Embracing Change

December 2018

Bold Voices

Embracing Change

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Pumpkin Spice Everything

AACN Facebook followers nearly went out of their gourd when we asked them recently about one of the essential issues that surfaces every fall: Pumpkin spice everything to get you through #Halloween? 😊 Yes or no?

• Kelsey Keenen: Lindsey Frankl: where have they been hiding this?!
• Lindsey Frankl: Kelsey Keenen: how did you not find this earlier?!!
• Kelsey Keenen: No clue ...
• Joy Wilcox: No. Apple cider is much better.
• Karen Schrem: Yes!!!!
• Kerry Dudley: No
• Debbie Sheneman: Yep ... that’s me ... 🎃🎃🎃🎃🎃
• PattinArt Henry: Yes!
• Nastassja Sealey: Noooooo!
• Nicole Mankowski: No.
• Stephanie Jeffers: nope
• Bekka Behm: Mainline please ...
• Marsha Brown Timbrook: No. That’s just disgusting.
• Monica McGee: Nope!!!
• Laura Logan: No thank ya
• George Carrillo: Yes
• Louise Hooper Saladino: No! Stop the pumpkin! I propose AACN use its Bold Voice on this important issue 😊
• Carol Portello-Steele: No
• Cheri Peterson: I’ve had 3 in the last week!
• Gio Calatrava: Ew no.
• Kristina Eaton: 😳😳
• Laura Cady Courtney: Draz Beck: 😳
• Emma Yee: Jennifer Lynn
• Jennifer Lynn: Emma Yee: yuck! 👎
Remember your first day on the unit? How long did it take you to figure out whom to go to with questions? My first job in nursing was at a large university hospital on a 40-plus-bed telemetry unit. Although it was over 35 years ago, I still remember Margo. It only took me about three shifts, and I knew that I could count on Margo for the answer. She had clinical expertise combined with institutional knowledge and situational common sense. She was an expert. I hoped to emulate Margo as I grew in my career.

I have always admired and respected my colleagues with THE answers … the experts.

It is natural to look up to those who have answers and solutions to our challenges. It is important to have experts in the field. But all too often having the answers can lead people to believe that questioning is the opposite, something bad. That someone who asks questions lacks ability or is perceived as weak or challenging tradition. Yet the simple definition of a question — “a sentence worded or expressed so as to elicit information” — does not indicate inability, weakness or disrespect.

Questions have benefits. The benefits of asking questions are understood by educators and teachers. They understand that questions express interest, keep people engaged, improve understanding of strengths and gaps, enhance recall and build a foundation for new knowledge.

Questions lead to innovation. Innovation is born from questions. Google’s CEO Eric Schmidt states, “We run this company on questions, not answers.” He believes that if his co-workers keep asking questions, they can keep finding better answers for their organization.

Questions have power. They are not neutral.

The work in the leadership process known as appreciative inquiry helps us understand the power in how we ask questions. Appreciative inquiry teaches us that how we ask the question formulates whether the answer will produce a positive or a negative result. Systems develop in the direction the question is asked. Think about the following scenarios and how to ask questions to give your voice strength.

When we advocate for our patients and safe care, our question may be: “Will this harm the patient?” Let’s alter the question to give our voice strength for positive change: “What is the optimal outcome we are seeking? Will this intervention/treatment help us achieve that outcome?”

So when there are changes in our responsibilities or processes, the question we want to ask might be: “You want us to do what?” But our inquiry voice for positive change may be: “Is this the best solution that also aligns with our mission and values?”

The voice of experts has strength. But equally as powerful and impactful is using our voice to question.

What’s a question you’ve been dying to ask? Let me know at OurStrength@aacn.org.

The important thing is not to stop questioning. Curiosity has its own reason for existing.

—Albert Einstein
NTI 2019: Registration Is Open — Make Your Case for Attending!

AACN’s National Teaching Institute & Critical Care Exposition (NTI), is May 20-23, 2019, with preconferences May 19, in Orlando, Florida.

At the premier conference for high-acuity and critical care nurses, earn 37.5 continuing education (CE) contact hours via live sessions, and additional hours of self-study during and for five months after the conference.

As we get into the busy holiday season and look forward to welcoming the new year, jump-start your NTI planning now:

☑ Discuss the value of attending NTI with your manager to request professional development funds and schedule time off. Our ROI toolkit includes a template request letter and planning worksheets. Focus on what you will specifically bring back to your unit or hospital in return for the opportunity to attend.

☑ Search the NTI educational program online, and personalize your program with a combination of sessions tied to your unit’s or hospital’s strategic initiatives and your professional development goals.

☑ Book your hotel early for the best selection and discounted rates, since reservations are assigned on a first-come, first-served basis. Visit www.aacn.org/nti > Hotel and Travel for a list of hotels and rates, and to book your hotel reservation.

☑ We’re traveling to Orlando, a favorite family destination with something for everyone. In addition to the city’s famed theme parks, cultural gems and performing arts abound. Learn more about the city at www.visitorlando.com.

Earn 37.5 hours of CE via live sessions and additional hours of self-study during and for five months after the conference.

AACN’s 50th Anniversary: Send Us Your Photos and Stories

2019 will mark AACN’s Golden Anniversary. That’s 50 years of acute and critical care nursing excellence. We salute and celebrate all that our exceptional nurses have accomplished over the last half-century, and we honor their past, present and future impact on nursing.

How long have you been an AACN member? Whether it’s been for one year or for all 50, we want to hear from you. Email us your stories, photos, clippings and observations on your AACN experiences throughout the years. We’ll try to use your contributions and share your stories in various AACN publications and social media throughout the year to mark this historic time for the AACN community.

So start sifting through your storehouse of memories and send photos and stories of your special mementoes of AACN through the years to AACN50th@aacn.org.

How long have you been an AACN member? Whether it’s been for one year or for all 50, we want to hear from you.
Certification Holiday Reflections

Happy Holidays! During this busy season, it is important for us at AACN Certification Corporation to pause and gratefully reflect on all that has transpired over the last year.

