For the Sake of Patient Safety:
An Interview With Alex Wubbels
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Certified Nurses Day, on March 19, was a festive occasion on all AACN social media platforms. Here are some of the ways you celebrated this year. ▼

Join the conversation on AACN social media today, and use the hashtag #MyBoldVoice.
Imagine this scenario: You are in the middle of a shift at work. Things are going well. Your patients are interesting, you’re able to keep up with what needs to be done, and colleagues are nearby to help if needed. Unexpectedly, a co-worker approaches and says, “Do you have a moment? I’d like to give you some feedback.”

Did you have a run of SVT? Your stomach plummet? Palms get sweaty?

Many of us go into panic mode at the start of a feedback conversation, even though we pride ourselves on being part of a learning profession, and feedback is an inevitable element. Skilled communication is one of the six Healthy Work Environment standards and plays a crucial role in making the other five standards possible. Every workplace provides workshops on how to deliver feedback, but opportunities to learn how to receive feedback are not as commonly available.

The truth is, we’re physiologically hard-wired to go into fight or flight mode when faced with a real — or perceived — threat. Because of the primal need to survive, there are significantly more communication pathways responding to negative, potentially harmful input than pathways responding to positive, pleasant input.

Negative feedback — actual or potential — is emotionally louder than positive feedback and elicits a more powerful response. Past experiences, relationships, emotional triggers and blind spots further influence the emotions and behaviors that follow what may be perceived as criticism.

Even when feedback comes from a trusted colleague and is positive, the initial response is often to prepare for the worst.

The WHY behind being able to receive feedback is obvious: It is one of the most important tools we have to help us learn and contribute to our worlds.

Douglas Stone and Sheila Heen, authors of “Thanks for the Feedback: The Science and Art of Receiving Feedback Well,” explain the neurophysiological and psychological rationale for the discomfort people experience during a feedback interaction. They offer strategies for listening to what was said, processing it and responding in a thoughtful, professional way.

• Stop to listen. Become aware of your posture and facial expressions, and take a deep breath. This sends calming signals to the emotional centers of your brain.

• Do not interrupt. If you’re busy coming up with a response, you’re not fully listening and may miss the heart of the message.

• Ask clarifying questions. When they’ve finished talking, ask any clarifying questions before offering a response. This ensures you’ve heard correctly and redirects any false assumptions about intent and content.

• Say thank you. And have compassion for the person coming forward. Not only does this show respect, it also triggers positive and quieting pathways in the brain.

The one thing that can solve most of our problems is dancing.

—James Brown
• **Offer your response without becoming defensive.** If you’re getting emotional, ask to take a break and return to the conversation when you’re feeling more settled.

• **Together, explore solutions.** Consider how proposed solutions can be facilitated and what kind of follow-up is warranted.

• **Reflect on the feedback.** What did you learn from the content of the information and the experience itself? How will this experience make you a better nurse, friend, co-worker or partner? There is always something about this type of event that will help you grow.

Receiving feedback is like being a communication dance partner. In dance, the leader and the follower must have equal skill for a well-executed performance. In communication, expertly given feedback also must be skillfully received and processed in order to build trusting relationships and healthy, thriving work environments. For every class on effectively giving feedback, there should be a second, equally as important class: elegantly receiving it.

Give me some feedback, or let me know about a time when feedback has affected you at GuidedByWhy@aacn.org. ▼

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**BECAUSE NURSES ARE CRITICAL TO PROVIDING QUALITY CARE.**

Looking for a fresh start in your critical care nursing career? Look no further than Mount Carmel in Columbus, Ohio.* We provide the kind of care that continues to win national awards for quality outcomes, performance, and patient experience. And with campus modernizations and new hospital construction underway, there’s never been a better time to be here.

*Relocation assistance may be available to qualified candidates.

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**Thrive at NTI: Some Tips for the Best Experience**

Are you joining us in Boston this month for the National Teaching Institute & Critical Care Exposition (NTI)? We hope so! The size of the conference alone can challenge NTI newcomers and veteran attendees alike. Use this checklist to start planning your week. Look for more tips on the FAQ page at www.aacn.org/nti.

- **Explore My NTI and get connected.** Sign in on the AACN website and use My NTI to create your schedule, plan your week and participate in discussions with facilitators and other attendees.

- **Organize your schedule and special events.** Create your schedule on My NTI, and be sure to add a Sunrise Session to secure your seat. Reservations are required.

- **Get NTI tips from the pros.** Join NTI Program Planning Committee chairs at “Navigating NTI 101,” Sunday, May 20, at 4:15 p.m. or Monday, May 21, at 8 a.m. They’ll walk you through how to make NTI an enjoyable and rewarding professional experience.

- **Take a tour of the convention center.** If you arrive early, consider joining members of the NTI and API program planning committees for a tour of the convention center on Sunday beginning at 10 a.m. every 30 minutes.

- **Maximize your conference experience with the Learning Action Journal.** Tools to assist you plan, learn and act on your conference education and activities are available at www.aacn.org/nti. The Learning Action Journal is included in your attendee bag.

- **Dress for comfort and temperature shifts.** Buy a pair or two of comfy shoes and break them in before the trip. Meeting room temperatures often fluctuate, so wear layers.

- **Plan meals and snacks, and drink plenty of water.** The Participant Map in your attendee bag highlights food options and hours at the convention center, but bring nutritious snacks such as fruit, granola or nuts and bottled water for your midday energy boost.

- **Explore Boston beyond NTI.** The diverse neighborhoods of Boston offer endless opportunities for cultural and outdoor activities. Get started at www.bostonusa.com or ask the locals at the Host Chapters Booth on-site.

- **Enjoy a fun-filled Nurses’ Night Off at Seaport World Trade Center,** Wednesday, May 23, 6:30-9:30 p.m. Unwind at this Boston landmark and dance to the city’s premier band, Night Shift.

Safe travels. See you in Boston! ▼
Matt and Jesse Malone had the kind of year they will never forget. In addition to welcoming their first child, Trevor, into the world this February, they studied together and both passed the CCRN exam in October 2017. They discussed their experiences with us.

