures under supplies, you could put them here.

13. **Miscellaneous**---anything that cannot be reasonably classed in the aforementioned categories could be included here.

*To determine your depreciation amount, you will need to list the “capital equipment” you need. Capital equipment is equipment that is over the depreciable limit set by you or the organization (usually $500 or $1000). Remember to ask the accountant about how many years the equipment needs to be depreciated.

- **What depreciable equipment will you need?**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Cost</th>
<th>Purchase Date</th>
<th>Depreciable Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Again, if it is an existing business/product, you can use previous data to forecast; if it is a new business/product, you must use your best educated guess.
### Example:

<table>
<thead>
<tr>
<th>Expenses</th>
<th>‘10</th>
<th>‘11</th>
<th>‘12</th>
<th>% Forecast</th>
<th>‘13 Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$50</td>
<td>$52.50</td>
<td>$80</td>
<td>38</td>
<td>110.40</td>
</tr>
<tr>
<td>Rent</td>
<td>$12</td>
<td>$12.60</td>
<td>$13.20</td>
<td>5</td>
<td>$13.80</td>
</tr>
<tr>
<td>Other</td>
<td>$20</td>
<td>$22</td>
<td>$25</td>
<td>0</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$82</td>
<td>$87.10</td>
<td>$118.20</td>
<td>26</td>
<td>$149.40</td>
</tr>
</tbody>
</table>

*The forecast is calculated by averaging the % of increase for each of the past 3 years and then estimating any additional increase or decrease based on market factors.*

### Complete the following chart to determine your projected expenses:

<table>
<thead>
<tr>
<th>Expense Source</th>
<th>For Existing Businesses/Products</th>
<th>For All Businesses/Products</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Year 1</td>
<td>Prior Year 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Cost per unit

- The next step is to determine the average cost per unit based on your projections. It is calculated as follows:
  - Average cost/unit = All expenses divided by the number of units
  - **Example:** $149,400 ÷ 2896 = $52 per visit

- From your charts above, fill in the blanks to determine your projected average cost per unit for each year.
  - **Year 1:**
    - Total expenses $_____ ÷ Total number of units _____ = $_____ per unit
  - **Year 2:**
    - Total expenses $_____ ÷ Total number of units _____ = $_____ per unit
  - **Year 3:**
    - Total expenses $_____ ÷ Total number of units _____ = $_____ per unit

### IV. Revenue forecast

Forecasting revenue is more difficult than forecasting expenses. There is no set rule for what your charge should be. Consideration must be given to what is charged for similar services, what the competition is charging, and what the market will bear. Wound, Ostomy and Continence Nurses Society compiled a salary and productivity survey of members in 2008. This beneficial tool can help you determine your fee for service based on your geographical location or expertise (WOCN, 2008).
<table>
<thead>
<tr>
<th>Setting</th>
<th>Number of Respondents</th>
<th>Median</th>
<th>Average</th>
<th>25th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>28</td>
<td>$67.50</td>
<td>$73.82</td>
<td>$56.88</td>
<td>$81.25</td>
</tr>
<tr>
<td>Home care</td>
<td>34</td>
<td>$65</td>
<td>$66.91</td>
<td>$53.13</td>
<td>$80</td>
</tr>
<tr>
<td>Subacute</td>
<td>14</td>
<td>$65</td>
<td>$61.25</td>
<td>$50</td>
<td>$78.75</td>
</tr>
<tr>
<td>Long-term care</td>
<td>34</td>
<td>$65</td>
<td>$68.63</td>
<td>$50</td>
<td>$80</td>
</tr>
<tr>
<td>Outpatient/wound care center</td>
<td>13</td>
<td>$55</td>
<td>$63.40</td>
<td>$52</td>
<td>$65</td>
</tr>
<tr>
<td>Education</td>
<td>29</td>
<td>$77.50</td>
<td>$74.98</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Expert chart review</td>
<td>22</td>
<td>$162.50</td>
<td>$164.80</td>
<td>$125</td>
<td>$200</td>
</tr>
<tr>
<td>Depositions</td>
<td>14</td>
<td>$250</td>
<td>$274.69</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>Protocol development</td>
<td>16</td>
<td>$77.50</td>
<td>$81.53</td>
<td>$45</td>
<td>$100</td>
</tr>
<tr>
<td>Workshop</td>
<td>20</td>
<td>$100</td>
<td>$129.47</td>
<td>$54.38</td>
<td>$150</td>
</tr>
</tbody>
</table>

If you have the luxury of using your charge in all cases, use the average cost per unit that you just calculated and add on an appropriate profit. If you have contracted rates that are different than your charge, you must consider the difference between your charge and the contracted rate. You will, however, most likely be charging different prices for different types of services.

- Example:

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Average Revenue/Unit</th>
<th>Number of Visits</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>$60</td>
<td>426</td>
<td>$25,560</td>
</tr>
<tr>
<td>Wounds</td>
<td>$72</td>
<td>1560</td>
<td>$112,320</td>
</tr>
<tr>
<td>Continence</td>
<td>$78</td>
<td>910</td>
<td>$70,980</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$208,860</td>
</tr>
</tbody>
</table>

- Determine your expected revenue by completing the following charts:
  - Year 1:

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Revenue per Unit</th>
<th>Number of Units</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
V. Break-even analysis

- The break-even analysis is important in determining how many units of service you need to provide in order to cover your expenses. It is calculated as follows:
  - Average revenue/unit × Number of units = Total expenses
  - **Example:** $70 × Number of units = $149,400
    - Number of units = $149,400 ÷ $70
    - Number of units = 2134

  This means that 2134 visits are needed to cover expenses. It is not unusual for a new business/product to lose money the first year or so; however, you need to project when you expect to break even and then start making a profit. During the years that you will be breaking even or losing, you need to have financial support to at least pay your bills.

- Calculate your estimated break-even point:
  - **Year 1:**
    - Average revenue/unit $____ × Number of units ____ = Total expense $____
    - Number of Units ____ = Total expense $____ ÷ Average revenue/unit $____
    - Number of units = ____
    - Breakeven? Yes □ No □
  - **Year 2:**
    - Average revenue/unit $____ × Number of units ____ = Total expense $____
    - Number of units ____ = Total expense $____ ÷ Average revenue/unit $____
    - Number of units = ____
    - Breakeven? Yes □ No □
VI. Pro forma income statement
Believe it or not, this is the easiest part. Very simply put, the pro forma income statement indicates the revenue minus expenses---information you have already calculated. It finally shows you what your “bottom line” will be over the next 3 years.

- **Example:** For the simple example that we have been following, the net income will be: $208,860 – $149,400 = $59,460
  
  For the body of the business plan, you need to include only the abbreviated financial analysis. Save all the details for the Appendix.

- Summarize your pro forma results:
  
  - **Year 1:**
    
    Total revenue $_____ – Total expenses $_____ = $_____
  
  - **Year 2:**
    
    Total revenue $_____ – Total expenses $_____ = $_____
  
  - **Year 3:**
    
    Total revenue $_____ – Total expenses $_____ = $_____

**Appendix**

The Appendix of your business plan includes all the backup documents that support the data you have included in your business plan. Some of the documents you may want to include are as follows:

A. External reports/information supporting your analyses.
B. Charts and graphs from which you drew your projections.
C. Product literature and lease agreements for capital requests.
D. Marketing material you will use.
E. Resumes of key members of the team.
Appendix S–I: Sample Business Plan for Always Wright Consulting Services

Introduction

I. “He who fails to plan, plans to fail.” Proverb
“Success in business is threatened if you can’t see the forest for the trees.” Unknown
“In the absence of clearly defined goals, we are forced to concentrate on activity and
ultimately become enslaved by it.”---Chuck Conradt (Marquis & Huston, 2006)

• What business endeavor, product, project, or proposal is you creating a business plan
for (ie, private practice consultation, a small consulting business, continence or stoma
clinics, skin care team, disease management program, etc)? Private
practice/consulting
• Is this a new or existing business/product or clinical service? New
• Have you started the business plan? Yes ☐ No ☒

II. Planning requires time: It typically takes several weeks to complete a good business plan.
Most of that time will be utilized in research and rethinking/rewriting your ideas and
assumptions. Make time to complete the task thoroughly.

Be realistic and do not underestimate the time you will need to create a thorough and
meaningful business plan or proposal. Whether you strive to improve clinical processes or
you are requesting another wound, ostomy and continence (WOC) position to better meet
current patient needs, planning will influence accomplishment. After the initial business
plan is implemented, revising should be an ongoing process. You should collect
information in your day-to-day activities and update the business plan 2 to 3 times a year.
Minimally, you should revise your business plan with new goals and strategies at least
once a year.

• How much time do you have to devote to a business plan? A few hours a week
• When is the business plan due for presentation? September 1, 2011
• How will you ration your time? 4 hours per week for 4

III. Why develop a business plan?
A business plan is essential because it allows you to:

1. Lay out the master blueprint to show a logical progression of steps needed to
reach the established goal. It is a powerful management tool that also helps you
consider alternatives or possibly a better way of doing things.
2. Communicate your business plan to your own team. This is important in order to
keep everyone on the same track and to be able to measure progress.
3. Communicate your business plan to others to gain their support. This may come
in the form of resources, financing, reimbursement, “word of mouth” referrals, or
just plain moral support.

• Who on your team needs to be included in the business plan?
Mary Smith—partner
Sally Jones—secretary/receptionist
Mark Williams—accountant
Sue Green—attorney
Richard Jones—small business consultant
• Who else needs to receive your business plan?
  Gretchen Call---finance officer at First City Bank
  Dr Steve Homes---supporter
  Mike Miller---administrator, General Hospital
  
  **Example:** For a personal business or consulting business plan with an agency, include team members such as business partners, attorney, accountant/banker, and technology/end user consultant. Other recipients of the business plan include your key physicians and/or clinical partners.
  
  If you as the clinical expert are creating a wound care program or an outpatient stoma clinic from within an agency or facility, include administrators, managers, nurses, and WOC nursing peers as appropriate. Depending on the scope of your services or proposal, you may seek guidance from the human resource department, data analyst, or an expert in billing and reimbursement. The knowledge, advice, and support you gain by collaborating with other leaders and thoroughly planning are critical to the business/product’s success.

**IV. Keys to convincing others**

When others are looking at your business plan, their decision to support it depends heavily on the following areas:

1. **Your understanding of the current environment and your vision of the future: Your team’s expertise**---it is essential to identify the key attributes unique to a WOC nurse: the focused application of nursing science and practice to the care of persons of all ages with wounds, stomas, fistulae, drains, tubes, pressure ulcers, and incontinence (Wound, Ostomy and Continence Nurses, 2010). You or your team must demonstrate that you have a balance of expertise in planning, educating, organizing, review/control, and leadership skills to impact patient care across health care systems.

2. **Your business/product**---culturally sensitive and age-appropriate care planning for patients across a variety of delivery systems is essential. Holistic care and guidance for psychosocial, sexual, and body image adaptation promotes optimal client outcomes. You should be able to describe how your business/product is different from others and how it will address current and future health care needs.
   
   **Example:** You may provide consultation in a remote service area without a formally educated or certified WOC nurse.
   
   Refer to http://www.wocn.org and http://www.wocncb.org for more information about the value of board-certified WOC nurses. There are many ways that our training and expertise can influence positive measurable outcomes.

3. **Your marketing plan**---market research is vital to the success of your business/product. There are 2 types of market research: (1) primary (gathering your own data) and (2) secondary (published information). You should have a strategy in place to market your business/product that includes expected growth as a result of marketing strategies. Wound, ostomy and continence nursing is a dynamic specialty that has been influenced by societal and health care needs of communities.

4. **Your projected financial statements**---you should be able to show that support of the business plan will result in an expected financial outcome. This will include
forecasted positive financial growth for your business/product and/or cost-effective utilization of resources with improved patient outcomes.

V. Before you start

- **Ask yourself:**
  - How much money is available (now)? Have $5000 seed money; will need a small business loan
  - Where will the money come from? First City Bank and Small Business Administration
  - Whom can I depend on for financial support? Dr Steve Homes, Mike Miller, Dr Jessica Isle, Family
  - Will I leave a primary salaried (hourly) position with benefits? ______
  - If so, will I be able to sustain myself financially until my business/product begins to profit? ______
  - Can you get support for the business/product? Yes
  - What outcomes/returns do I expect? Enough business to equal or exceed my current income; a more autonomous work setting
  - What expertise do my team and I have?
    - WOC clinical skills
    - Business development
    - Reimbursement
    - Inventory and supply control
  - Will I work out of a home, office, or separate dwelling? ______
  - How many hours am I/are we willing to invest? As much as it takes

- **Name your business/product:**
  1. Keep it simple and straightforward.
  2. Be descriptive, include specifics.
  3. Make it distinctive.
  - What key words describe your business/product?
    - Consulting
    - Service oriented
    - Solutions to problems
  - What will you name your business/product? Always Wright Consulting Services
  - Select outside advisors *(identify which of the advisor/consultant experts you will utilize and who they are):*
    - Attorney or legal council: Sue Green
    - Management consultant, manager, or administrator: Richard Jones (SBA)
    - Marketing consultant: ______
    - Accountant, value analysis manager: Mark Williams
    - Insurance agent: ______
    - Banker, billing, or reimbursement experts: Gretchen Call
    - Other consultants such as information services/technology (IS/T) for Web page design and privacy and safety compliance experts for sharing or storing electronic patient records: ______
• **Determine your “Unique Service Advantage”:**
  This is “That single, unique advantage, benefit, or appeal that others don’t offer or do as well as you.”
  You should consider years of experience, special skills or talents, particular areas of expertise, education, and service areas that are unique.
  o What is unique about your business/product? Not only provides clinical WOC nursing as a variable cost but also combines an organizational development aspect to assist with program development
  o What benefit(s) will your business/product bring that does not exist now? Combines the caring and service aspects of clinical care with a business perspective
  o What is unique about you or your team? Extensive clinical experience with over 15 years in home care (the fastest growing health care setting), nurse with an MBA

VI. Building your business plan
Your business plan should look professional but not glitzy. It should be bound with a cover, printed on quality paper, and be produced with a laser or letter quality printer.
  • What paper will you use for your business plan? My stationery, plain page
  • What color will the cover and coordinated paper be for your business plan? Coordinated with my logo colors
  • How will you bind your business plan? Velum binding
  • Will you need a quick print shop? Yes
  • Which one? Quik Print
  • How many copies of your business plan will you need? 15

**The Cover**
When you design the cover page of your business plan, keep the following in mind:
1. Keep it simple.
2. Clearly identify the business/product.
3. Include address and phone numbers.
4. Always date it.
5. Indicate a contact person.
• What information do you want on your cover sheet?
  o Name of business/product: Always Wright Consulting Services
  o Address: 1234 Maple Lane, Anywhere, PA 10023
  o Phone number: (555) 123-4567
  o Date: April 30, 2011
  o Contact person: Kristy Wright
  o Contact persons credentials: MBA, RN, CWOCN
  o Contact persons qualifications: 

Business Plan For:
Always Wright Consulting Services

April 30, 2011

Contact person:
Kristy Wright, MBA, RN,
CWOCN
1234 Maple Lane
Anywhere, PA 10023
555-123-4567

Table of Contents
A table of contents is imperative to facilitate the reader finding critical information with ease. The following is an ordered list of the usual contents of a business plan.
I. Executive Summary
II. Present Situation
III. Objectives
IV. Business/Product Description
V. Market Analysis/Strategy
VI. Operational Plan
VII. Financial Projections
VIII. Appendix

Executive Summary
An executive summary is a critical but frequently overlooked portion of a business plan. It must be designed to capture the intended reader’s interest by summarizing the key points and highlights of the business plan. It is a crystallization of the entire business plan in a brief overview format. Due to the nature of the executive summary, it is always located at the beginning of the business plan; however, it is one of the last portions that you will write.