From revised APRN exams and the crucial work of PCCN and CCRN exam development committees to creative new resources for celebrating Certified Nurses Day and the energetic Certification Celebration at NTI, 2018 has been an amazing year.

The truth is, none of this would matter or be possible without you, our community of certified nurses. We wish to share our heartfelt appreciation for your tremendous contributions to the nursing profession and your dedication to the sick and vulnerable who entrust you with their lives on a daily basis.

You are the reason we do the work we do each day. We are in awe of your steadfast commitment to excellence in the care of acutely and critically ill patients and their families. Your willingness to pursue lifelong education and stay at the forefront of evidence-based practice inspires us all.

By supporting you through answering questions, evaluating your applications, collaborating on exam development and creating new resources, we, too, experience the satisfaction that comes from doing meaningful work.

Thank you for all you do, and the very best to you in the new year.

Certified Nurses Day 2019: Start Planning Now

It’s not too early to start planning for Certified Nurses Day. March 19 will be here before you know it! Over the years, we’ve seen all kinds of imaginative ways AACN community members and their facilities choose to recognize and honor certified nurses on this special day. Be on the lookout for some of the most memorable moments — and ideas for your own celebration — in upcoming issues of AACN Bold Voices.

Oh, the ways we celebrate!
Here are a few examples of how our AACN community celebrated Certified Nurses Day this year.

Revised PCCN, PCCN-K Certification Exams Effective in January

On Jan. 31, 2019, AACN Certification Corporation will launch revised exams for our PCCN and PCCN-K adult progressive care certifications.

The revised exams are based on new test plans, which were updated to incorporate results of the national study of practice conducted in 2017. These periodic studies and resulting test plan changes ensure that certification exams are evidence-based and tied to current, relevant practice.

Changes in the updated PCCN and PCCN-K test plans are relatively minor. The most notable change is the number of items for two topic areas: Cardiovascular questions decreased 6 percent (from 33 to 27 percent), while pulmonary questions increased 3 percent (from 14 to 17 percent).

What does this mean for PCCN and PCCN-K exam candidates?
• Candidates testing now through Jan. 30, 2019, will take the exam based on the current test plans, found in the PCCN or PCCN-K exam handbooks.
• Candidates planning to sit for the PCCN or PCCN-K exam on or after Jan. 31, 2019, should reference the updated test plans available at www.aacn.org/newpccn.
• Current PCCN/PCCN-K exam study materials are still relevant and useful for those testing on or after Jan. 31, 2019.

Please contact us at certification@aacn.org if you have questions.
An AACN Scholarship Can Help You ‘Get Your BSN in 10’

In 2010, the Institute of Medicine (now called the National Academy of Medicine) recommended that 80 percent of the nursing workforce achieve their baccalaureate degree (BSN) by 2020.

This recommendation is becoming law in some areas. New York signed the “BSN in 10” bill in December 2017, making it the first state in recent years to require that all nurses enter practice with a BSN or earn a BSN within the first 10 years after initial licensure.

Other states are planning to follow suit, and several Magnet hospitals and organizations — including the U.S. Army, U.S. Navy, U.S. Air Force and Veterans Administration — already have rules in place requiring a BSN as a minimum education standard in certain nursing roles.

These requirements are based on clear evidence. Studies published in *JAMA: The Journal of the American Medical Association* and *Medical Care* show that a 10 percent increase in the number of BSN-educated nurses reduces the risk of patient mortality 5 percent.

If you plan to pursue a BSN or higher degree, consider taking advantage of an AACN scholarship to help you along the way! AACN members can receive up to $3,000 per year for:

- Tuition
- Personal growth
- Leadership development
- Conferences, and more

We are here to help you achieve your goals and improve patient outcomes. Learn more about AACN scholarships at www.aacn.org/scholarship, and please send your questions to scholarships@aacn.org.

$3,000
Amount members can receive per year for conferences, practice development, more

52%
Percentage of your fellow nurses pursuing more education within the next few years
Source: AMN Healthcare, 2017

$750
Share of your travel-related expenses that AACN scholarships can cover

$0
Cost to members when applying for an AACN scholarship

**Pursue your goals of personal and professional growth with an AACN scholarship — a unique benefit of membership.**

Higher Learning • National Seminars Webinars & eLearning • Networking & Local Events • Special Classes

![Image](https://example.com/image.png)

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[www.aacn.org/scholarship](http://www.aacn.org/scholarship)

800-899-2226
As nurses, we often see opportunities to improve patient care, but creating change can be challenging.

If you are considering a quality improvement project, the Patient Safety column by Easter and Tamburri, in this month’s CCN, is an excellent resource. The authors use clinical examples to explain statistical terms and describe the application of patient outcome data to identify needed change and to measure its impact. A case study illustrates the Plan-Do-Study-Act approach to quality improvement.

Three additional articles describe projects that successfully created desired change. Anderson et al. report on an electronic health record communication tool that an intraprofessional team used to implement an early mobility program. The results show an increase in staff satisfaction, a decrease in time to achieve the mobility goal and improved patient outcomes after implementation.

A study by McBeth et al. shows a reduction in ventilator-associated pneumonia in a pediatric ICU through all four phases of a project to improve adherence to an evidence-based bundle. Interestingly, one-to-one peer education was a key aspect of the implementation.

This month’s cover article by Rachwal et al. describes a project to promote relational competencies among health-care team members through educational sessions addressing unit-specific topics. Over a thousand attendees, more than half of them nurses, report high satisfaction with the program.

If your unit uses or is considering using teleICU, you will be interested in an article by Canfield and Galvin that describes nurse acceptance of teleICU services.

Have you been asked to work overtime lately? Lobo et al. surveyed nurses to better understand their decision to work or not work overtime hours.