Where did you meet?
Matt: We both work in the Surgical ICU at Inspira Health Network in Vineland, New Jersey. Jesse is full-time, and I am per diem there. I became a nurse in 2005, a few years before Jesse, who began in 2009. We crossed paths at the hospital a few times. But it was later when we had a few mutual friends we got to know each other socializing with them. We ended up going on a few dates together, and we were married in 2012.

When did you know you wanted to be certified?
Jesse: I knew I wanted to be certified from the moment I became a nurse. I knew it confirmed my expertise.
Matt: My current full-time employer, AtlantiCare’s Mobile ICU/Specialty Care Transport team, in Atlantic City, New Jersey, is very supportive and encourages all of their nurses to be certified in their specialty. I set it as one of my goals on my evaluation this previous year.

When did you find out you were pregnant, and how did that affect your plans to become certified?
Jesse: We had been trying to get pregnant around the time we decided we wanted to get certified. And one day, I just had a feeling — that it had happened. I said, “We need to go to the drugstore.” I found out I was pregnant that day — on Matt’s birthday, June 27!

Matt: So, we decided that we really had to buckle down and get certified. I said either we do this now, or it will be a long time before we’ll be able to do it.

How did that go — buckling down?
Jesse: Pretty smoothly. And we really did buckle down. A lot of the nurses we work with were really awesome, loaning us books and encouraging us. My hospital and Matt’s unit were just great to us.
Matt: We scheduled mini-workdays where we would just plan to study for the exam. But then Tuesday would roll around, and Jesse would be very tired or under the weather, so we’d change our plans. We’d watch Netflix instead. But we committed to studying and most of the time followed through when we could — unless we needed to go for a late-night pregnancy-related milkshake run!

Jesse: Our Brittany spaniel, Rocco, probably thought we were crazy — spending all our time studying.
Matt: Yeah, most of the time we were studying, he just looked at us like we were nuts. We would joke and make him the practice patient for scenarios. Honestly, he could have probably passed the CCRN by the time we were done.

So, when did you take the exam?
Jesse: We took it in October 2017 — week 20 of our pregnancy. We got our high-quality ultrasound picture the week before we were leaving to take the exam. We brought it with us for inspiration.

What was the experience of expecting a child and working toward the CCRN like?
Matt: I think they balanced each other out. I’m glad we did it while we had the free time. I can’t imagine doing it now with Trevor here — and I’m just the backup quarterback for Jesse.

Jesse: I’m so glad we went through the experience of getting certified together. We were able to bring different ideas and views to the table. If one of us understood an idea and the other didn’t, we could explain it to each other.
Were there any downsides to studying for the exam while you were expecting?
**Matt:** I would read about all the disease processes and think about my child. [laughs] You know, the same thing you tell your patients not to do.

How have the experiences of being certified and having Trevor changed you?
**Jesse:** We grew as people. I’m a better nurse as a result of being certified. I’m more professional. Having Trevor has made us more balanced and centered us.

**Matt:** The experience of finding out at the same time that we both had passed was wonderful. But nothing can compare to the way I felt when I held Trevor for the first time. Nothing.

What would you have done if — heaven forbid — one of you hadn’t passed the exam?
**Matt:** If one of us failed, we decided we would treat it as though both of us had failed. We would continue to study the way we did before, until we both passed.

If you could offer advice to anyone wanting to become certified, what would it be?
**Matt:** I would tell them it’s not just your job; it’s your career. You should take it seriously by getting certified. Also, pair up with someone if you can. It is a huge help in staying motivated throughout the hours of studying required.

**Jesse:** We decided to get certified mostly because of self-pride. But if we’re doing this work, we feel we should be certified in our specialty. It just makes sense.
This month’s issue of *American Journal of Critical Care* (AJCC) includes two studies weighing the efficacy of medical interventions and additional articles describing the impact of nurse-initiated care.

In a prospective study of 25 patients with severe acute respiratory distress syndrome (ARDS) who met extracorporeal membrane oxygenation (ECMO) criteria but did not receive ECMO, Sahetya and colleagues find that the mortality rate was similar to the predicted rate of mortality if the patients had undergone ECMO. While further research is needed, this study is part of the pool of evidence that questions the benefit of this technology, particularly for patients with ARDS who are older and sicker.

A separate retrospective study of 364 U.S. hospitals finds that early transfusion in patients with sepsis treated outside the ICU was associated with higher costs but not associated with improved survival (Raghunathan, et al.). By understanding that these interventions have an uncertain impact on patient outcomes, nurses can contribute to effective medical decision-making with patients, families and the intra-professional team.

Another article in this month’s issue validates nurses’ contributions to effective pain management. In a randomized controlled double-blinded study of 60 ICU patients, Papathanassoglou, et al. find that a multimodal intervention, including relaxation, guided imagery, massage and music listening, significantly reduced pain. Consider using these interventions with your patients, and be sure to obtain CE for reading this article.

The benefits of mobility in reducing delirium are often cited, but how can nurses put this intervention into practice? Two articles in this month’s AJCC offer strategies for addressing patient mobility. One describes how a pediatric unit implemented an intra-professional quality-improvement project to increase patient mobility (Colwell, et al.), and the other reports on an observational study that identifies opportunities to incorporate mobility into existing patient care (Young, et al.). Review the articles and consider how these approaches might work in your unit.

To see the table of contents for the May issue of AJCC, please visit www.aejcconline.org.
Jump-Start Your Professional Goals: Apply for an AACN Scholarship

Did you make academic advancement and career growth a professional goal this year? Are you saving to attend a national conference? Ready to make the leap from RN to BSN or higher?

Whatever your plans for further education and personal growth, an AACN scholarship may be just the spark to jump-start your journey.

Our community of nurses continually pursues lifelong learning, career enrichment and leadership development opportunities, and we know everyone can use a little help investing in themselves. AACN scholarships help our members fund a variety of educational pursuits, including:

- Health policy
- Evidence-based practice
- Healthy work environments
- Regional and national conferences
- Local events
- Skill building
- Personal growth
- Governance

The first step is to determine your learning path and pick an educational activity to fill an existing gap in your expertise or skill set. Next, apply online for an AACN scholarship. In the application you will explain your learning plan, describe the specific opportunity and detail how it will help you achieve your objectives. Advance planning is key. After your online submission, please allow us three to four months to process your application.