A few things to remember when writing the executive summary are as follows:
1. **Keep it brief**—1 page, if possible.
2. **Hit the high points**—do not get bogged down in details.
3. **Make it interesting**—you may want to change the summary for each intended reader and concentrate on the areas of most interest to that reader. **Example:** If presenting to physical therapist, explain how WOCN and rehab work together as a team.

Begin with a brief description of your business/product, how you developed it, and what your mission/purpose is. Next, describe the business/product that you will provide and how it will benefit the customer and/or the reader. (These topics should be stated succinctly in a few paragraphs.) One reference guide could be the information for Wound, Ostomy and Continence Nursing Certification Board “Are your Nurses Board Certified?” Do not assume that everyone is
knowledgeable about the specific expertise and professional/clinical benefits provided by the WOC nurse.

Next, write a paragraph or two describing the background information including the market analysis, customer characteristics, competitive analysis, critical success factors, and assumptions. Then spend sufficient time explaining your goals and strategies for obtaining them. This will lead easily into a summary of the financial picture and projections.

Close the executive summary with a 1-paragraph conclusion that highlights the points that you want this particular reader to remember.

**Present Situation**

Explain what factors and information have brought you to the decision to start this business/product. How does your business plan support the facility’s mission statement and organizational goals?

- What changes are occurring in the health care environment, which will actually/potentially affect your business/product? Managed care is increasing penetration in all health care settings in Western Pennsylvania. Many of the smaller hospitals and alternative settings are merging or affiliating to form larger networks. Everyone is trying to reduce costs and learn how to work more productively with managed care.

- What future changes or factors will impact your business/product? Include both those types of factors that will have a negative or a positive impact.

**I. External analysis**

The following factors are important when analyzing the external environment (remember to do your homework and research these areas below):

1. Demographics of the anticipated target patient population.
2. Technology requirements.
3. Regulatory/political.
4. Economic/reimbursement.

What does the average person in your market area demographically look like? (You can usually find this information in the census bureau report; local, state, and federal reports; and other documents located in your local library or online.)

- Average age? **73 years old**
- Fastest growing age group? **Over 80**
- Average income? **$25,000**
- Facility pressure ulcer prevalence and incidence? 
- Nonhealing wounds or diabetes patients, and so forth? 
- Colon or bladder cancer incidence? 
- Continence or stoma clinics? 
- What is the primary industry? **Manufacturing**
- Top 5 causes of mortality?
  1. Heart disease
  2. Diabetes (endocrine disorders)
  3. Traffic accidents
  4. Cancer
  5. Circulatory disorders
- Top 5 causes of morbidity?
1. Heart disease (congestive heart failure)
2. Diabetes
3. Circulatory disorders
4. Cancer (lung, breast, bladder)
5. Mental illness

- Other important information? The most costly diseases and disorders are congestive heart failure, wounds, and chronic peripheral vascular disease. One city (population approximately 20,000) has a significantly higher occurrence of bladder cancer. Due to the elderly population throughout the region, there is a high and relatively untreated incidence of incontinence. The long-term care facilities view this as their greatest concern followed closely by pressure ulcers. A growing health care workers’ shortage and the impending entrance of the baby boomers to the age group older than 65 years will put an additional strain on all systems.

II. Competitive analysis
There are many types of competitors. Some of the most difficult competitors are the least obvious. The following are the 3 most common types:
1. Input or resource---competes for the same resources as you.
2. Process---provides a business/product that is different than yours but has many of the same results (ie, physical therapist, case managers).
3. Output---does the exact same thing as you do.

- Who would compete for the same resources that you need? (Resources include money, space, staff, equipment, etc).
<table>
<thead>
<tr>
<th>Who?</th>
<th>What Resource?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

- Who provides a business/product with the same outcomes as yours or a business/product that makes yours obsolete?
<table>
<thead>
<tr>
<th>Who?</th>
<th>What Business/Product?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapists</td>
<td>Wound care</td>
</tr>
<tr>
<td>ABC Physician Group</td>
<td>Wound care</td>
</tr>
</tbody>
</table>

- Who is doing the exact same thing as you? Two other WOC nurses in the area

III. Internal analysis
The following areas are the most common areas reviewed in an internal analysis.
1. Past performance---can only be done when there is an existing business/product that has data from the past to analyze.
   a. Cost/profitability---reviews how profitable the business/product has been in the past. Profitability might be measured in actual revenue or net profit but could also be measured in other forms of benefits brought to an organization. Example: The business/product has been within budgeted expenses for the last 3 years and has had a net profit of “X” each year, or the business/product has stayed within the break-even projection and as a direct result of the business/product’s activities, visits to the outpatient clinic have increased by 20%.
   b. Utilization---can be expressed in whatever units of measurement you prefer. It might be measured in any or all of the following: number of visits, hours, and patients. This is a representation of “volume” of service.
c. **Quality (customer perceived and technical)**---technical quality is expressed as measurable outcomes and proven benefits. Perceived quality is from the customer’s point of view. Sometimes what makes a customer satisfied is not necessarily technical quality. **Example:** Many patients have a high degree of satisfaction with a health care provider who is friendly and caring, even though his/her clinical skills may be less than adequate.

2. **Strengths and weaknesses**---you must take a close look at what strengths and weaknesses you have. This can include an evaluation of your skills, your team’s skills, financial strength, your support systems, your competitors, and any other factor that will impact your business/product.

- **For EXISTING Businesses/Products Only:** This is a new business, so this section does not apply

  How many “units” of service (ie, visits, hours, patients) compared to budget have you provided in the past 3 years?

  - **Unit of Service: N/A**
    
    | Year 1: | Actual: | Budget: |
    |--------|---------|---------|
    | Year 2: | Actual: | Budget: |
    | Year 3: | Actual: | Budget: |

  - **Unit of Service: N/A**
    
    | Year 1: | Actual: | Budget: |
    |--------|---------|---------|
    | Year 2: | Actual: | Budget: |
    | Year 3: | Actual: | Budget: |

- **For All Existing and New Businesses/Products:**

  *It is very important to capture this information on an ongoing basis*

  - What proof do you have that your customers are satisfied or what types of methods will you use to measure your customers’ satisfaction? (This information can include customer/patient satisfaction reports, written statements from patients, physicians, etc) Customer satisfaction will be measured through random phone interviews during the provision of services and mailed satisfaction surveys (with self-addressed stamped envelopes).
  
  - What are your strengths and weaknesses?
    
    - Technical skills:
      
      | Strengths | Weaknesses |
      |-----------|------------|
      | Ostomy and wound care | Diagnostic skills in incontinence care |
      | Home care | Outcomes data |
      | Reimbursement | |
      | Business skills: | Weaknesses |
      | Strengths | |
      | Organizational development | Inability to negotiate capitated contract |
      | Financial analysis | “Sales” experience |
      | Marketing | |
      | Medical equipment/supplies | |
Other skills/talents:

- Strengths
  - Well known in community
  - Years of experience
  - Certified in quality improvement
- Weaknesses
  - Not well known by managed care org.
  - Not affiliated with a large system

What are your team’s strengths?

- Technical skills:
  - Strengths
    - Continence care
    - Complex clinical assessment
    - Burn therapy
  - Weaknesses
    - Complex ostomy care
- Business skills:
  - Strengths
    - Billing and bookkeeping
    - Customer service
  - Weaknesses
    - Database management
- Other skills/talents:
  - Strengths
    - Certified in critical care nursing
    - Certified in rehab nursing
  - Weaknesses
    - Public speaking

What financial strengths and weaknesses do you have?

- Strengths
  - Seed money of $5000
  - Small business loan
  - Two guaranteed contracts
- Weaknesses
  - Uncertain income

Who supports you? Who does not?

- Does
  - Dr Homes
  - Mike Miller
  - Dr Becket
- Does not
  - Peg Nando---previous boss
  - Hawk PT Group

What can you do better than your competitors? Provide a comprehensive service that not only includes clinical services but also offers protocol development, business development (ie, outpatient services), marketing to managed care, and assistance with reimbursement.

What can your competitors do better than you? Patients can get direct reimbursement, one WOC nurse has experience with capitated contracts, and the other WOC nurse has an established wound clinic.

What other things do you do well? Skilled at education and public presentation.

Goals and Objectives

Formulate a vision of where you want to be in 1 and 2 to 5 years and how you are going to get there. It is fine to be enthusiastic, but you should also be realistic. It is easiest to first set long-term goals and then establish a few objectives for each time period describing how you will achieve the goals. Do not get locked into a yearly time period; monthly time periods are very appropriate, especially for businesses/products.

- What are your goals?
  - Here are a few things to consider in setting goals.
When do you want to open or start the business/product? September 1, 2011
Do you want to stay a sole proprietor? No
Have partners? One now and then more
When do you want to break even? 12 to 18 months
Make a profit? 18 to 24 months
What kind of financial growth do you want over the next 5 years? Modest with 10% to 15% each year
How many patients/hours/units of service do you want to provide/serve over the next 5 years? Would like to increase contracts from the 2 current guaranteed contracts by obtaining contracts with at least 1 other hospital and include home- and long-term care. It seems realistic for each of the 2 WOC nurses in the practice to average 5 to 6 patients per day—equating to approximately 2600 patients per year. A modest 10% growth would result in approximately 3400 patients in 5 years. This would obviously require additional WOC nurses (at least part-time).
What debts must you incur to start the business/product and when do you want to have your start-up costs paid off? (Normally it takes 2-3 years to pay off start-up costs for supplies and 5-10 years for equipment.) Initially, start-up costs will be small. We will need about $5000 for equipment and office supplies. Rent and utilities will average about $150 per month. The largest debt at first will be payroll until the first billing period. The small business loan should cover those expenses for 6 months. I would like the initial loans to be paid off in no later than 5 years.
What do you need to do to overcome your identified weaknesses? Become more knowledgeable about capitated contracting, start collecting outcome data, and develop ties with health systems.
What other things do you need to consider? Education of other team members, ways to grow the business.
List at least 3 goals you want to achieve over the next 3 to 5 years:
1. Achieve a 10% to 15% growth over each of the next 5 years
2. Pay off start-up debt in 5 years
3. Realize a profit in 2 years
4. Assure quality of services with measured outcomes
5. Employ qualified team members

- Fill out the following charts:
  - **Goal 1:** Achieve a 10% to 15% growth over each of the next 5 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get contract with 2 hospitals</td>
<td>None additional</td>
<td>December 2012</td>
</tr>
<tr>
<td>Get contract with 3 home care organizations</td>
<td>Possibly half-time WOC nurse, funding, staffing, van, equipment</td>
<td>March 2013</td>
</tr>
<tr>
<td>Establish outpatient clinic</td>
<td>Funding, staffing, space</td>
<td>December 2015</td>
</tr>
<tr>
<td>Establish mobile clinic</td>
<td>Funding, staffing, van, equipment</td>
<td>December 2016</td>
</tr>
</tbody>
</table>
Goal 2: Pay off start-up debt in 5 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put 5% of revenue toward loans each quarter</td>
<td>Adequate revenue</td>
<td>Each quarter, ending in 2016</td>
</tr>
</tbody>
</table>

Goal 3: Realize a profit in 2 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get contract with 2 hospitals</td>
<td>None additional</td>
<td>December 2012</td>
</tr>
<tr>
<td>Get contract with 3 home care organizations</td>
<td>Possibly half-time WOC nurse, funding, staffing, van, equipment</td>
<td>March 2013</td>
</tr>
</tbody>
</table>

Goal 4: Ensure quality of service with measured outcomes.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop clinical guidelines for practice</td>
<td>WOCN guidelines</td>
<td>December 2012</td>
</tr>
<tr>
<td>Set up database to collect outcome data</td>
<td>Education for secretary on database management</td>
<td>March 2013</td>
</tr>
<tr>
<td>Analyze and report data</td>
<td>Time!!!</td>
<td>September 2013</td>
</tr>
</tbody>
</table>

Goal 5: Employ qualified team members.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOC nurses to attend WOCN conferences</td>
<td>Funding and patient coverage</td>
<td>Annually</td>
</tr>
<tr>
<td>WOC nurses to be certified</td>
<td>Funding</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Database management education for secretary</td>
<td>Funding and time</td>
<td>March 2013</td>
</tr>
</tbody>
</table>

Business/Product Description

Develop a clear explanation of what the business/product does and how it benefits your customers. To get support or financing for a business/product and to attract customers, you must show that you have researched and identified the need for the business/product. Moreover, you must be able to clearly describe the business/product and the benefits that it provides.

In a large organization, you cannot assume that others know what you do as a WOC specialty nurse. What is your vision? One of greatest contributions of leaders is having a driving purpose, a vision. This purpose is exhibited through your knowledge, passion, and experiences, and is reflective and empowers the group or culture (Grossman & Valiga, 2005).

The following are specific areas you need to consider:

1. **Service portfolio**---WOC services, direct care, education, research, and standards.
2. **Unique features**---these are specific to your business/product.
3. **Value-added benefits**---program development expertise, disease management.
4. **Pricing strategy**---this is unique to your situation and should reflect the economic environment, health care reform, and regulatory or market demands.
• What are the key features of your business/product? Clinical services and consultation: prevention, patient education, and comprehensive management for patients with wounds, ostomies, and incontinence. Case management: coordination, resource utilization, continuity, patient advocacy, and long-term management. Education and development: protocol development, staff education, program development (ie, outpatient clinics, continuum of care), and regulatory compliance. Research: clinical trials and outcome development.

• How do they differ from similar businesses/products? Other similar services concentrate on providing only the clinical piece. My service will provide a more comprehensive approach to the care of wound, ostomy and continence patients and will be available in all settings.

• What value-added benefits does your business/product bring to your customers? Contracting for services is a variable cost rather than a fixed cost. Assistance with resource management (ie, supplies) and reimbursement will ensure that services are revenue producing for the customer whenever possible. Assess and identify areas of opportunity related to pressure ulcer prevention, incontinence, or chronic wound management. Provide assistance with regulatory compliance through staff education, protocol development, and quality measurement. Decreased costs in a capitated system due to decreased length of stay, availability of services in the most appropriate setting, decreased complications, and decreased readmission to higher level of acuity.

• Does your business/product save money for your customers? How? Yes, resource management—care provided in most cost-effective setting, reduced complications, and risk management.

• Does your business/product improve quality of life? How? Yes, patient education, continuity, family involvement, decreased complications, and more rapid return to normal activities of daily living.

• Does your business/product create a competitive advantage? How? Yes, having the comprehensive services available in all settings as a variable cost puts the organization in a better position to negotiate with managed care organizations for capitated agreements.

• How do customers access your business/product? Phone: available 8 AM to 5 PM Monday to Friday, with 24-hour on call and emergency service available through an answering service. “Quick Referral”—a referral form will be available that can be faxed 24 hours or e-mailed to alwayswright@consult.com.

• What are your hours of availability? 8 AM to 5 PM, with 24-hour on call and emergency.

• Are you available for emergencies? Yes


Market Analysis and Strategy
Through market analysis, you can clearly identify your customers, your competitors, and your business/product’s position in the market. This is the first and most important step in marketing. It is what will drive your marketing strategy and your promotional efforts. It helps you understand the needs of your customers, who your competition is, and where pitfalls lie. Give yourself adequate time to research and analyze this information. Market information can be
obtained through analysis of past customer data, written or verbal surveys, and demographic information.