For pediatric nurses, an article by Peyton on plastic bronchitis and protein-losing enteropathy in patients undergoing the Fontan procedure can help guide recognition and management of these complications.

In Our Journals

In Our Journals

Transitions

Events in the Lives of Members and Friends in the AACN Community


Marilyn Chow, professor of nursing at the University of California, San Francisco, and Joanne Disch, professor ad honorem at University of Minnesota School of Nursing, Minneapolis, AACN past president and a member since 1973, are among the nursing leaders the American Academy of Nursing (AAN) recently designated as living legends, AAN’s highest honor.

Cindy Harmon, a member of AACN since 1982, who held CCRN certification for 35 years, has died. In her memory, an endowed scholarship fund has been set up at Louise Herrington School of Nursing at Baylor University, Waco, Texas.

Deedra Harrington, University of Louisiana at Lafayette, Felicia Lowenstein-Moffett, University of Nevada, Reno, Katherine Menard, Northern Michigan University, Marquette, and Jacqueline Meyer, Allen College, Waterloo, Iowa, are among those chosen for the American Association of Colleges of Nursing’s 2018 Leadership for Academic Nursing Program. Katherine Kenny, Arizona State University, Tempe, participated in the selection process.

Cheri Plasters, a critical care nurse in the Surgical ICU at UAB Hospital, Birmingham, receives the Barbara A. McLean Contributions to Critical Care Nursing Lifetime Achievement Award from the Southeast Chapter of the Society of Critical Care Medicine.

Dana Woods, AACN CEO, was interviewed for “Successful Association Leaders Do These Six Things,” an article in Forbes. Author Bruce Weinstein says, “What struck me most about my conversation with Woods was how humble she is. High-character leaders know their success depends on the contributions of many others. It is inspiring to find humility in a leader whose organization exceeds 120,000 members.”

Please send new entries to aacnboldvoices@aacn.org.

You may also honor or remember a colleague by making a gift to AACN at www.aacn.org/gifts.
Representing Critical Care Nurses Accurately

Re: Page 4 in September AACN Bold Voices

Dear Lisa Riggs,

Your piece in a recent AACN journal regarding how nurses are unfairly represented in the media resonates with me. I am a veteran (39 years) critical care nurse in a larger medical center just north of Chicago.

I also happen to be an experienced medical malpractice defense nurse expert and have testified in court many times. When I read depositions of nurses who are either respondents in discovery or defendants, I am routinely dismayed at how poorly they articulate a response to the question “What exactly does a nurse in a unit like yours do?” I have read answers like, “Well, I don’t know, we just take care of the patients” or “We’re the eyes and ears of the doctors” or “We help them out and take care of their needs,” etc. Each time, I want to leap out of my seat and exclaim to the air, “You do so much more!”

As you mentioned in your editorial, our work is complex, delicate, vital, lifesaving, educational, comforting and a thousand other things. I long for the day when all nurses will be prepared for an intelligent, public-reassuring, attorney-silencing answer.

Thank you for all the hard work you do to represent critical care nurses accurately.

Sheryl Brown
Clinical Coordinator, Intensive Care Unit, Evanston Hospital
Evanston, Illinois

“Aas you mentioned in your editorial, our work is complex, delicate, vital, lifesaving, educational, comforting and a thousand other things.”

AACN Bold Voices invites your letters for possible print and/or online publication. Please be concise. Letters may be edited before publication. Include your name, credentials, city, state and email address (for verification). Write to aacnboldvoices@aacn.org.
A project using collaborative retention strategies and AACN’s standards for a healthy work environment (HWE) was associated with a decrease in staff turnover.

“Hire, Develop, and Retain: Strategies to Improve Nurse Retention in the Critical Care Environment,” a poster presented at an Association for Nursing Professional Development conference, indicates that nursing turnover decreased at Duke University Hospital’s 32-bed cardiothoracic ICU (CTICU) from 40.6 percent in 2015 to 28.5 percent in 2016 and to 22.5 percent in 2017. Nurse satisfaction scores increased 6 percent from 2014 to 2016, and teamwork and staff recognition scores increased 3 percent.

Stacey O’Brien, clinical nurse educator for Duke’s heart center; and AACN members Kelly Kester, nurse manager, operations for CTICU; and Heather Pena, clinical lead of CTICU, participated in the poster presentation.

The project focused on three components:

- Nursing leadership included components of the HWE standards, community involvement and resiliency
- Recruitment and hiring included improved screening criteria and behavioral-based interview questions
- Clinical education and professional development involved weekly milestones and evaluations, preceptor engagement, standardized education plans and nurse residency.

With leadership’s embrace of the HWE standards, www.aacn.org/hwe, which included a “focus on appropriate staffing and skilled communication,” the resulting environment “supports retention and worker joy,” the poster notes. True collaboration “between nurse recruitment, leadership and education was vital to the success of improving hiring strategies and implementing a successful orientation program” that can be sustained and replicated.

“There is a strong correlation between an HWE and nurse recruitment and retention.”

Avoiding burnout begins during the job interview, and asking questions to determine if an employer offers a healthy work environment (HWE) is crucial.

In “6 Interview Questions to Find a Healthy Work Environment,” posted on The Burnout Book blog, Anna Rodriguez — an AACN member who served on the task force to revise “Scope and Standards for Acute and Critical Care Nursing Practice” and a social media influencer — advises nurses to use their assessment and observation skills to “interview your future employer as much as they’re interviewing you.”

Having experienced a burnout phase that led to her using social media as a platform to benefit other nurses, Rodriguez offers questions based on AACN’s six standards for HWEs.

When assessing staffing, she writes, “Know what your deal breakers are and ask those staffing questions because inappropriate staffing can be one of the quickest paths to burnout.” The way important information is communicated to the staff is worth asking, because “it addresses the issue of how information trickles down from hospital leadership and how the manager makes sure that it gets to the front line staff.”

On collaboration, Rodriguez encourages understanding the interdisciplinary teamwork and the ancillary support available on all shifts. To gauge decision-making structures, she advises asking if nurses on the unit are involved.