We want to support, inspire and lift you to new heights. An AACN scholarship — up to $3,000 per year, per person — helps you continue your education and achieve professional excellence. For further details, please visit www.aacn.org/scholarship. Questions? Send your email to scholarships@aacn.org.

Scholarship opportunities are a unique benefit of AACN membership.

Call for Nominations: AACN Board, Nominating Committee

Help ensure AACN’s future direction and influence the future of nursing: Submit your nominations for the 2019 election. Open positions include the AACN board of directors (three-year term beginning July 1, 2019, ending June 30, 2022) and the Nominating Committee (one-year term beginning July 1, 2019, ending June 30, 2020).

The call for nominations closes May 31. Visit www.aacn.org/nominations to review the accountabilities and leadership requirements for open positions. Nominating individuals for these positions is an important ongoing contribution that you can make to ensure a strong succession of leaders. Please consider the individuals you have interacted with over the past few years in regard to the qualifications for these roles, and submit nominations for those who could successfully fulfill them. Self-nominations are also welcome and encouraged.

For questions, please contact Melinda Messenger-Stout at 800-394-5995, ext. 331, or volunteers@aacn.org.

Scholarship opportunities are a unique benefit of AACN membership.
Insights to Combat Antibiotic Resistance

A study of leading antimicrobial stewardship programs (ASPs) at U.S. hospitals identifies themes to guide implementation in other hospitals and help develop the policy on antibiotic resistance. “The Expanding Role of Antimicrobial Stewardship Programs in Hospitals in the United States: Lessons Learned From a Multisite Qualitative Study,” in The Joint Commission Journal on Quality and Patient Safety, finds that successful ASPs engage many personnel and integrate information technology (IT) to improve efficiency. The study focuses on four leading ASPs, examining their structures, strengths, weaknesses, lessons learned and future direction.

A related news release summarizes the main themes:

- Evolution from a top-down structure to a more diffuse approach involving unit-based pharmacists, multidisciplinary staff and shared responsibility for antimicrobial prescribing under ASP leadership
- Integration of IT systems to enable real-time interventions and optimize antimicrobial therapy and patient management
- Identifying barriers to technology integration, including limited resources for data analysis and poor interoperability between software systems

In traditional ASP models, a single physician or pharmacy leader is responsible for improving antibiotic prescribing at a hospital, but this study recommends expanding that role. “Our results suggest an evolving role for the ASP in empowering an array of physicians across disciplines and pharmacists across hospital units to champion stewardship program activities and objectives.”

The study adds that even leading programs may struggle to use technology optimally, but as IT systems for stewardship become more commonplace, “technology driven interventions may augment or even replace more traditional ASP strategies, in addition to enabling new ones.”

ICU Wastewater, a Vast Reservoir of Bacteria

Wastewater samples from ICU drainage pipes and external manholes all contained carbapenemase-producing organisms (CPOs), suggesting a “vast, resilient reservoir” of drug-resistant bacteria.

However, the results of the National Institutes of Health (NIH) study do not translate to immediate harm to patients, according to “Genomic Analysis of Hospital Plumbing Reveals Diverse Reservoir of Bacterial Plasmids Conferring Carbapenem Resistance,” in mBio. The study reports a very low prevalence of patient infections with bla_KPC-positive organisms.

“This comprehensive [five-year] survey revealed a vast, unappreciated reservoir of CPOs in wastewater, which was in contrast to the low positivity rate in both the patient population and the patient-accessible environment,” the study notes.

In a related article in HealthLeaders Media, study co-author Karen Frank, an NIH microbiologist, says the comparison suggests that hospital infection-control surveillance minimizes patients’ infections, even when a reservoir of antibiotic-resistant plasmids is so close. That doesn’t mean, however, that the presence of plasmids in wastewater should be ignored.

The findings also compared five years’ worth of data on high-touch areas. “Remarkably, the high prevalence of carbapenem-resistant plasmids in the pipes and sewers wasn’t seen in parts of the hospital to which patients had access,” the article explains.

Understanding when plasmids get into the pathogens that infect patients can help hospitals monitor resistance-conferring genes. “In the big picture, the concern is the spread of these resistant organisms worldwide and some regions of the world are not tracking the spread of the hospital isolates,” Frank adds.


Reduced Readmissions Associated With Increased Heart Failure Mortality

“The Hospital Readmissions Reduction Program (HRRP) might have the unintended consequence of increasing mortality rates in fee-for-service Medicare patients hospitalized with heart failure.

According to "Association of the Hospital Readmissions Reduction Program Implementation With Readmission and Mortality Outcomes in Heart Failure," in *JAMA Cardiology*, implementation of the HRRP was “associated with a subsequent decrease in 30-day and 1-year risk-adjusted readmissions and an increase in 30-day and 1-year risk-adjusted mortality.”

In a related article in *MD Magazine*, study co-author Gregg Fonarow, Ahmanson-UCLA Cardiomyopathy Center, Los Angeles, refers to HRRP in stating, “There has been concern for unintended consequence on worsening patient outcomes, which our study uncovered.”

The large-scale observational study of 115,245 hospitalized Medicare patients with heart failure, average age 80.5, at 416 sites nationwide reviewed the time period before HRRP (January 2006-March 2010), during HRRP implementation (April 2010-September 2012) and the penalty phase (October 2012-December 2014).

While readmission rates declined slightly in the penalty phase, the 30-day risk-adjusted mortality rate grew to 8.6 percent from 7.2 percent before implementation, and the one-year rate rose to 36.3 percent from 31.3 percent.

“The penalties hit hospitals that care for the most vulnerable heart failure patients the hardest, denying them vital resources to provide care,” Fonarow says. “To avoid the penalties, hospitals have incentives to keep patients out of hospitals longer, which they would have otherwise readmitted on clinical grounds prior to this policy.”