You can define your market in one way by the type of customer. The 3 types of customers are as follows:

1. **Decision maker**---this is the customer who actually makes the decision to obtain your business/product. It may be the patient but also could easily be the physician or management-care case manager, for example.
2. **Influencer**---this customer influences the decision maker. It could be the patient’s family, another nurse, and so forth.
3. **End user**---this customer is the one who actually uses the business/product. The end user may also be the decision maker, but in healthcare the patient is frequently only the end user.

- Who are the consumers of your business/product?
  - Who are the “decision makers?”
    - Physicians
    - Administrators
    - Case managers
    - Sometimes the patient/family
  - Who are the “influencers?”
    - Staff nurses
    - Other clinical personnel in the care setting
    - Family
    - Some physicians
  - Who are the “end users?”
    - Patients
    - Families/caregivers
    - Administrators for program development

- What characteristics and needs do your customers have?
  - “Decision makers”
    - Physicians are interested in getting services for their patients with as few hassles for themselves as possible
    - Case managers are concerned with the least cost in the most appropriate setting and satisfied patients
    - Administrators want cost reduction, compliance with regulation, and satisfied customers
  - “Influencers”
    - They are usually other healthcare professionals
    - They are concerned primarily about the quality of the services and care of the patient
    - When it is family, they are usually the caregiver or are responsible for the patient’s care
  - “End users”
    - Patients and families want timely, consistent, high-quality care
    - They want to be at home if possible

Once you have analyzed your market and your customers, you can begin to plan a marketing and promotional strategy. Based on the individual characteristics of each customer group, you can plan a strategy that will appeal to each. Keep in mind that 1 strategy does not usually apply
to all 3 groups. **Example:** A case manager wants to hear how you will save money and achieve the expected outcomes. A patient, however, wants to know specifically what you will do and how available you are for phone calls.

When you plan your strategy, remember your Unique Service Advantage that you identified earlier. Focus strategies to highlight your uniqueness and benefits you bring to customers.

You will also need to decide what media you will use to market your business/product. If it is a business/product within an organization, a well-written, professional-looking business plan is the perfect medium. However, if it is an independent business/product, you will probably want to consider at least business cards, stationery, and perhaps brochures. Other techniques include the Internet, telephone books, human interest stories in the newspaper, speaking engagements, and face-to-face meetings. The key is to not get carried away and blow your budget on advertising and promotion. Start small, see what works, and then expand if you need to. Frequently, the most effective means of marketing a business/product is through word of mouth and networking. Go to where your customers are and talk to them!

**• What key points do you want to convey to each customer group?**
  - "Decision makers"
    - "Quick Referral" service available
    - Use of services decreases short- and long-term costs
    - Patients can return to less acute settings and still receive services
    - "Comprehensive" services are available in addition to clinical services
  - "Influencers"
    - Services will result in faster recovery, higher quality of life, and are easily accessible
  - "End users"
    - Services are available 24 hours and are easily accessible
    - Staff are competent and experienced professionals
    - Services will allow patient to be at home if at all possible

**• What media is best for each customer group?**
  - "Decision makers"
    - Brochure (designed for the professional; emphasizing the benefits and value added)
    - Follow-up (either verbal or in writing) whenever appropriate
    - Face-to-face visits
    - Networking
  - "Influencers"
    - Staff in-services word of mouth "working together" on cases
  - "End users"
    - Article in paper
    - Community involvement
    - Patient/customer-oriented brochure

**Critical Success Factors and Key Assumptions**

Critical success factors are the conditions that must be met to achieve the success of your business/product. They may be resource related or situation related. **Example:** Your continence clinic will succeed only if there is adequate dedicated space available in the current outpatient setting, or your independent practice will succeed only if you obtain a contract with the local 400-bed hospital.
Assumptions are similar to critical success factors; however, they differ in that the success of the business/product is not dependent on them. Assumptions may also be resource or situation related. Frequently, assumptions are financial or utilization (volume of business—number of patients, hours, visits, etc) related. Example: Available space in the outpatient clinic becomes an assumption if there are several other space options available. Example: You assume that you will get a contract with the local 400-bed hospital and have based your financial analysis on that assumption. This is not a critical success factor if there are other contract options available.

- What resources are critical to the success of your business/product (i.e., space, finances, personnel, equipment, etc)?
  - Office space
  - Phone/fax
  - Computer and printer
  - E-mail service
  - Copy machine
  - Capital to underwrite business for 6 months
  - Personnel: Two WOC nurses and a secretary
- What other factors are critical to the success of your business/product? We need at least the 2 hospital contracts.
- What assumptions are you making as you plan your business/product? That 2 of the 5 home care organizations will affiliate with the 2 contracted hospital. One of the WOC nurses now working in a hospital will be willing to come into the practice in 12 to 18 months

Qualifications

The success of your business/product depends on the skills that you and your team possess. In addition, gaining support from others for your business/product will also depend on your ability to demonstrate that qualified individuals will be involved. Therefore, as you write your business plan, describe who will be in charge of the different aspects of the business/product and what other expertise you will use. Example: If you are the sole proprietor of an independent practice, you will want to describe your abilities, and the outside advisors that you have chosen (i.e., attorney, accountant, etc).

For a business/product, it is likely that you will have several members of a team. The skills and responsibilities of each team member need to be clearly defined. Specific guidance documents or training classes may be necessary. It is helpful if several individuals are involved to identify specific responsibilities and explain who will manage each area. Example: Areas might be clinical services, reception, intake, billing, scheduling, marketing, quality improvement, purchasing, legal, accounting, and others as needed for your individual plan. Depending on how you are going to be using your business plan, you may want to include full resumes or curriculum vitae of individual team members in the Appendix of the plan.

You should also review the weaknesses of each team member. This is not a negative exercise. We all have areas in which we are less than perfect. Identifying those areas helps avoid putting people into situations in which they are sure to fail.

- Who are the members of your team? (Do not forget yourself!)
  - Kristy Wright
  - Mary Smith---partner
  - Sally Jones---secretary/receptionist
Mark Williams---accountant  
Sue Green---attorney  
Richard Jones---small business consultant

- What are the strengths and weakness of each?
  - **Member:** Kristy Wright, MBA, RN, CWOCN
    - **Strengths:**
      - Twenty years of WOC experience
      - Fifteen years in administration
      - Organized/efficient
      - “Big-picture”
    - **Weaknesses:**
      - Lack of clinical incontinence experience
      - Lack of experience with capitation
  
  - **Member:** Mary Smith, MSN, RN, CWOCN
    - **Strengths:**
      - Certified critical care
      - Certified rehabilitation
      - Excellent clinical skills
    - **Weaknesses:**
      - Little experience w/ostomy care
      - No “business” experience
  
  - **Member:** Sally Jones, Secretary/Receptionist
    - **Strengths:**
      - Medical secretary
      - Medical transcriptionist
      - Experience in customer service
    - **Weaknesses:**
      - Limited database management
      - Financial record keeping

- Who will be responsible for each functional area?
  - **Area:** Practice management
    - Kristy Wright
  
  - **Area:** Clinical services
    - Kristy Wright
    - Mary Smith
  
  - **Area:** Organizational development service
    - Kristy Wright
    - Mary Smith
    - Sally Jones
  
  - **Area:** Marketing
    - Kristy Wright
    - Sally Jones
    - Richard Jones
  
  - **Area:** Bookkeeping/accounting
    - Mark Williams
    - Sally Jones
  
  - **Area:** Legal
    - Sue Green

**Financial Projections**

It is critical in any business plan to formulate a pro forma budget that projects the expected revenues and expenses for 3 to 5 years or the length of the business/product and the break-even point. This helps you determine the validity of the business plan prior to starting the business/product and to evaluate progress over the ensuing years or life of the business/product.
Doing a pro forma is nothing more than creating an operating budget for the next 3 to 5 years. It should indicate at what point the business/product will break even and when it will start to show a profit. With businesses/products, the time frame may be in yearly quarters as opposed to entire years depending on the extent of the business/product.

I. Financial fundamentals

There are several fundamental principles that you must understand in order to do a pro forma budget. You will most likely need to employ the services of an accountant to actually do the budget; however, you will still need to understand the concepts and be able to provide certain information to the accountant (See Appendix S–III. A Business Financial Glossary).

The first principle you need to understand is what a balance sheet and an income statement are used for and what information they contain.

1. **Balance sheet**---a financial snapshot of a moment in time. A balance sheet profiles the overall financial condition of an organization. It can be likened to a complete physical assessment. It lets you know how things are at a given moment. The balance sheet specifically addresses a company’s assets (or resources of value) and liabilities (or debts).

2. **Income statement**---shows the results of operating activities. The income statement chronicles how a company got to the given moment in time that the balance sheet portrays. It can be likened to a record of how well or poorly a wound has healed over the past month. The income statement reports the total revenues (resources coming into the company), the expenses (resources going out of the company), and the net profit or net income (what’s left over after expenses are paid). The income statement describes a period in time; it is usually done every month or every quarter.

A pro forma budget is nothing more than an income statement that projects the next 3 to 5 years.

It is *not necessary* to completely understand all the items on a balance sheet. Refer to an accountant for assistance. A sample balance sheet follows.

<table>
<thead>
<tr>
<th><strong>Balance Sheet as of April 30, 2011</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assets</strong></td>
</tr>
<tr>
<td>Current assets</td>
</tr>
<tr>
<td>Property/plant/equipment</td>
</tr>
<tr>
<td>Investments</td>
</tr>
<tr>
<td>Intangibles</td>
</tr>
</tbody>
</table>

It is necessary to have some understanding of an income statement. However, it is not necessary to understand exactly how the numbers are calculated. Again, refer to an accountant for assistance. A sample of an income statement:
II. Financial concepts

There are also several financial concepts that you must understand in order to compile the information that the accountant will need to put together your pro forma budget.

1. Contractual allowances are like discounts. First, you will decide what your charge will be for a particular service. However, instances will occur in which you will need to discount your charge. This frequently happens with managed care contracts. If your charge is $80 but your managed care contract is for $75, the $5 difference is a contractual allowance. This amount will show up on the income statement in a format such as the following:

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>$80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less contractual allowance:</td>
<td>$(5)</td>
</tr>
<tr>
<td>Total revenue:</td>
<td>$75</td>
</tr>
</tbody>
</table>

   You must state your actual charge as revenue and then show your contractual allowances. You cannot just show the difference (ie, $75). This is an accounting rule that only accountants understand!

2. Charity and bad debt are similar to contractual allowances except that they are not planned for as in a contract. Charity is a discount that you determine you will give prior to providing the service. Example: You can decide to give a 10% charity write-off to a patient who has limited financial resources. The amount the patient would actually pay of the $80 charge would be $72.

   Bad debts are unplanned write-offs from what you had expected to receive for your services. Example: You billed a patient the $80 fee and he or she paid only $40 and never paid any more. After a period of time, you determine that this patient will never pay the remaining amount, and you write it off to bad debt.

   Bad debt and charity write-offs are expressed on the income statement:
Revenue (2 visits): $160
Less charity of 10% for 1 visit: $ (8)
Less bad debt: $ (40)
Total revenue: $132

3. Depreciation is the financial representation of the normal wear and tear on a large piece of equipment or property determined by taking the total value of the equipment or property and dividing it over a given number of years. This is also referred to as amortizing. The number of years is determined in many ways; the best thing to do is ask the accountant how many years to depreciate each piece of equipment you will need. Most organizations choose a specific dollar amount over which they will depreciate an item. **Example:** Anything over $500 or sometimes $1000 will be depreciated.

**Example:** You will need a biofeedback machine for your incontinence clinic that will cost $10,000. The accountant tells you that it will need to be depreciated over 5 years. The amount that will be “expensed” each year is $2000 ($10,000 divided by 5). The tricky part here is that the actual cash ($10,000) for the equipment will be spent when the equipment is purchased. However, the IRS will only let you recognize $2000 in expenses per year. In your pro forma budget, you will record an expense of $2000 each year for 5 years.

4. When determining the costs that must be considered for your business/product, you will need to decide which are fixed and which are variable costs. Fixed costs are those costs that do not vary with the amount of services you provide. **Example:** Rent and depreciation on equipment are fixed. If your rent is $1000 per month, it does not matter whether you see 5 patients or 50 patients, the rent will not change. Variable costs are those costs that vary with the amount of services provided. **Example:** Patient care staff salaries and supplies will vary with the number of patients. You will use more supplies to see 50 patients than you will to see 5 patients.

5. The importance of understanding fixed and variable costs is that you can control variable costs much more easily than you can control fixed costs. Frequently, you are more valuable to an organization as a variable cost than you are as a fixed cost. If you are a full-time employee with a set salary and benefits, you are a fixed cost. Whether you see 100 patients or 1000 patients, your salary and benefits will cost the organization the same. However, if you have a contract for a per unit fee, you are a variable cost. If your per unit fee is $75, the total amount the organization pays will vary with the number of units of service you provide. Therefore, if business is slow for your client (e.g., a hospital), they can pay you for just the number of visits or amount of service that they need. When business is better, they are able to pay you for increased amounts of service.

**The Budgeting Process**

Now that you understand a few of the basic concepts, you are ready to begin collecting data for the pro forma budget. You must determine how much total revenue by source and total expenses by source you expect.

To determine the revenues and expenses, certain exercises are necessary:
I. Statistical forecasting---trending
This is how you can determine the expected revenues for your business/product. If it is an existing business/product, you can use past data to forecast the coming year(s). If it is a new business/product, you will use your situation and market analyses to project the future years. This part of forecasting is based on utilization only. **Example:** You will determine the number of patients, procedures, visits, hours, and so forth, that you will provide. The unit to use is based on the mechanism by which you are paid. **Example:** If you are paid for the service by hour, you should project in hours, and so forth.

- **Example:**

<table>
<thead>
<tr>
<th>Patient Visits</th>
<th>‘10</th>
<th>‘11</th>
<th>‘12</th>
<th>% Forecast</th>
<th>‘13 Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>500</td>
<td>460</td>
<td>440</td>
<td>3%</td>
<td>426</td>
</tr>
<tr>
<td>Wounds</td>
<td>800</td>
<td>1000</td>
<td>1300</td>
<td>20%</td>
<td>1560</td>
</tr>
<tr>
<td>Continence</td>
<td>300</td>
<td>550</td>
<td>700</td>
<td>30%</td>
<td>910</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>1600</td>
<td>2010</td>
<td>2440</td>
<td>19%</td>
<td>2896</td>
</tr>
</tbody>
</table>

*The forecast is calculated by averaging the % of increase for each of the past 3 years and then estimating any additional increase or decrease based on market factors.

- Based on your analyses, complete the following chart:

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>For Existing Businesses/Products</th>
<th>For All Businesses/Products</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Year 1</td>
<td>Prior Year 2</td>
</tr>
<tr>
<td>Ostomy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Wound</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Continence</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Miscellaneous hourly consults</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. Expense forecasting
Now, you will begin to think in dollar amounts. You will need to list all of your expenses and do the same type of trending that you did in the statistical forecasting.

Expenses that you should consider are as follows:

1. **Salaries/benefits**---of all personnel (including yourself) involved in the business/product. You will need to know how much time will be worked and the salaries and benefits of each individual.

2. **Taxes and other employee expenses**---the accountant can provide this information.
3. **Rent.**

4. **Supplies/equipment**—this includes only the supplies and equipment that will not be depreciated. You can also include your brochures, business cards, and office supplies here. Repairs on equipment can be included here also.

5. **Depreciation**—this is where the $2000 of depreciation for the biofeedback machine in the example would be noted.