To understand if an employer embraces meaningful recognition, ask why a nurse manager has stayed at an organization. Asking about senior leadership’s engagement with staff can offer insight into whether they support an HWE.

Asking about senior leadership’s engagement with staff can offer insight into whether they support an HWE.
Employees With Tattoos Can Roll Up Their Sleeves

Many healthcare organizations have had a longstanding ban on visible tattoos, but times are changing.

“IU Health Employees Don’t Have to Cover Tattoos,” in Becker’s Hospital Review, notes that Indiana University Health (IU Health) is one of a growing number of healthcare organizations that are relaxing their stance on tattoos and other aspects of their dress codes. Officials at IU Health do not think hiding tattoos is authentic and want to give employees more discretion regarding their appearance.

IU Health’s support of employee self-expression isn’t the first. The Mayo Clinic also amended its Dress & Decorum policy to allow tattoos, notes “Mayo to Allow Visible Body Art With Some Exceptions,” in Post Bulletin. According to Mayo’s new policy, “tattoos may be visible if the images or words do not convey violence, discrimination, profanity or sexually explicit content.”

The policy shift coincides with the increasing popularity of tattoos. According to a related article in Indianapolis Star, 30 to 40 percent of Americans between the ages of 18 and 35 have a tattoo, and the trend is growing. Rue Dooley, Society for Human Resource Management, says in the article that employers are increasingly allowing tattoos, in part to keep good employees. ▼

Inviting Families to Witness Resuscitation

Family presence during resuscitation has been somewhat controversial and not widely implemented.

According to “Factors Associated With Nurses’ Perceptions, Self-Confidence, and Invitations of Family Presence During Resuscitation in the Intensive Care Unit: A Cross-Sectional Survey,” in International Journal of Nursing Studies, one third of surveyed nurses had never invited family members into the room during resuscitation, “and another 33% had invited family members to be present just 1–5 times.”

Experience with family presence during resuscitation was the strongest predictor of increased invitations. Education on family presence and a written policy were the workplace factors associated with more invitations. “Due to the apparent importance of clinical experience with family presence during resuscitation, it is recommended to initially provide this experience using simulation and role modeling,” the study adds.

The convenience sample involved 395 nurses working in ICUs across the country. A cross-sectional survey was used to create descriptive and correlational analyses that included personal, professional and workplace information. The “frequency of inviting family members to be in the room during resuscitation was collected by self-report.” ▼

Embracing Change: Building the Future of ICU Nursing in Ethiopia
An Interview With Mark Stambovsky

As ICUs gain acceptance and recognition in Ethiopia, the country’s critical care nurses and hospitals are experiencing growing pains. At the helm during this era of change is Mark Stambovsky, head of nursing at St. Paul’s Hospital Millennium Medical College and instructor at the School of Nursing. Faced with inadequate supplies, cultural barriers, hiring challenges and shoddy construction, Stambovsky often fights an uphill battle to establish world-class ICUs. Yet, his tremendous passion for the work and his love for the Ethiopian people shined through during his speech at NTI 2018 titled “Trials and Tribulations of Transforming a 3rd World ICU Into a 1st World ICU.”

**What is your position and where do you work?**
I am the nursing director in the adult ICU at St. Paul’s Hospital Millennium Medical College in Addis Ababa, Ethiopia. I am also the ICU clinical coordinator and instructor in the School of Nursing, a St. Paul affiliate.

**How did you get started in nursing?**
I was originally a music teacher but was laid off after the State of Massachusetts cut the school system’s music program budget. After doing some traveling and writing, I decided to take the advice of my sister — an ICU nurse — who suggested, “Hey, why don’t you go into nursing?” Sometimes, it’s good to listen to your little sister.

**Describe your decision to move to Ethiopia.**
After 16 years working in the ICU at Baystate Medical Center, I needed a change. I arrived in Ethiopia at the end of a trip across Equatorial Africa. I was immediately struck by the warmth, cordiality and gentleness of the people. They are also extremely forgiving, which is very comforting when you find that you’ve screwed something up ... not that we nurses ever mess up, right? I decided that taking a position in a hospital would open the doors of change I had been looking for.

**How easily did you adjust to your new life in Ethiopia?**
There is certainly variation between the world’s third- and second-world countries. But my earlier travels through South America and Asia essentially inoculated me against any cultural and/or economic shock.

**How do you deal with issues such as supply shortages, transportation and staffing needs?**
Shortages of disposables remains a big issue. I’ve stressed time and again the need to create commercial pipelines for essential ICU items, but bureaucratic wheels here move slowly. The same goes for staffing. The hiring process of new nurses is excruciatingly slow but, fortunately, the local supply of nursing manpower is sufficient to satisfy our needs at the moment. Transportation is improving. The hospital provost is supporting the initiation of an ICU van service that will essentially eliminate transportation issues.
In your previous life, you’ve taught music, been a writer and rehabbed houses. Have those skills been useful in your new role?

Happily, most of those skills have played a role in the evolution of my position in Ethiopia. While the primary language here is Amharic, many formal correspondences and documents are written in English. My ability to edit and economize the language has come in very handy.

During the design and construction of our new ICU, my real estate rehab skills provided much-needed guidance when we were faced with the shoddy workmanship typical of government construction. The construction contractors were thrilled, and management celebrated my guidance.

And you’re now a father. Tell us about that incredible story.

A young girl named Kokeb came into the ICU with renal failure and pulmonary edema. We had to extubate her three times during her 15-day stay in the emergency department due to repeated episodes of severe stridor. Every night, Kokeb’s sister, Selam, was right by her side. Kokeb remained on dialysis for a year before I could successfully arrange for Selam to donate a kidney. Throughout the long and arduous process, the sisters’ sweetness, courage and caring quickly stole my heart. They had been abandoned by their parents when they were very young and materially had nothing, but obviously deeply loved each other. We became a family — Kokeb and Selam have brought joy, laughter and great purpose to my life. As I said in my speech at NTI, “I saved Kokeb’s life, and she saved mine.”