The study recommends further research to confirm the findings while cautioning about continuing to include heart failure in the HRRP. “The policy should focus on incentivizing improving quality and outcomes of patients with heart failure and not on a misguided utilization metric of rehospitalizations,” Fonarow adds.


On-Demand Webinars Address Heart Failure Guidelines

AACN offers two on-demand webinars regarding heart failure guidelines: “Heart Failure Guidelines: Preserved Ejection Fraction and Comorbidities” was held Feb. 8, 2018, and “Heart Failure Guidelines: New Treatment Options” was presented Sept. 14, 2017. They are part of the AACN Critical Care Webinar Series, which offers knowledge and tools to help you stay current on the latest evidence-based acute and critical care clinical practice. These webinars also offer continuing education contact hours.

Dashboard Shows More Nurses Have BSN

As of 2016, 54 percent of employed RNs held a Bachelor of Science in Nursing (BSN) — a 5 percent increase since 2010.

“Progress Continues on IOM Future of Nursing Report Recommendations,” on the Campaign for Action website, includes the latest updates to the campaign’s dashboard, measures that show national progress in implementing the recommendations in 2010’s “The Future of Nursing: Leading Change, Advancing Health.” (Based in Washington, the IOM is now called the National Academy of Medicine.) The dashboard, which is updated semiannually, features “seven primary indicators: education, doctoral degrees, state practice environment, interprofessional collaboration, leadership, workforce data, and diversity.”

The dashboard’s secondary indicators include the following progress:

- South Dakota has joined eight other states giving nurse practitioners full practice and prescriptive authority, which shows progress in removing policy barriers.
- Racial and ethnic diversity is growing in the RN workforce.
- More nurses are serving on boards or other governing bodies.
- The percentage of nurses with doctoral degrees has more than doubled since 2010, surpassing the goal.
- “The number of required clinical courses and/or activities at top nursing schools that include both RN students and graduate students of other health professions” has increased.

The study recommends further research to confirm the findings while cautioning about continuing to include heart failure in the HRRP.
First Non-US Units Among 144 Beacon Award Recipients

AACN recognized 144 units from 113 hospitals with the Beacon Award for Excellence in 2017, including 32 gold-level awards, the program’s highest distinction.

For the first time, Beacon Awards were given to units from hospitals outside the U.S. — the medical-surgical ICU at St. Michael’s Hospital in Toronto, Canada, earns a gold-level Beacon, and three units from King Faisal Specialist Hospital and Research Centre in Riyadh, Saudi Arabia, garner a bronze-level award.

AACN President Christine Schulman, critical care and trauma clinical nurse specialist at Legacy Health in Portland, Oregon, praises the exemplary efforts of the units that achieved the Beacon Award.

“The caregivers in these units are healthcare professionals committed to the best in patient care,” Schulman says. “The continued growth of the Beacon Award program shows the commitment of caregivers and their hospitals to work together to achieve healthy work environments that support excellent care of patients and their families.”

Also, 2017 marks the first time units earned a Beacon Award three consecutive times. That milestone was achieved by the cardiovascular unit at Fresno Heart and Surgical Hospital in California; the cardiovascular ICU at Unity Point Health Methodist in Peoria, Illinois; and the medical-surgical ICU at Morristown Medical Center in New Jersey.

The Beacon Award — a three-year designation with gold, silver and bronze levels — pays tribute to hospital units that exemplify excellence in evidence-based practice to sustain a healthy work environment and improve outcomes for high-acuity and critically ill patients and their families.

AACN will honor these Beacon awardees at the 2018 National Teaching Institute & Critical Care Exposition, in Boston, May 21-24 (with preconferences May 20).

Any unit in which patients receive their principal nursing care after hospital admission is eligible to apply at any time. AACN membership is not a prerequisite to apply, and there is no submission deadline.

A complete step-by-step Beacon Award application guide and other resources are available at www.aacn.org/beacon.
Visionary Leader Awards

Marguerite Rodgers Kinney Award for a Distinguished Career

With this award, the AACN community recognizes individuals whose extraordinary and distinguished professional careers have made a significant impact on fulfilling AACN’s mission and vision. The annual award recipient shows consistent and exceptional contributions to enhance the care of acutely and critically ill patients and their families.

The award was first presented in 1997 to its namesake, Marguerite R. Kinney Handlin, for her influence on many levels — as AACN president, chair of AACN Certification Corporation, writer, editor, professor and tireless mentor at the University of Alabama at Birmingham — and across the world.

Beth Ulrich is a nationally recognized thought leader on nursing work environments and the experiences of graduate nurses as they transition from nursing school to the workforce.

She has been the primary investigator on a series of studies on the health of acute and critical care nursing work environments conducted for AACN. During her long and varied career, she has been instrumental in helping to define the specialty of nephrology nursing, develop the roles of nephrology nurses and improve the care of their patients.

A professor at Cizik School of Nursing at The University of Texas Health Science Center in Houston and a senior partner at Innovative Health Resources, Ulrich is also editor of Nephrology Nursing Journal. She is past president of the American Nephrology Nurses Association, a fellow at the American College of Healthcare Executives and the American Academy of Nursing, and has numerous publications and presentations to her credit.

Fierce compassion is a phrase that describes Jonathan Bartels. He is best known as creator of “The Pause,” a way to honor the death of a patient by having the care team present at the end of life take a moment for silent reflection. In his role as an emergency trauma nurse, he created The Pause after feeling emotionally empty following the death of a young woman in the emergency department. Since its inception, The Pause has profoundly impacted caregivers in hospitals throughout the United States and internationally.

Bartels is a trauma nurse, resiliency coach and retreat facilitator, educator, artist, mentor and writer. He is currently a palliative care nurse liaison at the University of Virginia (UVA) Health System, where he has worked in various roles for the past 19 years.

He is an original team member of the Compassionate Care Initiative at UVA School of Nursing, which helps educate nursing students, nurses, medical students and physicians in practices that promote resiliency and compassionate care.

Bernadette Melnyk’s groundbreaking work in evidence-based practice has changed bedside nursing practice worldwide and is essential to AACN’s mission to improve the quality of care and patient/family outcomes.