6. **Professional fees**—this would include your outside advisors such as accountants, attorneys, and so forth.

7. **Dues/membership**—you can include any professional journal subscriptions or memberships to professional organizations in this category.

8. **Education**—this would include any seminars or conferences that you plan on attending. Expenses in this category include flight, mileage, food, lodging, and so forth, related to the educational event.

9. **Travel**—these are travel costs associated with providing the service.

10. **Postage and shipping.**

11. **Utilities**—this would include phone, electric, gas, and so forth.

12. **Marketing/advertising**—include any media that you will be using. This could be online marketing, telephone book listings, advertising, and other expenses associated with marketing. If you did not include your business cards and/or brochures under supplies, you could put them here.

13. **Miscellaneous**—anything that cannot be reasonably classed in the aforementioned categories could be included here.

    *To determine your depreciation amount, you will need to list the “capital equipment” you need. Capital equipment is equipment that is over the depreciable limit set by you or the organization (usually $500 or $1000). Remember to ask the accountant about how many years the equipment needs to be depreciated.*

- What depreciable equipment will you need?

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Cost</th>
<th>Purchase Date</th>
<th>Depreciable Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer</td>
<td>$2000</td>
<td>June</td>
<td>5</td>
</tr>
<tr>
<td>Printer</td>
<td>$600</td>
<td>June</td>
<td>5</td>
</tr>
<tr>
<td>Copier</td>
<td>$1000</td>
<td>June</td>
<td>5</td>
</tr>
</tbody>
</table>

Again, if it is an existing business/product, you can use previous data to forecast; if it is a new business/product, you must use your best educated guess.

- Example:

<table>
<thead>
<tr>
<th>Expenses</th>
<th>‘10</th>
<th>‘11</th>
<th>‘12</th>
<th>% Forecast*</th>
<th>‘13 Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$50</td>
<td>$52.50</td>
<td>$80</td>
<td>38</td>
<td>110.40</td>
</tr>
<tr>
<td>Rent</td>
<td>$12</td>
<td>$12.60</td>
<td>$13.20</td>
<td>5</td>
<td>$13.80</td>
</tr>
<tr>
<td>Other</td>
<td>$20</td>
<td>$22</td>
<td>$25</td>
<td>0</td>
<td>$25</td>
</tr>
<tr>
<td>Total</td>
<td>$82</td>
<td>$87.10</td>
<td>$118.20</td>
<td>26</td>
<td>$149.40</td>
</tr>
</tbody>
</table>
The forecast is calculated by averaging the % of increase for each of the past 3 years and then estimating any additional increase or decrease based on market factors.

- Complete the following chart to determine your projected expenses:

<table>
<thead>
<tr>
<th>Expense Source</th>
<th>For Existing Businesses/Products</th>
<th>For All Businesses/Products</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prior Year 1</td>
<td>Prior Year 2</td>
</tr>
<tr>
<td>Salaries</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Taxes/employee expense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplies/equipment</td>
<td></td>
<td>$2,500</td>
</tr>
<tr>
<td>Depreciation</td>
<td></td>
<td>$360</td>
</tr>
<tr>
<td>Professional fees</td>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>Dues/members</td>
<td></td>
<td>$150</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>$1,200</td>
</tr>
<tr>
<td>Travel</td>
<td></td>
<td>$4,000</td>
</tr>
<tr>
<td>Postage</td>
<td></td>
<td>$250</td>
</tr>
<tr>
<td>Utilities</td>
<td></td>
<td>$600</td>
</tr>
<tr>
<td>Marketing</td>
<td></td>
<td>$1,500</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

III. Cost per unit
- The next step is to determine the average cost per unit based on your projections. It is calculated as follows:
  - Average cost/unit = All expenses divided by the number of units
  - Example: $149,400 ÷ 2896 = $52 per visit
- From your charts above, fill in the blanks to determine your projected average cost per unit for each year.
- **Year 1:**
  Total expenses $125,810 ÷ Total number of units 1800 = $70 per unit

- **Year 2:**
  Total expenses $129,720 ÷ Total number of units 1980 = $65.50 per unit

- **Year 3:**
  Total expenses $158,085 ÷ Total number of units 2625 = $60.25 per unit

**IV. Revenue forecast**

Forecasting revenue is more difficult than forecasting expenses. There is no set rule for what your charge should be. Consideration must be given to what is charged for similar services, what the competition is charging, and what the market will bear. Wound, Ostomy and Continence Nurses Society compiled a salary and productivity survey of members in 2008. This beneficial tool can help you determine your fee for service based on your geographical location or expertise (WOCN, 2008).

- **Table 1: Typical Hourly Rate for Contractual Services**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Number of Respondents</th>
<th>Median</th>
<th>Average</th>
<th>25th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>28</td>
<td>$67.50</td>
<td>$73.82</td>
<td>$56.88</td>
<td>$81.25</td>
</tr>
<tr>
<td>Home care</td>
<td>34</td>
<td>$65</td>
<td>$66.91</td>
<td>$53.13</td>
<td>$80</td>
</tr>
<tr>
<td>Subacute</td>
<td>14</td>
<td>$65</td>
<td>$61.25</td>
<td>$50</td>
<td>$78.75</td>
</tr>
<tr>
<td>Long-term care</td>
<td>34</td>
<td>$65</td>
<td>$68.63</td>
<td>$50</td>
<td>$80</td>
</tr>
<tr>
<td>Outpatient/wound care center</td>
<td>13</td>
<td>$55</td>
<td>$63.40</td>
<td>$52</td>
<td>$65</td>
</tr>
<tr>
<td>Education</td>
<td>29</td>
<td>$77.50</td>
<td>$74.98</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Expert chart review</td>
<td>22</td>
<td>$162.50</td>
<td>$164.80</td>
<td>$125</td>
<td>$200</td>
</tr>
<tr>
<td>Depositions</td>
<td>14</td>
<td>$250</td>
<td>$274.69</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>Protocol development</td>
<td>16</td>
<td>$77.50</td>
<td>$81.53</td>
<td>$45</td>
<td>$100</td>
</tr>
<tr>
<td>Workshop</td>
<td>20</td>
<td>$100</td>
<td>$129.47</td>
<td>$54.38</td>
<td>$150</td>
</tr>
</tbody>
</table>

If you have the luxury of using your charge in all cases, use the average cost per unit that you just calculated and add on an appropriate profit. If you have contracted rates that are different than your charge, you must consider the difference between your charge and the contracted rate. You will, however, most likely be charging different prices for different types of services.
- **Example:**

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Average Revenue/Unit</th>
<th>Number of Visits</th>
<th>Total $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>$60</td>
<td>426</td>
<td>$25,560</td>
</tr>
<tr>
<td>Wounds</td>
<td>$72</td>
<td>1,560</td>
<td>$112,320</td>
</tr>
<tr>
<td>Continence</td>
<td>$78</td>
<td>910</td>
<td>$70,980</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>$208,860</td>
</tr>
</tbody>
</table>

- Determine your expected revenue by completing the following charts:

  - **Year 1:**

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Revenue per Unit</th>
<th>Number of Units</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>$70</td>
<td>300</td>
<td>$21,000</td>
</tr>
<tr>
<td>Wound</td>
<td>$75</td>
<td>1000</td>
<td>$75,000</td>
</tr>
<tr>
<td>Continence</td>
<td>$75</td>
<td>400</td>
<td>$30,000</td>
</tr>
<tr>
<td>Consulting</td>
<td>$90</td>
<td>100</td>
<td>$9,000</td>
</tr>
<tr>
<td>Total</td>
<td>Average: $75</td>
<td>1800</td>
<td>$135,000</td>
</tr>
</tbody>
</table>

  If you have the luxury of using your charge in all cases, use the average cost per unit that you just calculated and add on an appropriate profit. If you have contracted rates that are different than your charge, you must consider the difference between your charge and the contracted rate. You will, however, most likely be charging different prices for different types of services.

  - **Year 2:**

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Revenue per Unit</th>
<th>Number of Units</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>$70</td>
<td>330</td>
<td>$23,100</td>
</tr>
<tr>
<td>Wound</td>
<td>$75</td>
<td>1100</td>
<td>$82,500</td>
</tr>
<tr>
<td>Continence</td>
<td>$75</td>
<td>440</td>
<td>$33,000</td>
</tr>
<tr>
<td>Consulting</td>
<td>$90</td>
<td>110</td>
<td>$9,900</td>
</tr>
<tr>
<td>Total</td>
<td>Average: $75</td>
<td>1980</td>
<td>$148,500</td>
</tr>
</tbody>
</table>

  - **Year 3:**

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>Revenue per Unit</th>
<th>Number of Units</th>
<th>Total Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ostomy</td>
<td>$70</td>
<td>350</td>
<td>$24,500</td>
</tr>
<tr>
<td>Wound</td>
<td>$75</td>
<td>1600</td>
<td>$120,000</td>
</tr>
<tr>
<td>Continence</td>
<td>$75</td>
<td>500</td>
<td>$37,500</td>
</tr>
<tr>
<td>Consulting</td>
<td>$90</td>
<td>175</td>
<td>$15,750</td>
</tr>
<tr>
<td>Total</td>
<td>Average: $75</td>
<td>2625</td>
<td>$197,750</td>
</tr>
</tbody>
</table>
V. Break-even analysis

- The break-even analysis is important in determining how many units of service you need to provide in order to cover your expenses. It is calculated as follows:
  - Average revenue/unit \times \text{Number of units} = \text{Total expenses}
  - **Example:** $70 \times \text{Number of units} = $149,400
    - \text{Number of units} = $149,400 \div $70
    - Number of units = 2134

This means that 2134 visits are needed to cover expenses. It is not unusual for a new business/product to lose money the first year or so; however, you need to project when you expect to break even and then start making a profit. During the years that you will be breaking even or losing, you need to have financial support to at least pay your bills.

- Calculate your estimated break-even point:
  - **Year 1:**
    - Average revenue/unit $75 \times \text{Number of units} = \text{Total expense $125,810}
    - \text{Number of units} = \text{Total expense $125,810} \div \text{Average revenue/unit $75}
    - Number of units = 1678 Year 1
    - Break-even? Yes ☑️ No ☐

*Always Wright Consulting Services will break even in the first year.*

VI. Pro-forma income statement

Believe it or not, this is the easiest part. Very simply put, the pro forma income statement indicates the revenue minus expenses---information you have already calculated. It finally shows you what your “bottom line” will be over the next 3 years.

- **Example:** For the simple example that we have been following, the net income will be: $208,860 – $149,400 = $59,460

  For the body of the business plan, you need only include the abbreviated financial analysis. Save all the details for the Appendix.

- Summarize your pro forma results: See appendix for detailed financial statements.

**Summary:**

- **Year 1:**
  - Total revenue $135,000 – Total expenses $125,810 = $9190
- **Year 2:**
  - Total revenue $148,500 – Total expenses $129,720 = $18,780
- **Year 3:**
  - Total revenue $197,750 – Total expenses $158,085 = $39,665
Appendix S–II: Sample Business Plan: Always Wright Consulting Services

Always Wright Consulting Services

April 30, 2011

Contact person:
Kristy Wright, MBA, RN, CWOCN
1234 Maple Lane
Anywhere, PA 10023
(555) 123-4567
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Executive Summary  
Present Situation  
Goals and Objectives  

Business/Product Description  
Critical Success Factors and Key Assumptions  
Always Wright Consulting Services Staffing Structure  
Proposed 2012 Budget  
Contractual Agreement  
Appendices *(Note: Sample items are not included here but would be included in an actual proposal.)*
Executive Summary

Always Wright Consulting Services (AWCS) is a professional nursing and organizational development firm that will provide clinical wound, ostomy and continence (WOC) services and assist with development of programs, clinics, protocols, outcome data, and regulatory compliance. AWCS is also expert in reimbursement issues.

In the proposed service area, the 5 diseases causing the highest incidences of mortality and morbidity are directly related to the service capability of AWCS. They include diabetes, cancer, circulatory disorders, and accidents. One city in the area has a particularly high incidence of bladder cancer with resultant cystectomy. In addition, due to the concentration of the elderly, there is a relatively high incidence of untreated incontinence. The long-term care facilities in the area feel that it is their greatest concern followed closely by pressure ulcers. AWCS will address the most costly physical manifestations of the aforementioned diseases that would express themselves in wounds, chronic peripheral vascular ulcers, incontinence, and ostomies.

In the current competitive managed care environment, health care organizations need to provide quality services in a cost-effective and efficient manner. The obvious benefit of utilizing AWCS is an improvement in the quality of life for patients. AWCS ensures this through individualized patient education, continuity of care across all settings, family involvement, decreased complications, and a more rapid return to normal activities. AWCS will benefit the contracting customer (organization) through cost savings by managing resources, ensuring that services and supplies are reimbursable, treating the patient in the most effective setting, reducing length of stay, and decreasing complications and readmissions. In addition, AWCS will assist with regulatory compliance through staff education, protocol development, outcome data collection, and quality measurement. These benefits will give the customers a competitive advantage and put them in a solid position to work with managed care organizations and negotiate for capitated contracts.

AWCS will serve a variety of customers and consumers, each with different characteristics and needs. Service delivery will remain flexible in order to target the needs of each customer group. A specific plan has been developed for each customer segment that includes customer characteristics, the “message” that needs to be conveyed to each customer, and strategies for improving customer relations.

The long-range goal is to financially break even by the end of the second year of business. In order to achieve this, the following goals have been established:

1. Achieve a 10% to 15% growth over each of the next 5 years.
2. Pay off start-up debt in 5 years.
3. Realize a profit in 2 years.
4. Ensure quality services with measured outcomes.
5. Employ qualified team members.

The success of AWCS is reliant on certain critical success factors. AWCS must acquire certain resources in order to achieve a successful and profitable business within the time frame stated in AWCS goals. Resources needed include personnel, equipment and supplies, and start-up capital. AWCS must also secure at least 2 hospital contracts prior to beginning business.

The current environment is exciting and promising for AWCS to begin business. Once established, the firm has plans to grow and expand in size, available services, and geographic area. The current partners are certified in WOC nursing. Plans are in place to hire additional professional staff as the business grows.
Present Situation
The current environment for this new business is very exciting. Managed care is increasing penetration into all health care settings in western Pennsylvania. Many of the smaller hospitals and alternative settings are merging or affiliating to form larger networks. The challenge is to reduce costs, maintain quality, and learn how to work cooperatively with managed care organizations.

External Analysis
The population in the area has an average age of 73 years, and the fastest growing age group is older than 80 years. Although the average income is relatively low ($25,000/y), the elderly population creates many opportunities for services by AWCS.

The 5 diseases causing the highest incidences of mortality and morbidity are directly related to the service capability of AWCS. They include diabetes, cancer, circulatory disorders, and accidents. One city in the service area has a particularly high incidence of bladder cancer with resultant cystectomy. In addition, due to the concentration of elderly in the area, there is a relatively high incidence of untreated incontinence. The long-term care facilities in the area feel that it is their greatest concern followed closely by pressure ulcers. AWCS will address the most costly physical manifestations of the aforementioned diseases, which would express themselves in wounds, chronic peripheral vascular ulcers, incontinence, and ostomies.

Competitive Analysis
There is moderate competition in the service area. Two other WOC nurses are in practice; however, both work full-time for acute facilities. Physical therapists and 1 physician’s group also provide wound care on an inpatient and outpatient basis.

The primary competitive concern is that physical therapists and the physician group receive direct Medicare reimbursement for their services. It is unlikely that Medicare will revise payment regulations to include WOC nursing. Therefore, AWCS will need to present their services to customers from a cost-savings perspective.