What was speaking at NTI like?

Speaking at NTI was my chance to present a compelling story to like-minded or curious nurses. My gut said I was ready after mentally practicing and rewriting the talk for months. Ten minutes before my talk, though, the butterflies were partying like 2099. I momentarily froze at the outset of my first session and choked up at the end when showing a slide of my Ethiopian girls, but the standing ovation and throng of well-wishers that approached me afterward pretty much confirmed that I did OK. I was fortunate to have had a fantastic audience of ICU nurses. I was off my game for the second session, because an upset stomach kept me up most of the night. It went well, but I thought it lacked the punch of the first.

What do you see for the future of nursing, especially in countries such as Ethiopia?

Not long ago, the concept and importance of ICU nursing was wholly misunderstood and underrecognized in Ethiopia. This is changing, as the Ministry of Health has embraced the importance of ICU nursing. The formal acknowledgment of our craft gives me great hope for the future of ICU nursing in Ethiopia. In contrast, hospitals in the USA are micromanaging nursing practice for greater profitability. I remember being mandated to do an ever-increasing number of tasks while being expected to provide the same level of safe care, all performed in the same amount of time. Something had to give and, in my observation, it was often nurse morale. While such change is notoriously difficult to quantify, I felt that some of the rewards and joys of the job were being slowly siphoned away. In Ethiopia, such pressures do not yet exist. I hope it remains this way for a very long time, and I’m glad that I’ve positioned myself to help lead this wave of change in the country.

How do you maintain a healthy work/life balance?

During the first couple of years, I spent inordinate amounts of time either at the hospital or taking care of Kokeb. I am now essentially still on call 24/7 because of my proximity to the hospital, but the skill level of the nurses has improved to the point that I can stay away an entire weekend day without worrying that everything will fall apart. I work out at a local gym every other day, and Kokeb, Selam and I always eat dinner together and typically watch a movie before bedtime. I’m planning on taking my daughters to see the ocean for their first time with a trip to either the Seychelles Islands or beaches of Zanzibar.

Why do you love being a nurse?

A patient who I thought would never survive, beat the odds. Months later, she suddenly walked into the ICU. She smiled broadly, reached for my hand, looked into my eyes and said, “They told me you saved my life.” Best job I ever had! ▼
Telehealth Helps Meet Community Needs During Natural Disasters

Telehealth providers offer new ways for health systems to meet the needs of their communities during natural disasters.

“Telehealth Offers Eye Into Hurricane Impact Zone as Florence Targets Carolinas,” in HealthLeaders, notes that telehealth providers such as American Well, Teladoc Health, Doctor on Demand and MDLIVE reached out to affected communities when Hurricane Florence hit the Carolinas. They offered free access to services for people who could not reach their regular healthcare providers during and after the storm.

This humanitarian effort is supported by evolving technology, adding a “critically useful element to the household disaster preparedness toolkit: a telehealth app.”

Nemours Children’s Health System discovered the power of telehealth last year when Hurricane Irma hit Florida. Calls to Nemours CareConnect, the system’s direct-to-consumer app, increased 2,000 percent compared with the same period the previous year.

“As we saw with Hurricanes Irma and Harvey, through telehealth, clinicians can be effectively mobilized, even if the patient is displaced during a storm, to deliver quality care,” Anne Stowell, Teladoc Health, notes in the article. She adds that telehealth technology helps clinicians take calls and provide care during disasters.

Telehealth technology helps clinicians take calls and provide care during disasters.

Hospitals Initiate Disaster-Preparedness Strategies

Hospitals deployed several disaster-preparedness strategies when Hurricane Florence approached the Carolinas.

“How Hospitals, Health Organizations Are Preparing for Hurricane Florence,” in Becker’s Hospital Review, notes that Conway Medical Center, South Carolina, has several backup generators and stocked up on extra supplies for additional patients and possible shipment delays. “If this storm were to hit anywhere along the Carolinas, we would anticipate a surge on supplies from our vendors, so we have to be ready to stock those supplies,” says Daniel Adamczyk, director of emergency management.

Medical University of South Carolina, Charleston, stocked enough food, water, vital medications and other supplies to last at least seven days. They also acquired a retired military vehicle to ensure the safe transfer of staff and patients. The vehicle, which can go through water as high as 6 feet, helps provide emergency transportation between buildings for patients and staff.
Patients with type 2 diabetes decreased MI risk by meeting targets.

Meeting two targets improved patients’ odds more than meeting one.

Meeting additional targets progressively improved outcomes.

Social concerns can impact the ability to target risk factors.

Swedish Study Finds Risk-Factor Targeting Improves Outcomes

Patients with type 2 diabetes who control five risk factors may have no greater risk of death, myocardial infarction (MI) or stroke than those without the disease.

According to “Risk Factors, Mortality, and Cardiovascular Outcomes in Patients with Type 2 Diabetes,” in The New England Journal of Medicine (NEJM), managing multiple risk factors in these patients can provide progressive benefits for additional controlled targets. A review of 271,174 patients from Sweden with type 2 diabetes shows that MI risk decreased for those meeting targets, although patients with diabetes required more hospitalization for heart failure.

The study, covering data from 1998 to 2012 with a median follow-up of 5.7 years, matched the patients with diabetes with 1,355,870 control-group patients. Compared to the healthy members of the control group, patients with diabetes whose risk factors were managed had similar rates of death from any cause, stroke, MI and hospitalization for MI. The five risk factors were elevated glycylated hemoglobin, LDL cholesterol, smoking tobacco, albuminuria and high blood pressure.

Meeting two targets improved patients’ odds more than meeting one, and meeting additional targets progressively improved outcomes. “We saw that not only if you lower blood pressure but if you also reduce blood lipids and blood sugar below contemporary guideline levels, it is actually possible to reduce the excess risk even further without putting the patient at unnecessary risk from side effects from intensive treatment,” lead author Aidin Rawshani, University of Gothenburg, Sweden, says in a related article in TCTMD.