She is founder and executive director of the Helene Fuld Health Trust National Institute for Evidence-based Practice in Nursing and Healthcare housed at The Ohio State University, where she serves as vice president for health promotion, university chief wellness officer and professor and dean of the college of nursing. Co-author of "Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice," her numerous books, publications and seminars have provided the foundation for nurses’ use of evidence-based interventions in hospitals, primary care settings and schools internationally.

She recently completed a four-year term on the National Institutes of Health’s National Advisory Council for Nursing Research. She is a member of the National Quality Forum’s Behavioral Health Standing Committee and the National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience.

Melnyk is also one of the few nurses to have served on the U.S. Preventive Services Task Force and to be elected the National Academy of Medicine.

Curtis N. Sessler is a pioneer in interprofessional and team-based care and research. His long career in critical care medicine, which focuses on patient care, clinical research and teaching, often includes partnering closely with nurse researchers.

His research has addressed crucial clinical issues, including sedation and analgesia in the ICU, mechanical ventilation, procedural competency and prevention of nosocomial infections. He led the group that created and validated the widely used Richmond Agitation Sedation Scale.

The Orhan Muren Distinguished Professor of Medicine at Virginia Commonwealth University Health System, he is medical director of the Medical Respiratory Intensive Care Unit and director of the Center for Adult Critical Care. Sessler has held numerous leadership roles, including president of the American College of Chest Physicians (CHEST), where he helped strengthen the partnership between AACN and CHEST.

He says one of his most satisfying professional roles has been participating in the Critical Care Societies Collaborative — which links AACN, CHEST, the American Thoracic Society and the Society of Critical Care Medicine — to address issues central to critical care.

EXCELLENCE AWARDS

AACN Pioneering Spirit Award

This award recognizes significant exploration and innovation that exemplify a pioneering spirit and influence the direction of acute and critical care nursing. The contributions are clearly defined and have a regional or national effect. They are timely and address or resolve a significant issue facing acute and critical care nursing related to the mission, vision and values of AACN.
CIRCLE OF EXCELLENCE

Each year, the Circle of Excellence awards recognize individuals who exemplify excellence in the care of acutely and critically ill patients and their families. Award recipients must be current AACN members and nominated by a colleague who is also an AACN member. The nominating colleague attests to the nominee’s achievement of the award criteria:

- Relentlessly promotes patient-driven excellence
- Models skilled communication, true collaboration, effective decision making and meaningful recognition
- Transforms thinking, structures and processes to address challenges and remove barriers to advance patient-driven excellence
- Enriches own and other organizations by influencing and mentoring others in achieving excellence
- Furthers AACN’s mission and key initiatives at influential forums
- Achieves visible results that validate the impact of individual leadership contribution to organizational excellence

Nicolas Abella
Director of Critical Care and Medical-Surgical Services
Community Health Systems
Franklin, Tennessee

Nicolas Abella’s leadership of the STOP Sepsis Collaborative has resulted in reducing sepsis mortality across affiliated hospitals. The collaborative is composed of approximately 25 hospitals with the purpose of improving sepsis mortality outcomes through early sepsis identification and timely evidence-based treatment. Abella helped each hospital form interprofessional teams, including laboratory staff, nurses, case managers, midlevel providers, hospital leadership and physicians, and then coached these teams on all aspects of evidence-based sepsis care. His emphasis on consistently monitoring quality outcomes and giving honest feedback to his cohorts has yielded tremendous results. Abella also reinforces the idea of making a difference wherever care is delivered by modeling empathy to those he mentors.

Leanne Boehm
Registered Nurse
Vanderbilt University School of Nursing
Nashville, Tennessee

Leanne Boehm is a postdoctoral fellow and instructor at Vanderbilt University School of Nursing in Nashville, Tennessee. Boehm models skilled communication, true collaboration, effective decision making and meaningful recognition in her everyday interactions across multiple disciplines and teams through teaching, mentoring, coaching and networking in her pursuit of sharing valuable knowledge with others. She has received three grants to conduct research, published 16 manuscripts in peer-reviewed journals and delivered more than 50 presentations at regional, national and international meetings. Since Boehm is a member of the ICU Delirium and Cognitive Impairment research team, her influence reaches even further. Her work, as well as the work she inspires others to do, has led to sustained improvements in patient and family outcomes.

Odette Comeau
Adult Critical Care Clinical Nurse Specialist
University of Texas Medical Branch
Galveston

Odette Comeau acts with integrity, is committed to excellence and promotes change based on evidence-based practices. Comeau was instrumental in the development, implementation and evaluation of an interdisciplin ary early progressive mobility program for the critically ill patient population. She has been recognized as an organizational leader, which includes her role helping the organization achieve gold-level recognition for resuscitation outcomes four years in a row through the American Heart Association’s “Get With the Guidelines” program. Comeau is focused on improving quality and outcomes for intensive care patients and their families.
Anna Dermenchyan leads, facilitates and implements improvement initiatives in hospital medicine and population health management. She has worked with interdisciplinary teams to understand the root causes of mortality in order to learn from each patient’s death. Through her leadership, the health system has achieved better outcomes in reducing avoidable readmissions by making hospitalizations less stressful and the recovery period more patient-centric. Dermenchyan has consistently provided leadership for many critical care nurses and mentored countless new nurses. As the founding president of the AACN Chapter at UCLA, she has championed students to become involved in professional organizations early in their careers. Dermenchyan’s tireless dedication to improving care delivery, while placing patients and families at the center of care, is truly exceptional.

Sandra Hagstrom lives the mission and values of AACN in her daily work, particularly through setting and achieving high-quality clinical practice standards and patient outcomes, focusing on patient safety and quality care, and enacting AACN’s healthy work environment standards. She engages nurses to own their practice, helping them understand the implications of proposed changes and supporting them with needed resources to drive excellence. Her philosophy is that bedside nurses can best determine how to improve patient care, if given support, leadership and coaching from an advanced practice nurse.