AWCS has an edge over competitors by offering a comprehensive service that includes not only clinical care but also organizational development. This allows AWCS to provide protocol development, business development (including outpatient clinics), marketing to managed care, and assistance with reimbursement.

Internal Analysis
AWCS has the ability to provide expert WOC care in all settings. The staff possesses a variety of clinical skills and certifications including special expertise in delivering care in the patient’s home. In order to fully meet the demands of potential customers, the company will need to collect outcomes data to present to organizational customers (including managed care). In addition to clinical expertise, AWCS has a unique strength in other related business skills, including organizational development, reimbursement issues, financial analysis, marketing, and medical equipment management. In order to work within the managed care environment, knowledge and skill with capitation will need to be developed.

Financially, the company has obtained a small business loan, has $5000 in start-up cash, and has 2 guaranteed contracts. Although total income is uncertain, the AWCS could remain financially solvent through the first 2 years.
Goals and Objectives

AWCS planned on beginning business on September 1, 2011, as a partnership. The long-range goal was to financially break even by the end of the second year of business and then to add other staff. In order to achieve this long-range plan, the following goals have been established:

1. Achieve a 10% to 15% growth over each of the next 5 years.
2. Pay off start-up debt in 5 years.
3. Realize a profit in 2 years.
4. Ensure quality services with measured outcomes.
5. Employ qualified team members.

The following objectives have been developed to meet AWCS’s goals:

Goal 1: Achieve a 10% to 15% growth over each of the next 5 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get contract with 2 hospitals</td>
<td>None additional</td>
<td>December 2012</td>
</tr>
<tr>
<td>Get contract with 3 home care organizations</td>
<td>Possibly half-time WOC nurse funding, staffing, van, equipment</td>
<td>March 2013</td>
</tr>
<tr>
<td>Establish outpatient clinic</td>
<td>Funding, staffing, space</td>
<td>December 2015</td>
</tr>
<tr>
<td>Establish mobile clinic</td>
<td>Funding, staffing van, equipment</td>
<td>December 2016</td>
</tr>
</tbody>
</table>

Goal 2: Pay off start-up debt in 5 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put 5% of revenue toward loans each quarter</td>
<td>Adequate revenue</td>
<td>Each quarter, ending in 2016</td>
</tr>
</tbody>
</table>

Goal 3: Realize a profit in 2 years.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get contract with 2 hospitals</td>
<td>None additional</td>
<td>December 2012</td>
</tr>
<tr>
<td>Get contract with 3 home care organizations</td>
<td>Possibly half-time WOC nurse funding, staffing, van, equipment</td>
<td>March 2013</td>
</tr>
</tbody>
</table>

Goal 4: Ensure quality services with measured outcomes.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop clinical guidelines for practice</td>
<td>Wound, Ostomy and Continence Nurses guidelines</td>
<td>December 2012</td>
</tr>
<tr>
<td>Set up database to collect outcome data</td>
<td>Education for secretary on database management</td>
<td>March 2013</td>
</tr>
<tr>
<td>Analyze and report data</td>
<td>Time!!!</td>
<td>September 2013</td>
</tr>
</tbody>
</table>
Goal 5: Employ qualified team members.

<table>
<thead>
<tr>
<th>Steps to Achieve</th>
<th>Resources Needed</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>WOC nurses to attend Wound, Ostomy and Continence Nurses conferences</td>
<td>Funding and patient coverage</td>
<td>Annually</td>
</tr>
<tr>
<td>WOC nurses to be certified</td>
<td>Funding</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Database management education for secretary</td>
<td>Funding and time</td>
<td>March 2013</td>
</tr>
</tbody>
</table>

Business/Product Description

AWCS will provide comprehensive clinical, business, and development services that include the following:

- Clinical services and consultation
  - Comprehensive management of patients with wounds, ostomies, and incontinence
  - Assessment
  - Prevention
  - Patient education
  - Treatment selection and implementation
- Case management
  - Care coordination
  - Resource utilization
  - Continuity
  - Patient advocacy
  - Long-term management
- Education and development
  - Protocol development
  - Staff education
  - Program development (ie, outpatient clinics, etc)
  - Regulatory compliance
- Research
  - Clinical trials
  - Outcome data

The obvious benefit of utilizing AWCS is an improvement in the quality of life for patients. AWCS ensures this through individualized patient education, continuity of care across all settings, family involvement, decreased complications, and a more rapid return to normal activities. AWCS will benefit the contracting customer (organization) through cost savings by managing resources, ensuring that services and supplies are reimbursable, treating the patient in the most effective setting, reducing length of stay, and decreasing complications and readmissions. In addition, AWCS will assist with regulatory compliance through staff education, protocol development, outcome data collection, and quality measurement. These benefits will give the customers a competitive advantage and put them in a solid position to work with managed care organizations and negotiate for capitated contracts.

Most importantly, in the current economic environment of health care, contracting for services is a variable rather than fixed cost. This allows the customer to have “just in time”
service without the overhead costs associated with employee downtime and fluctuations in productivity.

**“Quick Referral” System**

AWCS has developed a “Quick Referral” system to streamline access to services. Referral forms will be provided to each customer on disk and in hard copy. Written referrals may be faxed 24 hours a day or e-mailed to alwayswright@consult.com. In addition, referrals can be called directly to the office from 8 AM to 5 PM or to the 24-hour answering service. AWCS also has 24-hour on call staffing for emergencies.

**Service Area**

- AWCS provides the full range of services to the following areas:
  - Butler County
  - Armstrong County
  - Lawrence County
  - Alle-Kiski Valley area

**Critical Success Factors and Key Assumptions**

AWCS will require certain resources to be in place in order to achieve a successful and profitable business within the time frame discussed in the AWCS goals. Resources needed include the following:

**Personnel**

- Administrator
- Two clinical staff (certified WOC nurses)
- One secretary/receptionist

**Equipment**

- Office space to accommodate the clinical staff and administrative personnel
- At least 3 phones and phone lines (1 dedicated to fax/modem)
- Two computers (with built-in fax/modem capabilities)
- Two printers
- Copy machine
- E-mail and Internet service

**Capital**

- Start-up funding to purchase equipment and supplies
- Funding to underwrite operations for 6 months

**Other**

- In order to meet financial obligation and reach financial and business goals, AWCS will need to secure at least 2 hospital contracts before beginning business. The following assumptions were made when planning the needs and goals of AWCS:
  - Two of the 5 area home care organizations will affiliate with area hospitals
  - One of the WOC nurses currently working in an area hospital will join AWCS within 12 to 18 months.
Always Wright Consulting Services Staffing Structure

Staff (Note: CVs for each professional staff member are included in the appendix.)
- Kristy Wright, MBA, RN, CWOCN---Managing partner
- Mary Smith, MSN, RN, CWOCN---Partner clinical director
- Sally Jones---Secretary/receptionist
- Mark Williams, CPA---Accountant
- Sue Green, JD---Attorney
- Richard Jones, MBA---Small business consultant

Always Wright Consulting Services

Proposed 2012 Budget

<table>
<thead>
<tr>
<th>Budget Items</th>
<th>Proposed for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
</tr>
<tr>
<td>Ostomy</td>
<td>$21,000</td>
</tr>
<tr>
<td>Wound</td>
<td>$75,000</td>
</tr>
<tr>
<td>Continence</td>
<td>$30,000</td>
</tr>
<tr>
<td>Consults</td>
<td>$9,000</td>
</tr>
<tr>
<td><strong>Total revenues:</strong></td>
<td><strong>$135,000</strong></td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>$110,000</td>
</tr>
<tr>
<td>Taxes---employee expenses</td>
<td>$3,250</td>
</tr>
<tr>
<td>Rent</td>
<td>$1,000</td>
</tr>
<tr>
<td>Supplies/equipment</td>
<td>$2,500</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$720</td>
</tr>
<tr>
<td>Professional fees</td>
<td>$1,000</td>
</tr>
<tr>
<td>Dues/memberships</td>
<td>$150</td>
</tr>
<tr>
<td>Education</td>
<td>$1,200</td>
</tr>
<tr>
<td>Travel</td>
<td>$4,000</td>
</tr>
<tr>
<td>Postage</td>
<td>$250</td>
</tr>
<tr>
<td>Utilities</td>
<td>$600</td>
</tr>
<tr>
<td>Marketing</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td><strong>$126,170</strong></td>
</tr>
<tr>
<td>Revenue over expenses</td>
<td><strong>$8,830</strong></td>
</tr>
<tr>
<td>Net profit</td>
<td><strong>$8,830</strong></td>
</tr>
</tbody>
</table>
Always Wright Consulting Services

Contractual Agreement

Contractual Agreement Between ABC Agency and Sarah Smith, BSN, RN, CWOCN
(Note: Usually begins with introductory paragraph explaining the purpose of the contract.)

Purpose
Whereas ABC Agency (hereinafter referred to as “Agency”) desires to assure the provision of outcomes-oriented and cost-effective care to its patients with compromised skin integrity, chronic wounds, ostomies, or incontinence, and Sarah Smith, BSN, RN, CWOCN (hereinafter referred to as WOC nurse), desires to provide these services on a contractual basis, these parties hereby enter into this contractual agreement.

May include general background information regarding scope of practice and qualifications.

Background
The WOC nurse is minimally a baccalaureate-prepared RN who has graduated from a nationally accredited program in wound, ostomy and continence (WOC) nursing. The designation CWOCN reflects National Board Certification by the Wound, Ostomy and Continence Nursing Certification Board and is a nationally recognized measure of current knowledge and competence in the field of WOC nursing.

The WOC nurse scope of practice includes the following:
- Assessment and early intervention for patients at risk for skin breakdown.
- Outcomes-oriented management of chronic wounds such as pressure ulcers and lower extremity ulcers.
- Rehabilitative care for patients with ostomies or continent diversions.
- Cost-effective management of chronic percutaneous tubes, draining wounds, and fistulas.
- Implementation of effective bowel and bladder programs to correct or manage urinary and/or fecal incontinence.

The contract should include specific responsibilities of each party. See the following example:

Specific Responsibilities of WOC Nurse:

1. WOC nurse agrees to provide the following patient care services upon consultation:

   Wound Care:
   - Assessment of etiologic factors with recommendations for correction.
   - Baseline assessment of systemic factors impacting on healing, with recommendations for further assessment/intervention as needed.
   - Assessment of wound status and recommendations for topical therapy.
   - Conservative sharp wound debridement when indicated (and with MD order).
   - AgNO₃ cauterization of hypertrophic granulation tissue and/or nonproliferative wound edges when indicated.
   - Recommendations for referral when indicated.
Establishment of effective pouching system for patient with draining wound or fistula.

**Ostomy Care:**
- Preoperative teaching and stoma site marking.
- Postoperative assessment of stoma, output, and pouching surface; selection of appropriate pouching system.
- Patient and family education regarding ostomy management.
- Patient counseling to facilitate adaptation and resumption of preoperative lifestyle.

**Continence Care:**
- Assessment of etiologic factors, patterns of incontinence, and potential for restoration of continence.
- Recommendations for referral when indicated.
- Recommendations for management to include bowel and bladder training programs; toileting programs; instruction in clean intermittent catheterization; instruction in pelvic muscle exercises; and appropriate use of devices, absorptive products, and skin care products.

2. WOC nurse agrees to respond to consult within 24 working hours unless alternate arrangements are made.
3. WOC nurse agrees to obtain MD orders for all care provided and to communicate all care recommendations to staff and MD via written documentation on the progress notes and the plan of care and verbal communication to the staff.
4. WOC nurse agrees to provide in-services to staff within areas of expertise upon request and within mutually agreed upon parameters regarding length, content, materials to be provided, program dates, and compensation.
5. WOC nurse agrees to maintain current registration as RN within state of _________ and current board certification as WOC nurse, with documentation provided to Agency upon request.
6. WOC nurse agrees to maintain own professional liability insurance with minimum of $1 million per incident and $3 million aggregate coverage and to make documentation of coverage available to Agency upon request.
7. WOC nurse agrees to provide documentation of acceptable health status to Agency (to include negative PPD updated every 6 months; immunity to measles, mumps, and chicken pox documented by titers or by immunizations x2; immunity to hepatitis B documented by titers or by evidence of HeptaVax x 3, or signed statement of declination and acceptance of responsibility).
8. WOC nurse agrees to submit monthly invoice to Agency for services provided; invoice for each month of services will be submitted by the 15th of the following month along with itemized statement delineating services provided.
9. WOC nurse agrees to pay own federal, state, and social security taxes.

**Specific Responsibilities of Agency:**
1. Agency agrees to provide WOC nurse with staff privileges and to orient WOC nurse to agency.
2. Agency agrees to appoint a contract person and supervisor for the WOC nurse.
3. Agency agrees to notify the medical staff and nursing staff in writing of the appointment of the WOC nurse to the Agency’s consultant staff; such notification shall be accompanied by the following:
   - List of specific services provided (as outlined in Item 1 of previous section “Specific Responsibilities of WOC Nurse”).
   - Guidelines for initiating a consult.
   - Relevant agreements, that is, time frame for WOC nurse’s response to a consult, WOC nurse’s responsibility for obtaining any needed orders, WOC nurse’s communication with staff, and documentation on patient record.
4. Agency agrees to notify WOC nurse by beeper (beeper #) of patients to be seen and reason for consult.
5. Agency agrees to handle all patient billing.
6. Agency agrees to remit payment for services provided within 4 weeks following receipt of invoice. Payment shall be made according to the attached fee schedule. Would need to attach a fee schedule; see fact sheet on contractual agreements for tips.
7. Agency agrees to provide institutional liability coverage for WOC nurse services.
8. Agency agrees to provide free parking to WOC nurse.
9. Agency agrees to provide all patient care supplies required for WOC care.

Joint Responsibilities:
1. Both parties agree to hold an evaluation conference annually to review the services being provided and to resolve any issues or problems. In addition, each party agrees to meet at any time upon the second party’s request to discuss and resolve any issues.
2. This agreement may be terminated at any time by mutual consent or by either party with written notification of the second party; such notification must be made 60 days prior to the termination date.
3. This agreement is effective ___________________________ ____________________

_________________________  ______________________
Agency representative      Provider
Appendix S–III: A Business Financial Glossary

**Account payable**---A liability representing an amount owed to a creditor, usually arising from purchase of merchandise or materials and supplies. Normally a current liability.

**Account receivable**---A claim against a debtor usually arising from sales or service rendered. Normally a current asset.

**Accrual basis of accounting**---The method of recognizing revenues as goods that are sold or services that are rendered, independent of the time when cash is received. Expenses are recognized in the period when the related revenue is recognized, independent of the time when cash is paid out.

**Asset**---A resource with exchange or economic value.

**Bad debt**---An uncollectible account receivable.

**Balance sheet**---A financial report that profiles the economic condition of an organization as of a moment in time.

**Budget**---A financial plan used to estimate results of future revenues and expenditures.

**Capital budget**---Plan of proposed outlays for acquiring long-term assets and the means of financing the acquisition.

**Cash**---Currency and coins, negotiable checks, and balances in bank accounts.

**Current assets**---Cash and other assets that are expected to be turned into cash, sold, or exchanged within the normal operating cycle of the firm, usually 1 year. Current assets include cash, receivables, and inventory.

**Depreciation**---An expense that represents the normal wear or deterioration experienced by an asset.

**Direct costs**---Costs that can be identified with and that result from the production of a specific good or delivery of a specific service.