Social concerns, including poverty and healthcare access, can affect the ability to target risk factors. “A cautionary note is that pathways to target levels of risk factor variables are not always straightforward and often involve issues of lifestyle, adherence to medication, and other behaviors that are hard to modify, despite best attempts,” adds an accompanying editorial in NEJM, which is referenced in the related article.


Glucose Meter Receives FDA Clearance

A glucose meter for critically ill patients with or without diabetes becomes the first to receive 510(k) clearance from the Food and Drug Administration (FDA).

According to “FDA Clears First Glucose Meter for Critically Ill Patients,” in Endocrine Today, the clearance follows an evaluation noting that StatStrip’s outcomes were equivalent to laboratory results.

“StatStrip is the only glucose technology for point-of-care testing that measures and corrects for abnormal hematocrit and has no clinically significant interferences, which can lead to the mismanagement of critically ill patients,” the article explains.

The glucose meter can be used with arterial, venous or capillary specimens and is considered “safe, effective and reliable for use by CLIA- [Clinical Laboratory Improvement Amendments] waived operators with critically ill patients.” With this clearance, clinicians do not need to define “critically ill” to use the meter.

The clearance involved both prospective and retrospective studies using data from 16,778 patients across a range of settings. “StatStrip’s capillary results were equivalent to the arterial and venous plasma results measured on a central laboratory isotope dilution mass spectrometry (IDMS) traceable reference method.” ▼
For patients with atrial fibrillation (AF), the guidelines outline many variables to consider when prescribing anticoagulation.

“Antithrombotic Therapy for Atrial Fibrillation: CHEST Guideline and Expert Panel Report,” an updated guideline in CHEST, provides antithrombotic treatment recommendations for patients with AF based on varying risk levels for stroke and in a variety of clinical settings.

A 12-person expert panel — chaired by lead study author Gregory Y.H. Lip, University of Birmingham, England — conducted a literature review to identify relevant articles published since the last guideline was released in 2012. The quality of the evidence was assessed using the GRADE approach.

Treatment recommendations focus on three topics: stroke and bleeding risk assessment, antithrombotic therapy in general, and antithrombotic therapy in special situations, such as acute coronary syndrome and stenting, chronic atrial flutter, pregnancy and chronic kidney disease.

The 60 key recommendations include the following:

• Patients with AF who do not have valvular heart disease, including paroxysmal AF, and are at low risk for stroke should not receive antithrombotic therapy

• Patients with ≥1 non-gender CHA2DS2-VASc stroke risk factors should be considered for stroke prevention using oral anticoagulation

The panel also recommends that clinicians be aware of modifiable bleeding risk factors. These factors include uncontrolled blood pressure, labile international normalized ratios, excessive alcohol intake, or concomitant use of aspirin or nonsteroidal anti-inflammatory drugs for patients taking oral anticoagulants. ▼


Antithrombotic Therapy Recommendations for Atrial Fibrillation

Therapeutic interventions aimed at preventing nonventilator hospital-acquired pneumonia (NV-HAP) are often not provided for patients in acute care hospitals.

“Hospital Acquired Pneumonia Prevention Initiative-2: Incidence of Nonventilator Hospital-Acquired Pneumonia in the United States,” in American Journal of Infection Control, notes that this “multicenter, nationwide study highlights the significant burden of NV-HAP in the U.S. acute care hospital setting.” It adds that “NV-HAP occurred on every hospital unit, including in younger, healthy patients,” indicating that although some patients are at higher risk, all patients carry some NV-HAP risk.

Inadequate oral hygiene is associated with an increased risk of hospital-acquired pneumonia. The facility had averaged four cases of pneumonia every month over the past 10 years, but after the program was launched in 2016, the rate decreased. The incidence of HAP has dropped 92 percent, and the program is being tested at other healthcare systems. ▼

Electronic Tools Can Reduce Catheter-Associated Infections

Integrating electronic clinical decision support (CDS) tools into the use of indwelling urinary catheters (IUCs) can reduce new catheters, total catheter days, reinsertions and catheter-associated urinary tract infections (CAUTIs).

“Reducing Indwelling Urinary Catheter Use Through Staged Introduction of Electronic Clinical Decision Support in a Multicenter Hospital System,” in *Infection Control & Hospital Epidemiology*, finds that CDS tools are a “viable and scalable intervention to target hospital-wide IUC use, and they hold promise for other quality improvement initiatives.”

The study involved 3.85 million hospitalized patient days at the multi-campus New York Presbyterian Hospital from 2011 to 2015. In all, 2,121 CAUTIs occurred during the study period for a rate of 3.30 per 1000 catheter days or 5.50 per 10,000 hospitalized patient days.

Four interventional phases involved the following:

- **Phase 1**: Staff were trained in standardized best practices for catheter placement and electronic documentation
- **Phase 2**: An electronic quality checklist tool automatically tracked IUC duration
- **Phase 3**: A triggered alert reminded clinicians of IUC duration
- **Phase 4**: Catheter orders automatically expired at noon the second day after placement, triggering catheter removal. Also, new IUC orders required consideration of alternatives to catheterization and selection of an appropriate indication

The CAUTI rate per 10,000 hospitalized patient days declined in each phase, from 9.66 in phase 1 to 1.65 in phase 4, for an overall decrease of 81.8 percent. “Similarly, the CAUTI rate per 1,000 catheterized patient days declined from 4.67 in phase 1 to 1.17 in phase 4, for an overall decline of 74.8 percent.”

**CDS tools are a viable and scalable intervention to target IUC use in hospitals.**

Limitations include a before-and-after design that did not account for confounding factors that could affect CAUTI rates and catheter use. Also, simultaneous interventions in phase 4, one that involved a nurse-driven automatic stop order and the other clinician-driven selection of placement criteria, made it challenging to compare the effects of each strategy.