Linda Lopazanski epitomizes the qualities of a transformational leader. She advocates for national certification; 87 percent of the ICU staff have earned a CCRN. Lopazanski facilitates the Practice Guidelines Committee, Critical Care Collaborative, Sepsis Initiative, and Nurse Practice and Quality Committee. She also serves on the Bioethics Committee, speaking on behalf of patients who can no longer speak for themselves. Under her leadership, there have been no CAUTIs, CLABSIs or hospital-acquired pressure ulcers for the last two years. Lopazanski advocates and encourages staff participation in decision making and ensures staff accountability, while creating a sustainable healthy work environment to improve the delivery of excellent care to patients and families.
Lauren Macko
Clinical Nurse Specialist
Carolinas Healthcare System
Charlotte, North Carolina

Lauren Macko’s clinical expertise and passion for managing patients with stroke and other neurological conditions is showcased in her various projects and roles. Her recent involvement in the Society of Critical Care Medicine’s ICU Liberation collaborative has driven evidence-based practice across the 29-bed Neurosurgical ICU and led to improved patient outcomes, such as increased mobility and decreased mechanical ventilator hours, ICU days and delirium. Macko plays an integral role in leading daily multidisciplinary rounds to improve communication with patients, families and team members. Her collaborative approach has led to post-acute care starting the discharge plan while patients are still in the ICU. She makes a difference, and her team is better because of her influence, commitment and leadership.

Debra McCann
Executive Director of Patient Care
Froedtert & Medical College of Wisconsin
Community Hospital Division
Menomonee Falls

Debra McCann was involved in the design of the ICU, advocating for the addition of family sleep rooms to facilitate family presence during critical illness. She is not afraid of failure and uses it as a means to change and improve processes. Employees are encouraged to approach her with new ideas for patient care and unit improvement. New technology and best practice guidelines are incorporated into patient care as well as the constant search for new learning opportunities. McCann was also part of the team that helped create a professional practice model for the nursing staff. She empowers nursing staff to participate in shared governance. Staff engagement is the fundamental element that supports overall excellence in patient care outcomes.

Sandia Royal
Clinical Nurse Educator
Robert Wood Johnson University Hospital
New Brunswick, New Jersey

Sandia Royal’s relentless pursuit of excellence has resulted in numerous patient care improvements. In the Neurosurgical Intensive Care Unit, this work resulted in zero fall injuries, zero central line-associated bloodstream infections and zero ventilator-associated pneumonia for more than two consecutive years. Royal also served as lead writer for the Beacon Award application, which resulted in silver-level recognition. Her expertise in collaboration and communication is widely recognized throughout the organization as evidenced by her effective decision making, which positively impacts safety, service and quality outcomes for nurses, patients, family members and the community. Royal’s most impactful achievement is the establishment of the New Jersey Brain Aneurysm & AVM support group in 2013.

Jason Thornton
Director of Nursing and Patient Services
Cardiac Intensive Care Unit,
Cardiovascular Operating Rooms
Boston Children’s Hospital

Jason Thornton’s impact on pediatric cardiac patients and their families can be felt across the care continuum. He is an authentic leader committed to addressing challenges and removing barriers to improve the health of the work environment and optimize patient outcomes. His commitment to evidence-based practice and clinical excellence is exemplified by the Cardiac ICU receiving the AACN Beacon Award, gold level. His calm, rational demeanor helps him ensure quality care for his patients and their families and lead large interdisciplinary teams. He relentlessly promotes patient-driven excellence, shows poise when confronted with complex or emergent situations, calmly deliberates problems and priorities, and anticipates overall challenges that might impact operations.

Happy National Nurses Week — May 6-12

AACN celebrates National Nurses Week and the enduring enthusiasm and unwavering spirit of our community of exceptional nurses. You inspire us with your commitment to the profession and the knowledge and compassion you extend to your patients and their families. We celebrate the extraordinary care you deliver every day.
In July 2017, University of Utah Hospital intensive care nurse Alex Wubbels was arrested for preventing a Salt Lake City police officer from taking an unwarranted blood sample from an unconscious patient. After a video of her rough arrest went viral, she was thrust into the media spotlight, hailed as a hero, spurred a change to the Utah blood draw law and ignited a national campaign to raise awareness about healthcare workplace violence.

Where do you work?
I work at the University of Utah as a burn trauma ICU nurse, burn ICU educator and member of our enteral feeding tube placement team.

You were an Olympic skier and competed in the 1998 Nagano and 2002 Salt Lake City Winter Games.
Correct. I grew up in a ski town and instead of a babysitter we had a mountain and went skiing. I spent eight years on the national team and qualified for two Olympics. I’m also a U.S. national champion in giant slalom and slalom. That was my past life.

How did your Olympic experiences form who you are today?
More than anything it reinforced the concept of having passion for something — work ethic as well. You can’t just be good at something. You have to work for it. You can be the best in the world and not win a gold medal.

What fueled your passion to become a nurse?
As a professional skier, I worked with a sports psychologist. He gave me a test that matched personality with potential professional skills. The second he said nursing, I thought, “That’s what I’m going to be!”

What’s great about being a nurse?
Nursing to me is all about privilege. It’s the privilege of caring for someone in their most intimate moments, when they have fear and vulnerability, and trying to delicately manage that and help them through a scary time.

Tell us about “the incident.”
I’m so grateful to be a nurse. I think nursing is the toughest, most inclusive, caring and understanding profession in the world. Nurses reached out to me, not just within my state, region and country, but internationally. People want to make it about me, but it was about the patient and his rights fundamentally. That’s something that I don’t want to overlook. No nurse ever asks for a gold star. We’re not writing the orders — we’re providing the care. It solidified in me that I picked the right profession.

Were you prepared for it?
The aftermath I was not prepared for. [During the incident] I knew when to call and who to call. I also knew my organization would not let me down. They’re not going to put a policy out there that’s fundamentally flawed or illegal. Because of that, I was able to stand my ground. As a profession, we’re obligated — first and foremost, no matter what — to the safety of
our patient. But, we’re also obligated to our license and profession. It was never clearer to me than during this incident that my obligations are parallel.