**Expense**---Use of assets in producing revenue or carrying out other activities that are part of operations.

**Fixed cost**---An expense that does not vary with volume of goods or services produced.

**GAAP**---Generally accepted accounting principles.

**Income**---Excess of revenues over expenses. Also referred to as net income.

**Income statement**---Financial statement of revenues, expenses, and net income.

**Indirect costs**---Costs of production not easily associated with the production of specific goods or services. Also referred to as overhead.

**Liability**---Financial responsibilities and debts resulting from current operations and investment in fixed assets.

**Long-term debt**---Debt or liability that will typically be repaid over a period greater than 1 year. This debt is usually acquired in obtaining fixed assets.

**Net income**---See *income*.

**Overhead**---Any cost not associated directly with the production of goods or services. Also referred to as indirect costs.

**Pro forma**---Hypothetical financial statements as they would appear if some event such as a merger, increased production, or addition of a new service had occurred. Frequently done in the form of a pro forma budget.

**Revenue**---The monetary measure of a service rendered or goods sold.

**Variable costs**---Expenses that vary with the volume of goods produced or services rendered.
References
Appendix T: Sample WOCN Society Member’s Research Grant Proposal

*Note: The following is an example of a research grant proposal provided by the Center for Clinical Investigation (CCI) of the Wound, Ostomy and Continence Nurses Society Foundation. This document was developed by the CCI and is available at the WOCN Web site (http://www.wocn.org/ResearchFunding). The document is provided here only as an example and is subject to change. Please contact CCI or check the Web site to verify current funding opportunities and the proposal process.

**Funding Priorities:**

**WOCN Society Member’s Research Grant---$10,000:**

Any topic of WOC nursing practice that promotes the science or practice of the WOC nursing specialty.

This grant proposal is divided into 4 sections:

I. Grant Submission Instructions
II. Title Page
III. Proposal Guide
IV. Checklist

**I. GRANT SUBMISSION INSTRUCTIONS**

**A. Notice of interest**

- Please submit a *Notice of Interest* e-mail to Linda Dahle, Program Associate (dahle081@umn.edu) when you are considering applying for a Member’s Research Grant. This is not a commitment, and you can notify CCI later if you change your mind. This will enable CCI to send you any updates or resources to assist you. Please include the following information in the *Notice of Interest* e-mail:
  - Principal investigator’s (PI) name
  - Topic you are considering studying and the title of proposal
  - A statement of the purpose of the study
  - E-mail address
  - Telephone number

**B. The title page to be completed includes the following information:**

- Title of research grant
- Principal investigator’s name
- Academic degrees
- Current professional certification
- Home address
- Current employer
- Employer address
- Preferred mailing address
- Work/home telephone numbers
- Fax number
- E-mail
- Registered nurse/license number/state of PI and Co-PI
- WOCN Society Co-I Member Number of PI and Co-PI
If you have team members as part of your study, please fill out, “Other Team Members Contact Information” (please copy table on separate pages for as many team members as you have).

C. The following sections are included in the Proposal Guide, and need to be completed in order to be considered for funding:

A) Title Page
B) Abstract (summary of proposal)
C) Scientific Plan (statement of problem including fit with grant and relevance to WOC nursing, research questions/aims, review of literature, references, methods)
D) Bio-sketch of Principal Investigator (PI)
E) Co-Investigator(s) Bio-sketch
F) Statement of Team Qualifications/Strengths
G) Project Budget
H) Budget Justification
I) Human Subjects/Ethical Considerations
J) Timeline
K) Scientific and Funding Overlap---Duplicative funding will not be accepted (ie, funding for same project by more than 1 grant). Please see the “K. Scientific and Funding Overlap” section for more detail.
L) Receipt of Funds
M) Appendix (Letters from research mentor; permission of holder of any records to be used, administrative approval to conduct study in an agency, etc, are required)

D. Research proposal preparation

- The Scientific Plan of the research proposal is a maximum of 10 typed pages in length single space (see Section C), but does not include the abstract, references, biographical sketches, budget, human subjects/ethical considerations, timeline, and other appendix materials.
- Submission content must be:
  o Typed single space---maximum 10 pages (references should also be single spaced)
  o Leave 1-inch margins on all sides
  o Use a 12-point font Arial
  o Number every page
  o Do not use proportional spacing or justified margins
  o One Microsoft Word document that includes ALL the sections of the proposal will be accepted---no PDFs will be accepted.
- The institutional review board (IRB) approval is not required at the time of submission, but an IRB application must be submitted within 30 days of award.

E. References

- The authors are responsible for the accuracy of the References. References should use an established format such as in the *AMA Manual of Style*, 9th ed (p. 43), or *Publication Manual of the American Psychological Association* (6th ed).

F. Submission of a grant proposal:

Linda Dahle, Program Associate: dahle081@umn.edu

- E-mail the completed grant proposal by ____________________ to:
  
  Date
G. Questions?
If you have questions about your proposal submission, please contact Linda Dahle at dahle081@umn.edu or 612.625.8159. If you have any scientific questions, please contact Dr Donna Bliss, Director of the Center for Clinical Investigation, at bliss@umn.edu.

II. TITLE PAGE
A. WOCN Society Member’s Research Grant---$10,000: Funding priorities: Any topic of WOC nursing practice or that promotes WOC nursing specialty practice.

| ▪ Title of Research Project: |
| ▪ Principal Investigator’s Name: |
| ▪ Academic Degrees: |
| ▪ Current Professional Certification: |
| ▪ Home Address: |
| ▪ Current Employer: |
| ▪ Employer Address: |
| ▪ Preferred Mailing Address: |
| ▪ Home Number: |
| ▪ Fax Number: |
| ▪ PI’s Registered Nurse License Number/State: |
| ▪ Co-PI’s Registered Nurse License Number/State (if applicable): |
| ▪ PI’s WOCN Member Number: |
| ▪ Co-PI’s WOCN Society Member Number (if applicable): |
B. OTHER TEAM MEMBERS’ CONTACT INFORMATION
(Please copy table on separate pages for as many team members as you have.)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Credentials</th>
<th>Work Affiliation</th>
<th>Responsibilities/Contributions to Study</th>
<th>Address</th>
<th>Telephone/Email Address</th>
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<tr>
<td>Co-Investigator(s)</td>
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<tr>
<td>Research Mentor</td>
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<tr>
<td>Statistician</td>
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<tr>
<td>Consultant</td>
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<tr>
<td>Other</td>
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<td></td>
</tr>
</tbody>
</table>
III. PROPOSAL GUIDE

A. COMPLETE TITLE PAGE

B. ABSTRACT (250-300 words maximum). The abstract is a summary of the entire proposal written in lay language. The abstract needs to include significance, purpose, research questions, aims, design, sample and summary of main procedures, planned statistical analyses, and expected outcomes.

C. SCIENTIFIC PLAN---No more than 10 pages single space in length maximum, and include the following 4 areas:

1. **Statement of the Problem:** includes significance, innovation of study, and how you meet priority of the grant (approximately 1-2 pages). Opening sentences should communicate what the study is about. Be succinct, clear, and direct.
   a) **Significance:**
      - What is this study about?
      - Why is the topic important?
      - What new knowledge will your study offer?
      - Is it timely?
      - What is its relevance to WOC nursing?
      - What is the clinical or scientific problem and need for your study?
        - Support with statistics, epidemiology.
        - Expert opinion.
        - Formal position/white papers of societies.
   b) **Innovation of Study:**
      - Explain what is unique or new about the study.
      - Are you bringing 2 ideas together in an innovative way?
      - Are you proposing a new way of thinking?
      - Are you proposing a new solution to an existing problem?
      - Are you proposing a novel approach of studying problem?
   c) **Priority areas of grant:**
      - How do your priority areas fit with the priority areas of the grant?

2. **Research Questions/Aims:**
   - ½ page in length
   - Questions you will answer (2-3 questions is usually enough).
   - Statements of what you intend to do and accomplish.
     - Make known your main variables, sample, study design.
     - Must be measurable outcomes.
       - Be clear.
       - Not too broad---must be measurable.
       - Not too narrow---must be relevant.
       - Not too complicated---must be understandable.
       - Not too simplistic---must be important.
       - Should be specific, not general or ambiguous.

3. **Review of Literature**
   - 2 to 3 pages in length
   - Critique quality of key individual studies.

Appendix T – Sample WOCN Society Member’s Research Grant Proposal
• Do not just describe---why is your study better/needed than what is published?

• Evaluate state of science/evidence base.
  o Across all studies.

• Interpret conflicting information.

• Demonstrate knowledge about the problem and area of science.

• Identify the GAPS in knowledge that your study will address:
  o What information is missing that is important to know?
  o What new contribution to knowledge will your findings make?
  o Has practice or technology changed so that new information from your study is needed?

• Include only most relevant studies.
  o Include most current articles and only pivotal historical ones.

4. Methods (4-5 pages in length)
   a) Design
      • Specifically identify the design
      • Determined by the research question
      • Provides logical link among aims/questions, procedures, and analysis
        
        Question---Design---Methods---Analysis
      • Consult a statistician, experienced researcher about best approach

   b) Procedures
      • How will the proposed research be conducted?
      • Address the following:
        o Sample---the number and characteristics of subjects to be studied.
        o Sampling---strategies for recruiting subjects from where they will be recruited.
        o Explain procedures in good detail what you plan to do.
        o Describe groups you will form, including any control/placebo groups.
        o If doing random assignment, describe how it will be done.
        o Indicate points of interaction and data collection with subjects.
        o If you will do an intervention, explain what the intervention is, how you will implement it, and the data collection points. Include explanation of any placebo.
        o What are the expected outcomes of the study and how will they will measured, what instruments will be used, etc.?
        o How will you obtain data? Describe instruments, surveys, etc., that will be used to collect data.
          ▪ Address their validity and reliability.
        o Potential problems and how you plan to address/avoid them.

   c) Analysis
      • Describe statistical testing or qualitative analysis as appropriate
        (frequencies, correlations, chi-square, t tests).
      • Appropriate statistical tests or analyses (for research question, type of data, frequencies, correlations, chi-square, t tests).
      • Organize by research aim/question.
• Consult a statistician whenever possible.

THE FOLLOWING ARE NOT INCLUDED IN THE 10-PAGE LIMIT:

D. BIO-SKETCH OF PRINCIPAL INVESTIGATOR (PI) and Co-PI (2-4 pages)
   1. An example of a National Institutes of Health biosketch that you can follow is available at: http://grants.nih.gov/grants/funding/2590/biosketchsample.pdf
   2. A biosketch includes:
      • Name and credentials
      • Education (post--high school through present; institution, location, dates of attendance, degree, date degree was awarded)
      • Professional employment (title of position(s), address of employer, inclusive dates, certifications, and dates)
      • Publications
      • Any previous research experience (including funded research where you were the investigator, years, funder, and monetary amount of grant; role on other projects or other experience that would support your role as a PI; briefly describe type and level of experience/participation)

E. COINVESTIGATOR(S) BIOSKETCH (2-4 pages maximum for each person). List any coinvestigators and attach a biosketch for each that contains information as described for a PI in D. above.

F. STATEMENT OF TEAM QUALIFICATIONS/STRENGTHS. (Approximately ½-1 page in length)
   Include a statement about the role of each team member on the study, the qualifications and strengths of the research team, whether you have worked effectively together before, and what the consultants (if any) will add, etc.

G. PROJECT BUDGET:
   In preparing your budget, please address the following categories of items: Supplies, Equipment, Photocopying, Services, Postage, Consultants, Technical Support Staff, Computer-related, Other Costs, and Indirect Institutional Administrative Costs, followed by a Total Amount of Budget Requested (see below).
   A few items to note:
   1. Funds cannot be used as salary support of the PI, Co-PI, or any Co-I or mentor, but can be used to support technical staff, such as statistician or data collector, etc.
   2. Up to 10% of the total budget can be used for indirect institutional administrative costs.
   3. Up to $500 may be used to purchase any type of computer.
   4. Principal investigators are expected to use software available at the agency at which they are conducting the study (eg, workplace or school has SPSS license that PI can use).
   5. Include travel costs for ONE PI to attend the WOCN Society’s annual conference to present findings. The total amount of grant budget should include the travel cost. Estimate $1200 to $1500.
   6. $500 will be withheld from your grant until an abstract reporting the study findings is submitted to the WOCN Society annual conference, and a manuscript of final results is submitted to CCI as a final report and to JWOCN for review for publication.
**Budget Line Items**

1. **Supplies**  
   (e.g., camera, tape recorder)  
2. **Photocopying**  
   (e.g., survey data forms, consent forms, etc.)  
3. **Services**  
   (e.g., poster printing, data entry, etc.)  
4. **Postage**  
   (e.g., to mail a survey)  
5. **Consultants**  
6. **Research & Technical Support Staff**  
   (statisticians, data entry)  
7. **Computer-related**  
   (e.g., special software, laptop)  
8. **Travel/Mileage**  
   (to present findings, mileage to/from subject’s homes)  
9. **Other Costs**  
10. **Indirect Institutional Administrative Costs**  
    (no greater than 10% of total)

**TOTAL AMOUNT OF BUDGET REQUESTED:**  $

**H. BUDGET JUSTIFICATION.** Please include a brief explanation of what each item is, why it costs, what it does, and indicate how each item relates to the research plan. The information should be sufficiently detailed to address cost and need.

**I. HUMAN SUBJECTS.** If human subjects will be involved or medical record information of human subjects will be used, briefly explain the risks related to the study and how you will protect the safety and confidentiality of human subjects or their information. Indicate whether informed consent will be needed. If multiple institutions are data collection sites, address IRB approval at the various sites.

**NOTE:** Final approval of the study by an institutional review board/ethics committee is required after an award is made and before funds will be released.

**J. TIMELINE.** Provide a timeline starting from submission of IRB proposal through data collection and analysis to submission of findings to WOCN Society annual conference and final report.

**K. SCIENTIFIC AND FUNDING OVERLAP.** Explain if there is any overlap of the proposed project with other funds/grants received or pending by the principal investigator or study team:

1. If your proposed study is contingent upon receiving a grant from another funding source, PI must explain which portion CCI will fund and which portion will be funded by the other funding source. CCI will take into consideration the ability to complete CCI portion of the grant independently from the other grant.

2. If there is a majority or entire overlap of the grant submitted to CCI and another funding source and you are awarded funding by both, you must choose which grant you will accept.

**L. RECEIPT OF FUNDS.** Please check below if the principal investigator or the employment institution will be accepting the funds:
Principal investigator (If you choose this option, you will be required to include this as income on your income tax.)

Employment institution

Name and complete mailing address of person/institution to whom funds will be sent:

M. APPENDIX. The following materials are required or recommended in an Appendix:

- Letter of agreement to participate in study from institution in which the study will be conducted, or letter of agreement from Director of the clinical practice from which subjects will be recruited (required);
- Letter of agreement from consultants (required);
- Letter of support from a research mentor on the project, if applicable (required);
- Data collection instruments that are not readily accessible in the public domain/literature (recommended);
- If the study has already been approved by an IRB, please include in the Appendix.

NOTE:
- By accepting this grant, I agree to the terms of the Grant Award as outlined in the Research Grant Terms of Agreement.

IV. CHECKLIST
- All sections of the grant proposal must be completed in the final grant submission.
- Use this checklist to determine if your grant proposal is complete.
- Please assemble your grant submission in the following order, and put an “X” in the box to indicate that the item is completed:

  II. A. Title Page
  II. B. Other Team Members Contact Information
  III. B. Abstract
  III. C. Scientific Plan
  III. D. Biosketch of Principal Investigator/Co-PI
  III. E. Coinvestigator(s) Bio-sketch
  III. F. Statement of Team Qualifications/Strengths
  III. G. Project Budget
  III. H. Budget Justification
  III. I. Human Subjects
  III. J. Timeline
  III. K. Scientific and Funding Overlap
  III. L. Receipt of Funds
  III. M. Appendix

  I have reviewed the “Research Grant Terms of Agreement” and agree to its terms if funded.