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End-of-Life Care for Patients With Limited English Proficiency

A language barrier may affect the kind of end-of-life care that patients with limited English proficiency (LEP) receive in the ICU.

Although ICU death rates were the same for all patients regardless of language spoken, patients with LEP were 62 percent less likely to have orders for comfort measures before they died, notes “Differences in Code Status and End-of-Life Decision Making in Patients With Limited English Proficiency in the Intensive Care Unit,” in Mayo Clinic Proceedings. The retrospective cohort study examined data on 27,523 patients admitted to seven ICUs in an academic medical center during a three-year period. The total included 779 patients with LEP.

Patients with LEP were also more likely to be put in restraints (16% vs. 12%) and less likely to have an advance directive (11% vs. 36.8%), the study notes. Patients with a language barrier had hospital stays that were, on average, 2.7 days longer than patients whose primary language was English.

“This study shows that the end-of-life care that patients with limited English proficiency receive is different than for those who do not have [a] language barrier,” lead study author Amelia Barwise, Mayo Clinic, Rochester, Minnesota, explains in a related article in Becker’s Hospital Review.

“This may be because more patients with limited English proficiency have an authentic desire to die with more aggressive medical therapies or that communication or other barriers prevent healthcare teams from optimally assessing and implementing a less aggressive approach for dying patients with limited English proficiency,” she adds.


Short Courses of PTZ/VAN and Risk of Moderate-to-Severe AKI

Short courses of piperacillin/tazobactam and vancomycin (PTZ/VAN) are not associated with a greater risk for moderate-to-severe acute kidney injury (AKI) compared with similar antibiotic combinations.

“Incidence of Acute Kidney Injury Among Critically Ill Patients With Brief Empiric Use of Anti-Pseudomonal Beta-Lactams With Vancomycin,” in Clinical Infectious Diseases, compared the risk of AKI with a short course of PTZ/VAN to other anti-pseudomonal beta-lactam/vancomycin combinations for 3,299 eligible ICU patients.

The study notes a 9 percent overall incidence of stage 2 or 3 AKI. Compared with cefepime and meropenem, PTZ/VAN did not pose a greater risk for stage 2 or 3 AKI.

Further research is needed to understand the underlying mechanism of previous associations between PTZ/VAN and AKI, adds a related article on www.healio.com.

Surgery-Specific Pain Management Guidelines

Guidelines for prescribing opioids after 20 common surgeries may serve as tools to combat the opioid crisis by limiting overprescribing.

Led by The Johns Hopkins University School of Medicine, Baltimore, “Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus,” in Journal of the American College of Surgeons, involved a multidisciplinary panel of surgeons, pain specialists, outpatient surgical nurse practitioners, surgical residents, pharmacists and patients.

The panel developed postoperative pain management guidelines for opioid-naive adults undergoing procedures in eight surgical specialties: general, breast, thoracic, cardiac, orthopedic, urologic, otolaryngology, and gynecologic and obstetrics. Opioid recommendations — defined as oxycodone 5 mg oral equivalents — varied by procedure from 0 to 20 tablets, with a median of 12.5 tablets.

“These procedure-specific recommendations provide a framework to limit unwarranted prescribing variation in opioid-naive adults after surgery,” the study explains, adding that future work is needed to develop guidelines for other medical procedures and for children and patients previously exposed to opioids.

According to a related article in The Baltimore Sun, it is hoped that the study will encourage surgical associations and hospitals to abandon the one-size-fits-all approach to opioid prescriptions.

“Everyone is different,” study co-author Martin Makary, professor of surgery and health policy expert at Johns Hopkins, says in the article. “Opioid prescribing should fall within a best practices range and currently we don’t do very well with that. Our hope is that this represents a first step in better understanding how we can treat pain better.”

Patients with heart failure (HF) who enter hospice use less healthcare, live longer and are less likely to die in a hospital, but predictors of enrollment are uncertain.

According to “Predictors of Hospice Enrollment for Patients With Advanced Heart Failure and Effects on Health Care Use,” in JACC: Heart Failure, a propensity-score matched review of Medicare patient data shows potential advantages for enrolling in hospice in the six months after discharge for a second HF admission.

“Hospice care for patients with advanced HF is more likely to optimize patient goals if those goals include: living longer, dying at home, focusing on comfort, and avoiding hospitalizations,” Craig Blinderman, Columbia University Medical Center, New York, adds in a related article in MedPage Today. He was not involved in the study.

Comparing 3,067 patients with HF who entered hospice with the same number who did not, the hospice cohort averaged fewer emergency department visits (2.64 to 2.82), intensive care stays (1.25 to 1.51) and hospital days (3.90 to 4.67). Hospice patients lived an average of 80 days (vs. 71 for non-hospice), and only 3 percent died in a hospital (vs. 56 percent).

Despite the better outlook, the study finds few markers to help clinicians recommend hospice. “When we looked at patient characteristics, such as their symptoms, their ability to perform normal daily activities and the amount of healthcare they use, none of these predict if an individual will receive hospice,” lead study author Laura Gelfman, Icahn School of Medicine at Mount Sinai, New York, adds in the related article.


A tailored hospice model may increase enrollment and offer benefits to patients with HF.

For adults with out-of-hospital cardiac arrest (OHCA), initial laryngeal tube (LT) insertion was associated with greater 72-hour survival compared with endotracheal intubation (ETI).

“Effect of a Strategy of Initial Laryngeal Tube Insertion vs Endotracheal Intubation on 72-Hour Survival in Adults With Out-of-Hospital Cardiac Arrest: a Randomized Clinical Trial,” in JAMA: The Journal of the American Medical Association, compared survival rates among 3,004 adults with OHCA who were treated by providers from 27 emergency medical services (EMS) agencies. About half of the patients received an LT treatment, while the others received traditional ETI.