**How did you cope in the aftermath?**

It took two days to come down emotionally from the incident. I was on the phone with our newly developed Resiliency Center, completely crying, bawling. It was a very emotional letdown, and I recognized that I was now the patient and provider. I had to tell myself, “Alex, you need help. It’s OK to take some time off.” Part of me didn’t want to take time off, because that meant I’d have to deal with it.

“This isn’t scaring people away; it’s making it more magnetizing and more exciting to be a nurse.”

**Did you know how big this would be?**

No. I had no idea. We [nurses] all have a very deep understanding as to what is right and wrong — a moral compass. Everything we do is for the sake of patient safety. That night, after I was released from handcuffs and being arrested, I said to my bosses, “I’m accountable. Tell me what I did wrong so I never do it again.” They said, “Alex, you did nothing wrong.” I felt like I had to have done something wrong to be treated like that. No one deserves to be treated like that when they’ve done nothing wrong.

**Do you consider this an act of workplace violence?**

I was at work, in my scrubs, had a badge on, dutifully protecting my patient. So, yes, technically it was workplace violence. Once I saw how often this happens — workplace violence and violence against nurses — I was comfortable and committed to the pledge that the ANA [American Nurses Association] helped write to stop nurse abuse. A lot of professions are dangerous, so when it comes to workplace violence for nursing, we should be the ones to prevent this and stop it. We have to stand up for ourselves, while keeping in mind that it’s not only about us. One of the things I’m most proud of out of all this was getting letters and posters from a kindergarten class in California; they all wanted to be nurses! It’s about instilling that trust that we have earned for so long and making it so worthy that people want to join our profession. This isn’t scaring people away; it’s making it more magnetizing and more exciting to be a nurse.

**You’re going to speak about your experience this month at the National Teaching Institute & Critical Care Exposition in Boston.**

Yes, on May 24, I will participate in “Protecting Your Practice: A Panel Presentation on Responding to Workplace Violence” and discuss my experience and strategies for building personal resilience.

**How has this impacted the way you practice now?**

When it comes to the actual care I provide and the professionalism, I don’t think that has changed. It’s made what I do more meaningful. It’s stoked the fire. As nurses, there’s the constant ebb and flow of this immense amount of passion, drive and burnout. I’m empowered by this incident. I don’t want to be a half-ass woman standing there with my fist in the air trying to empower the rest of her profession to do what people in my profession already do every single day. From the very beginning, I could never have imagined the amount of support that poured out from nurses all over the world. It resonated with everyone, not just nurses, but nurses stood and took the flag and carried it. As the American Association of Critical-Care Nurses, that’s what we do ... we think critically, right? We’re constantly thinking outside the box about how to bring things to our profession, to our patients. In that critical care context, hopefully I can be successful in making sure this never happens to anyone again. ▼

**Three Lessons From Alex Wubbels’ Experience**

In the aftermath of Alex Wubbels’ headline-grabbing arrest last summer for defending the rights of her unconscious patient, she ignited a national crusade to ensure such an event never happens again.

In her own words, here are three lessons from her harrowing experience:

**For nurses:** “Know your chain of command, and make sure your facility has a policy on how to handle the police’s unwarranted requests for patients’ blood samples. You don’t have to know everything. You don’t necessarily even have to know exactly what the policy says, but you should know that you have one and how to access it. Any nurse should know they’re empowered to stand up and commit to their own moral compass. And you should have the confidence to know that it’s in line with your profession and employer.”

**For hospitals:** “Make sure your institution’s policies are parallel and protect both the patient and the provider. When a nurse must make a split-second decision, in the heat of the moment when a potential life is on the line, they shouldn’t have to worry if they are going to lose their license or job for doing what’s right. Help nurses understand, long before they’re put in that position, that the policy in place is legitimate and lawful.”

**For law enforcement:** “We have to work together to provide care to those that can’t care for themselves or need assistance. We are public service defenders. We are here for our fellow citizens and for the benefit of society. We must figure out how to do that in a cohesive, holistic and compassionate way.”

www.aacnboldvoicesonline.org
Solving the Mystery of How Propofol Works

Propofol is known to potentiate inhibitory receptors in the brain’s sleep/wake circuits, but a study from Australia finds that it also targets neural mechanisms, impairing presynaptic release of neurotransmitters.

“Trapping of Syntaxin1A in Presynaptic Nanoclusters by a Clinically Relevant General Anesthetic,” in *Cell Reports*, finds that general anesthetics propofol and etomidate restrict mobility of syntaxin1A protein on the plasma membrane.

**General anesthesia is sometimes problematic, and some patients wake from surgery with memory loss or other cognitive impairments.**

Conducted on nonhumans at University of Queensland, Brisbane, the study focused on intravenous propofol and etomidate but adds that future research may reveal other general anesthetics have the same effect on syntaxin1A mobility. “In addition to identifying an alternative target process for this widely used sedative, our findings may provide a more complete understanding of general anesthesia.”

Study co-author Bruno van Swinderen, with Queensland Brain Institute, says in a related article in *New Atlas* that the findings show propofol makes surgery possible by disrupting presynaptic mechanisms, which likely affects neuron communications throughout the brain much differently than a sleeping pill. This insight may help explain why general anesthesia is sometimes problematic and some patients wake from surgery with memory loss or other cognitive impairments.

“The discovery has implications for people whose brain connectivity is vulnerable, for example in children whose brains are still developing or for people with Alzheimer’s or Parkinson’s disease,” van Swinderen adds. Additional research may provide a better understanding of how anesthetics affect the brain’s ability to generate consciousness.


HoloLens Augmented Reality Aids Reconstructive Surgery

Surgeons in London successfully tested the wearable HoloLens augmented reality (AR) technology to view overlays of six patients’ internal anatomical structures.

“Through the HoloLens Looking Glass: Augmented Reality for Extremity Reconstruction Surgery Using 3D Vascular Models With Perforating Vessels,” in *European Radiology Experimental*, explains that HoloLens offers the potential to reduce patients’ time under anesthesia as well as adverse events. Using preoperative CT scans to generate internal maps that precisely detail bone, tissue and blood vessel locations, the surgery team targeted the grafted skin placements through three-dimensional imagery displayed on their headsets.