Questions?
If you have questions about your proposal submission, please contact Linda Dahle at dahle081@umn.edu or 612.625.8159. If you have any scientific questions, please contact Dr. Donna Bliss, Director of the Center for Clinical Investigation, at: bliss@umn.edu.
Appendix U: Web Sites for Evidence-Based Resources

ACP Journal Club
http://acpj.acponline.org

Agency for Healthcare Research and Quality
http://www.ahrq.gov/clinic/epcix.htm

Agency for Health Care Research and Quality (AHRQ): Quality and Patient Safety
http://www.ahrq.gov/qual/index.html

AHRQ Research Funding Opportunities
http://www.ahrq.gov/fund

American Academy of Nutrition and Dietetics
http://www.eatright.org

American Diabetes Association
http://www.diabetes.org

American Podiatric Medical Association
http://www.apma.org

American Society of Pain Educators
http://www.paineducators.org

Campbell Collaboration*
http://www.campbellcollaboration.org
*Site requires registration or a subscription through OVID or a similar service.

Canadian Centre for Health Evidence
http://www.cche.net

Centre for Evidence Based Medicine
http://www.cebm.net

Center for Gerontology and Healthcare Research
http://www.chcr.brown.edu

Centre for Reviews and Dissemination
http://www.york.ac.uk/inst/crd

Essential Evidence Plus
http://www.essentialevidenceplus.com
Implementing Best Practice Gateway  
http://www.nursingsociety.org/Education/Pages/NewIBPKnowledgeGateway.aspx

Institute for Health Care Improvement (IHI)  
http://www.ihi.org

Institute for Health Care Research and Policy (Georgetown Public Policy Institute)  
http://ihcrp.georgetown.edu

Joanna Briggs Institute  
http://www.joannabriggs.edu.au/Home

National Association for Continence  
http://www.nafc.org

National Guidelines Clearinghouse  
http://www.guideline.gov

National Institute for Clinical Excellence  
http://www.nice.org.uk

National Pressure Ulcer Advisory Panel  
http://www.npuap.org

Registered Nurse Association of Ontario  
http://www.rnao.ca/bpg

Sigma Theta Tau International  
http://www.nursingsociety.org/default.aspx

Society of Urological Nurses and Associates  
http://www.suna.org

The Urology Care Foundation  
http://www.urologyhealth.org

United Ostomy Associations of America, Inc  
http://www.ostomy.org

University of Texas Health Sciences School of Nursing Academic Center for Evidence Based Practice  
http://www.acestar.uthscsa.edu/index.asp

US Preventive Services Task Force  
http://www.uspreventiveservicestaskforce.org/uspstr09/epbnursep/epbnursep.htm
Virginia Henderson International Nursing Library
http://www.nursinglibrary.org/vhl

WOCN Society
http://www.wocn.org/?page=research_funding

**Searchable Databases**

- Cochrane Collaboration
  http://www.cochrane.org

- Cumulative Index of Nursing and Allied Health Literature
  http://www.ebscohost.com/academic/cinahl-plus-with-full-text

- EMBASE
  http://www.embase.com

- MEDLINE

- PsycINFO

- PubMed
  http://www.pubmedcentral.nih.gov

**Government Resources**

- Centers for Disease Control and Prevention
  http://www.cdc.gov

- National Institutes of Health
  http://www.nih.gov

- US Department of Health and Human Services
  http://www.hrsa.gov
Appendix V: Wound, Ostomy and Continence Nurses Society™ Advocacy and Grassroots Toolkit

Influencing Public Policy: Strengthening the Voice of the Wound, Ostomy and Continence Nursing Community

Originated By:
Wound, Ostomy and Continence Nurses Society (WOCN) National Public Policy/Advocacy Committee

Date Completed:
February 15, 2012

Table of Contents

Introduction
WOCN Society Grassroots Toolkit for State Advocacy
The Basics: Communicating Directly With Your Legislator
Increasing Your Voice: Building a Relationship With Your Legislator
About Congress: Resources to Help You Navigate the Legislative Process
Introduction

The future growth and vitality of wound, ostomy and continence (WOC) nursing is largely dependent on the ability of our professionals to influence key decisions made in our state and nation’s capitols. These policy decisions are essential to preserving the future of our practices, our health care facilities, and the patient populations that we serve. To protect our field of nursing, we must develop and deliver effective messages from credible messengers to our elected officials about the quality of our patient care and its importance to the community. This is the essence of advocacy, which can be implemented on many levels and take many different forms.

This toolkit will present a variety of options for incorporating advocacy efforts into your operations, from simply establishing regular communications with your elected officials to the more advanced efforts entailed in developing a grassstops or grassroots program to strengthen your influence in Washington, District of Columbia, or in your state capitol. The WOCN Society has prepared this toolkit as a resource for its members to enhance their own, individual efforts at public policy/advocacy. The WOCN Society continues to conduct direct lobbying on Capitol Hill, provide advocacy support and training, and coordinate all of the Society’s government relations activities.

WOCN Society Grassroots Toolkit for State Advocacy

It is important for WOCN Society members to recognize that to be an effective advocate for our profession, we need to become involved in every level of government, including state and local policy. While the bulk of this toolkit focuses on federal activities, state legislatures across the country are playing a bigger role in health care policy than ever before. Since the enactment of the “Affordable Care Act” in 2010, states have been given broader authority and responsibilities with regard to health care policy decisions. Going forward, states will be largely responsible for the expansion of Medicaid authority, granted in the Affordable Care Act, and the establishment of their state Health Insurance Exchanges. State legislators will be more involved in coverage and reimbursement decisions than in past years.

WOCN Society members must be engaged at a state level because we are the eyes and ears of our profession and our patients. Policy decisions often happen quickly at the state level and can be made without the input of all stakeholders if those stakeholders are not engaged in the process. So, how do you become engaged in the process at the state level? There are some simple steps that can be taken:

1. **Stay Alert.** Try to read about the activities of your state legislature in the newspaper or on health policy blogs that might be available in your state.

2. **Engage Other Stakeholders.** Reach out to patient group leaders in your state as well as the public policy representatives you might have at your institution and ask that you be kept involved and considered a resource on health policy decisions.

3. **Research.** Two great resources are listed later that can help you become well informed about state policy and your state legislatures. The National Conference of State Legislatures (NCSL) has a wealth of information about state policy and state legislators and has a dedicated Health Policy section. In addition, Project Vote Smart can help you identify who your state legislators are and how to contact them.
   - [http://www.votesmart.org](http://www.votesmart.org)
4. **Reach Out.** The WOCN Society encourages all of its members to reach out to their state representatives, just as they would with their federal representatives. Being engaged is the best way to protect both your profession and your patients.

**The Basics: Communicating Directly With Your Legislator**

Legislators are greatly influenced by what they know and what they hear---especially from the people they represent. By communicating with a state legislator or a member of Congress, you can have a profound impact on the government policies that most affect your practice and the field of wound, ostomy and continence nursing.

Your elected officials need to hear from you. They hear from constituents and special interest groups about many diverse issues ranging from education to transportation to foreign policy. They need to hear from the nursing community as well. Do not assume that they know all the facts about the important role that wound, ostomy and continence specialty nurses play in delivering patient care in your community. It is incumbent upon you to provide them with the information they need to fully understand and appreciate the vital role of WOC specialty nurses.

Remember that you also should communicate with legislators from around your state and not just the elected representative from the district in which your facility or institution is located. Legislators from neighboring districts need to know that your WOC specialty nursing practice is essential and impacts their constituents.

**Suggested Steps**

Send an introductory packet to your congressional delegation, especially new legislators.

*The beginning of a new Congress is an ideal time to introduce (or reintroduce) wound, ostomy and continence nursing.*

- If a new member of Congress was just elected from your state, send a congratulatory letter to the legislator.
- Send a letter of congratulations to those who were reelected.
- Use this mailing as an opportunity to provide key information about your practice/facility to legislators from your state.

Provide information, such as the WOCN Society’s position statements, to educate or update legislators in your state about the important role WOC specialty nursing plays in your community.

*Use this first mailing to develop or strengthen your relationship with the office.*

- Follow up with a phone call to the legislator’s office.
- Remind the staff to contact you as a resource for further information.
- Extend an invitation for a visit to your practice/facility.

Maintain regular contact with a legislator’s office.

*Keep your legislators informed about your practice and facility.*

- Find opportunities to send positive articles and information about wound, ostomy and continence nursing (eg, press clips, success stories, WOCNews [the official WOCN Society newsletter]) at least a few times a year.
Communicate clearly about relevant legislation—do not assume that they know where you stand.

- Communicate if you are for or against a piece of legislation.
- Thank the legislator for supporting any relevant legislation.

Depending on the urgency of the situation, use one of the following methods of communications:

- **Fax**---Faxed letters are very effective as they are likely to be given to the legislative staff immediately.
- **Letter writing**---Use letters primarily to accompany information packets, articles, etc., because postal mail arrives very slowly to Capitol Hill offices.
- **E-mail**---E-mail is particularly effective if you communicate directly through a staff’s individual e-mail address, or if you are mobilizing a large number of people through the legislator’s Web site.
- **Phone calls**---Phone calls are very effective because they provide an opportunity to talk directly to the staff, which reinforces your relationship with the office.

Writing a Letter

Constituent letters are a common way of communicating with a legislator and an effective advocacy tool.

- A personal letter will get more attention than a form letter or preprinted postcard.
- Make sure you include your name and address. Some offices will not open a letter if it is not from his or her state.
- Fax the letter to your member’s office. Mail takes a long time to arrive because of security concerns with mail sent through the postal service.

Your letter should be simple and direct.

- If possible, limit your letter to one page.
- State the purpose of your letter in the first paragraph, identifying a specific bill number, if applicable.
- Focus on one particular issue and request specific action from the legislator.
- Explain how the issue will affect your local community.

Letters should be addressed as follows:

**To a Senator**

The Honorable (Full Name)
US Senate
(Room Number; Building Name) Senate Office Building
Washington, DC 20510

Dear Senator (Last Name):
To a Representative

The Honorable (Full Name)
House of Representatives
(Room Number; Building Name) House Office Building
Washington, DC 20515

Dear Representative (Last Name):

Sending an E-mail

E-mail is an easy way to communicate with a legislator or staff member.

- If possible, try to secure an e-mail address of a particular staff member (the health Legislative Aide or the District Office Director) and e-mail him or her directly. This is highly effective.
- All legislators have a Web page with a link to contact the legislator. While this is a very easy way to communicate, it is less effective unless you are mobilizing a large number of people. Remember, legislators receive thousands of e-mails a week, so one individual e-mail can get lost.

State key information in the subject line.

- As it is easy to erase e-mails, you want to communicate key information in the subject line.
- State that you are a constituent and reiterate the issue in the subject line (eg, “Your constituent writing about _______ legislation”).

Keep your message brief and to the point.

- Do not forget your name and address in the text.
- Embed your message in the text. Attachments should be for background information, fact sheets, or endorsements.

Finding your legislator’s Web site and e-mail.

- You can find your legislator’s e-mail address by visiting either the House or Senate Web sites (www.house.gov or www.senate.gov) and searching for or selecting your legislator’s name.

Telephone Calls to an Office

Phone calls are effective in delivering information quickly and directly, especially on days of key votes.

- State your position and ask what position the elected official is taking.
- Be prepared to explain how the issue will affect your practice and the legislator’s constituents.
Calling the District Office.
- While the District staff may be less influential in terms of legislation compared to the DC staff, they are more accessible to constituents.
- Establishing a good relationship with the District Director is a very effective way to influence policy because the District office staff is responsible for constituent services.

Calling the Washington, DC, Office.
- When you call the Washington, DC, office, ask to speak with the health legislative aide.
- Remind the aide that you are a constituent and how many people your practice/facility serves in the state.
- Try to develop a dialogue that will allow you to call back in the future. Encourage your congressional staff contact to call you as a resource for information.

Sample Phone Script. Reference the legislator’s Web site for the Washington and District Office phone numbers. You can locate his or her Web site by going to www.house.gov for House members and www.senate.gov for Senators. You also can call the Capitol operator at (202) 224-3121 and they will direct you to your legislator’s office.

Sample Letter to a Legislator on a Key Issue. Constituent letters are an extremely effective advocacy tool. Your letter should be simple and direct. Ideally, it should not be more than 1 page since short letters tend to have the greatest impact. It should address only 1 issue and you want to be very clear about your position and request. Print your letter on personal stationery, if possible.

The Honorable (First Name; Last Name)
US House of Representatives/Senate
Washington, DC 20515 (for House)/20510 (for Senate)

Sent via facsimile: (202) (fax number)

Dear Representative/Senator (Last Name):

Sincerely,

Tips for Writing a Letter to a Legislator
1. **Fax Your Letter**
   - In light of security concerns on Capitol Hill, send your letter by fax rather than through the postal service.
2. **Opening Paragraph**
   - Introduce yourself as a constituent and how you are connected to the district.
   - Thank the legislator for any past support that is applicable.
   - State the purpose for your contacting the legislator. If applicable, reference a specific bill number.
3. **State the Facts**
   - Back up your position with facts.
4. **Explain Consequences**
   - Provide information on the impact of opposing your request.
   - Explain the impact on your community.

5. **Ask for a Response**
   - Restate your position.
   - Ask for a response.

6. **Close the Letter**
   - Be sure to provide your contact information.
   - If applicable, include a professional or organizational affiliation so the legislator sees that you are connected to the larger community.

**Common titles and job functions in a congressional office.** Members of Congress rely on their staff to assist him or her during a term in office, so knowing and understanding the titles and roles of these staff members are critical to communicating effectively with Congress. These are some of the common staff members in a congressional office:

**Administrative Assistant (AA) or Chief of Staff (CoS).** The AA or CoS is usually a person in charge of overseeing office operations and supervising key staff, but most importantly, this person reports directly to the Member of Congress. The AA/CoS typically has responsibility for evaluating the political outcomes of various legislative proposals in the member’s district or state and constituent requests.

**Legislative Director.** The Legislative Director is typically the staff member who monitors the legislative schedule according to the interests and committee assignments of the member, supervises legislative assistants, and makes recommendations to the CoS or the member based on the likely or expected outcomes of particular issues.

**Legislative Assistant.** A legislative assistant is usually a staff person with specific interest and expertise on a particular issue or a number of issues. There are typically several legislative assistants in a given member’s office and they will usually vary based on the interests of the member and his or her constituency.

**Press Secretary (Press Secy.) or Communications Director (Comm. Dir.).** The responsibility of the Communications Director is to establish clear and open lines of communication between the member, their constituency, the media, and the public at large. This staff member must be able to effectively promote the views and positions of their member on specific issues to these parties as clearly and briefly as possible.

**Personal Secretary.** This secretary or scheduler is responsible for appropriating the member’s time to accommodate the many demands on his or her time including congressional and constituent requests and staff requirements. These responsibilities may involve making travel arrangements, scheduling speaking engagements or visits to the district, or making appointments with the member.

**Caseworker or Legislative Correspondent.** This staff member typically deals with constituents’ requests, addressed to the member or to a federal agency, and prepares replies to those requests for the member’s signature. These staff people will also address or resolve constituents’ concerns over the phone. There are usually several of these correspondents in any given congressional office.
Increasing Your Voice: Building a Relationship With Your Legislator

Over time, you will have a much greater impact on public policy by developing and sustaining relationships with your elected officials and their staff. As a starting point, it is important for legislators to be aware of your practice and the community that it serves. However, for you to affect their decision making, they must come to know you, your hospital and clinics, the people you serve, and the other community leaders who form the backbone of your support.