Overall, patients in the LT group had better outcomes, according to a news release from the National Institutes of Health.

The findings suggest that LT insertion may be considered as an initial airway management strategy in patients with OHCA.

For example, 18.3 percent of patients survived three days in the hospital, and 10.8 percent were discharged. For the group with traditional ETI, the survival numbers were 15.4 and 8.1 percent, respectively. Also, the proportion of patients retaining good brain function was higher in the LT group.

The findings suggest that LT insertion may be considered as an initial airway management strategy in patients with OHCA. However, limitations of the pragmatic design, practice setting and ETI performance characteristics suggest that further research is warranted.

Out-of-Hours ICU Discharges Linked to Poor Outcomes

Discharging patients from ICUs out of hours is associated with in-hospital mortality and ICU readmission rates, but more research is needed to determine why. “Out-of-Hours Discharge From Intensive Care, In-Hospital Mortality and Intensive Care Readmission Rates: A Systematic Review and Meta-Analysis,” in *Intensive Care Medicine,* notes that poor outcomes persisted for all definitions of “out of hours” and in healthcare systems worldwide. “Whether these increases in mortality and readmission result from patient differences, differences in care, or a combination remains unclear,” the review adds.

Conducted at the University of Oxford, England, the analysis involved 18 cohort studies from 1994 to 2014 with 1.19 million patients in five geographic locations: United Kingdom, Australasia, America and Canada. Although “out of hours” definitions varied — “beginning between 16:00 and 22:00 and ending between 05:59 and 09:00” — related discharges increased subsequent in-hospital mortality about 41 percent and ICU readmissions about 30 percent.

Future research should investigate the reasons for the adverse outcomes — accounting for factors such as age and illness severity, and assessing the impact of care differences. “These would include measures of ICU exposure (length of ICU stay), illness severity at the point of discharge and ongoing care requirements and quantification of post-discharge care.”

Whether increases in mortality and readmission result from differences in patients or care, or a combination, is unclear.

The impact of post-discharge care “has so far only been explored to a limited extent in a single study, despite clearly being key to further understanding the problem.”


Patient-to-Nurse Ratios in ICUs

A Massachusetts law that mandates patient-to-nurse ratios in ICUs based on patient-acuity tools did not change patient outcomes or increase nurse staffing levels.

“Patient Outcomes After the Introduction of Statewide ICU Nurse Staffing Regulations,” in *Critical Care Medicine,* examines the Massachusetts mandate, which took effect in 2016, requiring 1-to-1 or 2-to-1 patient-nurse ratios based on patient complexity scores. The study at Beth Israel Deaconess Medical Center (BIDMC) in Boston involved 29,754 ICU admissions at Massachusetts hospitals and 572,951 admissions at 114 academic hospitals in other states.

In Massachusetts, patient-nurse ratios changed only slightly before and after the law, from 1.38 patients to 1.28 patients per nurse. Elsewhere in the U.S., ratios were similar at 1.35 (baseline) to 1.31 (post-mandate) during the same period.

Additionally, patient mortality and complications remained stable in Massachusetts and elsewhere, with no significant changes associated with the regulations, the study reveals. In an analysis in *HealthLeaders,* lead study author Anica C. Law, BIDMC, says the findings suggest the mandate did not affect staffing or outcomes. “The modest changes in nurse staffing we saw in Massachusetts — approximately one extra nurse per 20-bed ICU per 12-hour shift — remained unassociated with changes in hospital mortality,” Law adds.

Proper staffing is more than fixed ratios and pure numbers, and new approaches must value patient safety and better outcomes rather than expense, as noted on a related AACN webpage. AACN is leading initiatives toward change, partnering with other nursing associations, healthcare executives and patient safety groups.

“We must work together,” the webpage reads, “to develop new staffing solutions that advance patient outcomes while ensuring a better work environment for nurses and all the other members of the healthcare team.”

New Editions of ‘AACN Essentials’ Textbooks

The fourth editions of the popular, highly acclaimed and authoritative “AACN Essentials of Critical Care Nursing” and “AACN Essentials of Progressive Care Nursing” by editors Suzanne M. Burns, professor emerita at the University of Virginia, and Sarah Delgado, an AACN clinical practice specialist, are hot off the press!

As in previous editions, the books’ content is written by experts in their field and is provided in a user-friendly format.

The first section covers fundamental concepts essential to all practice areas such as pain management, ethics and cardiac monitoring, and the next covers pathological conditions by body system. The final section provides advanced content and quick reference information. New guidelines and practice-based research are integrated into each chapter. The “Essential Content” cases and principles of management teach and test mastery of essential content.

The books are a comprehensive resource to expand knowledge and to prepare for the CCRN or PCCN certification examinations. They are also an excellent resource for practicing clinicians and for nurses starting their career in critical or progressive care. Although the books are similar, there are differences.

“The focus of ‘Essentials of Critical Care Nursing,’” Burns says, “is to ensure that nurses working in any critical care unit are provided key information to rapidly and accurately interpret, anticipate and act on changes that emerge in our patients’ status.”

The book also addresses the diversity in how critical care is delivered. For instance, some hospitals have multiple ICUs that each care for a specific patient population, such as cardiac surgery, neurosurgery, trauma or medical ICU, while others have one ICU that provides care to all critically ill patients, regardless of their diagnosis. Recognizing these differences, “Essentials of Critical Care Nursing” provides specific content related to the critical care specialty as well as broader critical care foundational information. Advanced chapters offer complex information on topical areas.

“Essentials of Progressive Care Nursing” is one of the few resources created specifically to meet the needs of nurses who provide progressive care.

“We know that patients who need progressive care regardless of the setting — surgical step-down, transitional care, telemetry unit, long-term acute care — have the potential to become unstable at any time,” Delgado says. “This book supports nurses with information they need to safely and effectively monitor patients throughout the trajectory of their illness, across a wide range of diagnoses.” The text covers essential information relevant to nurses who provide progressive care.

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