Keep in mind that you also want to develop relationships with legislators from around your state, not just your elected representative. Legislators from neighboring districts need to know that wound, ostomy and continence nurses are providing essential nursing care to their constituents—even if the actual practice is not located in their district.

People respond to people, and it is important to build personal relationships. These can be with legislators or with their key legislative staff. Building a relationship will take time and hard work, but if done well, it has the potential to yield significant results for the WOCN Society and our practice. Ideally, you will be able to involve your stakeholders and build upon their existing relationships with legislators. Here are just a few ideas to get you started.

Suggested Steps

Get to know the district staff.

Building relationships with the district office can prove to be very useful.

- The district staff is responsible for constituent services. They will, therefore, be interested in meeting with you and learning about you and your practice.
- Begin by asking the District Director to meet with you and other leaders from your practice at the district office.

Use the first meeting to cultivate a relationship.

- At the first meeting, provide the staff with an overview of the practice/facility and the patient population that it serves.
- Invite the District Director to visit your practice/facility for a tour to learn first-hand how the practice of wound, ostomy and continence nursing impacts your community.
- Once you have developed a personal relationship with the District Director, it will be much easier to call him or her about a key piece of legislation.

Arrange for a visit to your medical or research facility by your legislator.

A first-hand tour of your facility is the most effective way to educate an elected official.

- Invite elected officials to visit your practice/facility by sending a letter or fax. Ideally, each legislator from your area, including those from neighboring districts, should visit your facility once a year.
- Follow up with a phone call to the office, remembering that legislators are in the district offices during congressional recess and on most Mondays and Fridays.

Prepare for the visit with clear goals.

- Prepare for the visit by coordinating closely with the legislator’s staff, and determining the length of the visit.
• Develop a very clear agenda, identifying exactly who the legislator will be meeting with, what departments you will be visiting, the message, press availability, and the purpose for each stop on the tour.
• Use the tour to demonstrate the needs of the practice/facility and not just the accomplishments; identify services that could be provided with additional funding.
• Identify your legislative request(s), if any.
• Prepare appropriate take-away materials for your elected official.

**Encourage a tour of the entire facility, including clinics.**

• Given the breadth and depth of many practices/facilities, consider inviting legislators to see one of your clinics or community centers (eg, rural site).
• A visit provides an opportunity to develop a personal relationship with the legislator and senior stakeholders of the practice.
• Include opportunities for the legislators to meet with board members or other senior stakeholders. The goal is not just to educate the legislator but to build a relationship between the legislator and your leadership.

**Visit your elected officials in Washington, District of Columbia** Ultimately, you will want to schedule a personal visit to your members of Congress in Washington, District of Columbia. Elected officials will take notice of your visit. Taking the time out of your schedule to travel to Washington, District of Columbia, sends a very clear message to your legislators about the importance you place on public policy matters. Plan your visit carefully by being clear about what you seek to accomplish and whom you want to meet.

• The best days to visit a legislator in Washington, District of Columbia, are Tuesday, Wednesday, and Thursday.
• Make your appointments in advance. Ideally, you should contact the member’s scheduler to seek an appointment a few weeks in advance.
• Call or fax a written request for a meeting with the legislator and his or her staff. Remind them if you are a constituent and how many constituents are served by your facility.
• Remember that a meeting with a member’s legislative staff can be as important and productive as a meeting with the legislator.

**Prepare for the meeting.** Be prepared to state your specific request. Develop 2 to 3 well-documented talking points reinforcing your message.

• Use data if applicable to support your points.
• Be prepared to explain how your legislator’s constituents benefit from this issue.
• If multiple people will be attending the meeting, determine in advance each person’s role.

**Follow up to the meeting.**

• Send a thank you for the meeting.
• Include any information the legislator asked for and provide additional information to reiterate your message.
• Continue to cultivate the relationship.
• If the legislator acts positively upon your request, make sure you thank him or her and, if possible, publicize his or her support within your local practice, hospital, or research facility.
• The WOCN Society also publicizes government relations meetings and activities in the Society’s newsletter.

Invite a legislator to one of your meetings.

Inviting an elected official to speak at a special facility, practice or hospital meeting is an opportune way to enhance the relationship. Take advantage of relationships that any of your leadership or board members may have with the legislator in arranging for the visit.

• Prepare for the visit by developing a clear presentation about your practice/facility and the services they provide to the community.
• If possible, incorporate senior leadership into the presentation.

Thank legislators and staff for their interest and support.

Take the time to thank legislators and staff whether it is for a meeting or support of legislation.

• Be certain to express your appreciation to a legislator following a meeting, practice/facility visit, or any other personal contact.
• Use the thank you as a way to continue building the relationship and as an opportunity to follow up with additional materials on your facility or on a particular legislative issue.

Sample Meeting Request Letter to a Legislator

Meeting face-to-face with a legislator is an effective way to develop a relationship and to impress upon an elected official the importance that you place on particular issues. Your letter should be simple and direct about your request for a meeting. If you are proposing to meet in Washington, District of Columbia, or in the legislator’s district, be clear as to the specific date and time you will be available to meet.

The Honorable (First Name; Last Name)
US House of Representatives/Senate
Washington, DC 20515 (for House)/20510 (for Senate)

Sent via facsimile: (202) (fax number)

Dear Representative/Senator (Last Name):

On behalf of (your facility’s name) in (your city), I am writing to request a brief meeting with you on (day and date) anytime between (specific hours of availability). Representatives from our community, including (reference types of stakeholders; eg, “nurses”) will be in Washington, District of Columbia, that day and would welcome the opportunity to talk to you about the essential role that wound, ostomy and continence specialty nurses play in the local community.

As you may know (your practice/facility’s name) is a vital part of our community’s health care delivery system. We provide quality, accessible health care to all segments of our community. (Insert information about your facility, including the number of patients you serve, the number of people you employ, and your areas of expertise in medicine.)
Thank you for considering our request for a meeting on (date). We would very much appreciate it if your scheduler would contact me (or name of your government relations director if signed by someone else) at (phone number) to schedule an appointment.

Sincerely,

Tips for Writing a Meeting Request Letter to a Legislator

1. Fax your letter
   - In the light of concerns on Capitol Hill, particularly since the anthrax scare, send your letter by fax rather than through the postal service.

2. Open the letter
   - State up front the purpose of your letter, which is to request a meeting with the legislator in his or her office.
   - Indicate if other people will be joining you and what subject you want to discuss.
   - Bold the sentence that specifies the proposed date and times for the meeting so that it stands out.
   - Be sure to reference the day of the week and the date (e.g., “Wednesday, March 3, 2005”) and the specific times during which you will be available to meet (e.g., “between 10 AM and 12:30 PM”).

3. Provide facts on your practice
   - Provide some background information on your practice/facility highlighting its role in the community and the number of constituents served.

4. Specify follow-up steps
   - Request that the legislator’s scheduler call you to schedule the meeting or indicate that you will be following up.
   - Provide contact information so the scheduler can follow up or call with any questions.

5. Close the letter
   - The letter could be signed by you, your practice or hospital leadership.
   - Be sure to provide the person’s title.

Do’s and Don’ts: Tips for Meeting Your Representatives

Meeting with your elected officials is often the most effective way of educating them on a public policy issue. A face-to-face meeting provides an excellent opportunity to convey and receive information and to develop relationships that will benefit your cause. You can simplify the process by following the tips and guidelines outlined later.

Before the meeting

- Request the meeting in writing and follow up by phone to confirm the date and time and who will be attending the meeting.
- If other people will be accompanying you to the meeting, decide in advance each person’s role. Designate one person as the facilitator.
- Be clear about the purpose of the meeting and what you want to accomplish.
- Do your homework ahead of time; research the legislator’s voting record and know whether he or she sits on any key committees that affect your issue. You should visit the member’s Web site and search online for useful background information.
• Prepare materials to bring to the meeting both as “props” during your presentation and as a leave-behind for the legislator.

During the meeting
• Be sure to arrive on time and dress appropriately (business attire).
• All participants should introduce themselves and indicate their position with their institution, and be sure to specify that you are a constituent.
• Start the meeting by thanking the legislator for meeting with you and, when appropriate, for being supportive of your position on an issue.
• Present your issue in a clear and concise manner.
• Try to incorporate a personal reference or anecdote to make the issue more real to the legislator.
• Request specific action from your legislator (e.g., support for, or opposition to, a specific bill; floor remarks; talking to leadership).
• Do not argue.
• Do not lecture.
• After presenting your position, listen to the Legislator or Legislative Aide.
• If you do not know the answer to a question, do not be afraid to say that you do not know and that you will follow up after the meeting.
• Thank the legislator or aide for his or her time.
• Give the legislator the leave-behind packet you prepared.

After the meeting
• Write a thank you letter to the legislator that summarizes your conversation and any commitments that were made.
• Follow up and provide any additional information that was requested or offered.
• Please notify the WOCN Society’s Executive Director about the substance of your meeting if relevant to the WOCN Society’s membership at large.

About Congress: Resources to Help You Navigate the Legislative Process

This section contains background information on the US Congress and the legislative process. Included are links to a variety of Web sites that will be useful to you in tracking the status of legislation and planning your advocacy activities in Washington, District of Columbia.

For specific information about the WOCN Society’s advocacy efforts and federal legislation affecting the field of nursing, visit the WOCN Society’s Web site at: http://www.wocn.org and click on “About Us” and then click “Advocacy and Policy.”

Congressional Calendar

The US House of Representatives and the US Senate maintain their own calendars of legislative activity. To obtain the most current calendar produced by each legislative body, you can visit their respective Web sites:
  • www.house.gov
  • www.senate.gov
Status of Legislation
You can track the status of a piece of legislation through an online service offered by the Library of Congress. This Web site offers you the option of searching by a bill number, if known, or by a word or phrase. You can also monitor committee action and floor votes by visiting:
http://thomas.loc.gov

Contacting Your Members of Congress
To obtain contact information for your Senator or Representative (ie, phone number, fax number, or e-mail address), you should access their Web site. The easiest way to get to a member’s individual Web site is through the House or Senate sites:
www.house.gov
www.senate.gov

Congressional Committees
Each House and Senate committee has its own Web site with more detailed information on committee action and the status of legislation under its jurisdiction. Among the committees you may want to monitor are the following:

House jurisdiction relating to health care.
- **Committee on education and labor.** This committee deals with a number of health care-related education and labor issues including the access to quality health care for working families, worker health and safety, programs and services for at-risk youth, child nutrition, and poverty programs.
- **Committee on energy and commerce.** This committee and its subcommittees address issues pertaining to public health, hospital construction, mental health and research, biomedical research and equipment, Medicaid and national health insurance, food and drug regulation, drug abuse, and toxic substances.
- **Committee on ways and means.** This committee and its subcommittee on health address bills and matters related to programs providing payments for health care, health delivery systems or health research, programs under the Social Security Act, and tax credit and deduction provisions of the Internal Revenue Code dealing with health insurance premiums and health care costs. Specific programs addressed by this committee include Medicare, Temporary Assistance for Needy Families Program (TANF) and Old-Age, Survivors & Disability Insurance.

Senate jurisdiction relating to health care.
- **Special committee on aging.** This special committee addresses matters pertaining to problems and opportunities of older people including health maintenance and issues to obtaining care and assistance.
- **Committee on health, education, labor, and pensions (HELP).** HELP addresses matters relating to education, labor, health and public welfare, aging, biomedical research and development, occupational safety and health, and public health.
- **Committee on finance.** This committee concerns itself with issues of taxation and revenue, as well as insular possessions. More specifically, related to the concern for taxation and revenue issues, this committee addresses and has jurisdiction over most
programs authorized by the Social Security Act and other health programs financed by a specific tax or trust fund. This includes Medicare parts A through D, Medicaid, Children’s Health Insurance Program (CHIP), TANF, Maternal & Child Health Title XX Social Services Block Grant Program, Old-Age, Survivors & Disability Insurance, and the Physician Payment Review Commission.

**House of Representatives**

**Appropriations**
www.house.gov/appropriations  
(202) 225-2771  
H-218 Capitol Building

**Labor, Health and Human Services, Education, and Related Agencies Subcommittee**
(202) 225-3508  
2358 Rayburn House Office Building

**Energy and Commerce**
http://energycommerce.house.gov  
(202) 225-2927  
2125 Rayburn House Office Building

**Health Subcommittee**
(202) 225-2927  
2125 Rayburn House Office Building

**Ways and Means**
http://waysandmeans.house.gov  
(202) 225-3625  
1102 Longworth House Office Building

**Health Subcommittee**
(202) 225-3943  
1136 Longworth House Office Building

**Senate**

**Appropriations**
http://appropriations.senate.gov  
(202) 224-7363  
S-128 Capitol Building

**Labor, Health and Human Services, and Education Subcommittee**
(202) 224-7216  
184 Dirksen Senate Office Building
Finance
http://finance.senate.gov
(202) 224-4515
219 Dirksen Senate Office Building

Health Care Subcommittee
(202) 224-4515
219 Dirksen Senate Office Building

Health, Education, Labor and Pensions
http://help.senate.gov
(202) 224-5375
428 Dirksen Senate Office Building

How a Bill Becomes a Law
For a quick review of the federal legislative process, visit the Web site below. This site will step you through the process beginning with the introduction of legislation by a member of Congress, the role of committees, floor action, and eventually the President’s signature.
www.vote-smart.org/resource_govt101_02.php

Glossary of Legislative Terms
The vote-smart Web site also includes a brief glossary of basic legislative terms. For a more comprehensive listing, visit the following Web site: www.thecapitol.net/glossary

Relevant US Government Agencies
To fully follow the development of policy in our nation’s capital, you may also want to contact or access the Web sites of several executive offices, including Cabinet departments and federal agencies. These offices play a role in developing legislative proposals, which the administration submits to Congress for consideration. Depending on the issue and the legislation being proposed, you may want to contact officials in these offices to discuss any concerns or recommendations.

The White House
www.whitehouse.gov
(202) 456-1414
1600 Pennsylvania Avenue, NW
Washington, DC 20500

US Department of Health and Human Services
www.dhhs.gov
(202) 690-7000
200 Independence Avenue, SW
Washington, DC 20201
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
(410) 786-3000  
4700 Silver Hill Road  
Suitland, MD 20746

Food and Drug Administration  
www.fda.gov  
(301) 827-2410  
5600 Fishers Lane  
Rockville, MD 20857

National Institutes of Health  
www.nih.gov  
(301) 496-4000  
9000 Rockville Pike  
Bethesda, MD 20892

Office of Management and Budget  
www.omb.gov  
(202) 395-3080  
725 17th Street, NW  
Washington, DC 20503

Date Approved by the WOCN Society Board of Directors: March 20, 2012
How Medicare Policy Is Established

U.S. Congress (passes legislation)

Dept. of Health and Human Services Secretary

Administers the Medicare Program

Centers for Medicare and Medicaid Services Department Secretary

Bureau of Program Operations Director

Bureau of Health Standards and Quality Director

Bureau of Policy Development Director

Issues National Medicare Policies

Office of Coverage and Eligibility Policy Director

Office of Payment Policy Director
Appendix X: How Medicare Policy Is Implemented
15000 Commerce Parkway, Suite C
Mount Laurel, NJ 08054
www.wocn.org
888-224-WOCN (9626), toll-free