Key points are as follows:

- “Augmented reality can demonstrate subsurface vascular anatomy before incisions are made.
- Manual alignment is sufficiently fast and accurate to guide the operative incision.
- Automated registration would further open access of the HoloLens in clinical use.”

The study explains that “HoloLens proved to be a powerful tool that has the potential to reduce anaesthetic time and morbidity associated with surgery as well as to improve training and provide remote support for the operating surgeon.” In addition, “detailed feedback from the surgical team verified that this new approach is more reliable and therefore considerably less time-consuming than audible Doppler ultrasound, the prevailing standard method of navigation.”

One downside is the required presence of a technical assistant to launch the system and perform preliminary positioning before the surgeons can take over system control. The system also requires an elaborate preoperative transfer of information to produce what is needed to be clinically valuable during the procedure.

Nurses should keep sepsis in mind when observing subtle changes in patients to establish early intervention and improve outcomes.

“CE: Managing Sepsis and Septic Shock: Current Guidelines and Definitions,” in American Journal of Nursing, notes that co-authors and AACN board members Mary Beth Flynn Makic, University of Colorado College of Nursing, and Elizabeth Bridges, University of Washington School of Nursing, assess how the new Surviving Sepsis Campaign (SSC) guidelines and Sepsis-3 definitions help nurses rapidly identify sepsis and treat patients.

“The new guidelines have increased the focus on early identification of infection, risks for sepsis and septic shock, rapid antibiotic administration, and aggressive fluid resuscitation to restore tissue perfusion,” they write.

Definitions from the Sepsis-3 task force emphasize that infection is the trigger for sepsis, and systemic inflammatory response syndrome (SIRS) does not appropriately identify patients with sepsis, because numerous conditions besides infection can cause SIRS. “The Sepsis-3 definitions focus on the understanding that sepsis is a multifaceted patient response to infection and results in dysfunction.” The term severe sepsis is no longer recommended because it’s difficult to identify and doesn’t help guide treatment, and septic shock is now defined as a “subset of sepsis in which the patient has profound hypoperfusion.”

The two primary assessment tools are Sequential Organ Failure Assessment (SOFA), which requires laboratory results, and quick SOFA (qSOFA), an abbreviated organ dysfunction assessment. There is a debate, the article explains, about whether simplifying the terms can aid in early identification, and neither SOFA nor qSOFA is a clinical requirement under the new SSC guidelines. “Bear in mind that the qSOFA score is a predictor of mortality risk and not a defining characteristic of sepsis” and therefore is best used to identify patients at higher risk of organ failure.

New Guidelines Emphasize Early Identification of Sepsis

Guidelines for Using REBOA Strategy

Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA) is a new strategy for treating certain patients with truncal hemorrhage.

“Joint Statement From the American College of Surgeons Committee on Trauma (ACS COT) and the American College of Emergency Physicians (ACEP) Regarding the Clinical Use of Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA),” in Trauma Surgery & Acute Care Open, guides this therapeutic strategy, explaining that “REBOA is indicated for traumatic life-threatening hemorrhage below the diaphragm in patients in hemorrhagic shock who are unresponsive or transiently responsive to resuscitation.” The guidelines address patient indications, complications and management, implementation and provider training.

The statement adds that REBOA is less invasive than resuscitative thoracotomy for non-compressible torso hemorrhage and may be more rapidly applied. It is already standard practice for select patients at a small number of trauma centers where surgeons manage its use.

“Based on published data, best evidence, and expert opinion,” the guidelines include the following:

• REBOA should be performed by an acute care surgeon or an interventionalist trained in the strategy, and protocols should be developed in conjunction with vascular surgery.
   - EMCC (emergency medicine continuous certification) “physicians trained in REBOA must not perform REBOA unless a surgeon is immediately available.”
• An acute care surgeon must be available immediately to address the cause of the hemorrhage to avoid the “complications of truncal and/or spinal cord ischemia from prolonged aortic occlusion.”
• Complications of REBOA include arterial disruption, dissection, pseudoaneurysms, hematoma, thromboemboli and extremity ischemia.


AACN Resources on Sepsis

AACN offers a dedicated sepsis webpage, www.aacn.org > clinical resources > sepsis, which includes Sepsis by the Numbers and links to journal articles, webinars, videos and other resources.

Survey: Healthy Work Environments Can Reduce Moral Distress

Results of an online survey find that critical care nurses with lower moral distress have higher job satisfaction and are more likely to practice in healthy work environments.

“Predictors of Moral Distress in a US Sample of Critical Care Nurses,” in American Journal of Critical Care, notes the results of an online survey of 328 critical care nurses indicating “moral distress was modestly associated with negative perceptions of the practice environment and patient safety. Job satisfaction, practice environment, and the participant’s age were statistically significant predictors of moral distress.”

“Moral distress is a symptom of unhealthy work environments and inadequate supports for critical care nurses,” study author Catherine Hiler, who led the project when she was a doctoral student at Case Western Reserve University, Cleveland, explains in a related article in Medscape News.

Patricia Flynn, a critical care nurse at Long Island Jewish Forest Hills, New York, adds, “We have successfully incorporated aspects of the AACN standards into our practice. Information is disseminated to staff, and safety issues are discussed through daily briefs and huddles. The management team is highly visible on the unit and sponsors an ‘open door policy,’ which allows for real-time communication and resolution of concerns.” She also describes the facility’s Collaborative Care Council, which “empowers the staff to be active participants in any unit decisions and initiatives to improve care, not only for patients but to optimize working conditions for the staff.”

Beth Steinberg, associate chief nursing officer, The Ohio State University Wexner Medical Center, Columbus, “integrates interventions such as mindfulness, yoga and other interprofessional resilience-building activities into the workplace” to help prevent moral distress.


AACN Resources: Beacon Award and HWE Standards

The accompanying study explains that nurses who work in Beacon Award units report less moral distress, although Beacon designation was not a predictor of moral distress frequency. Learn more about the Beacon Award for Excellence at www.aacn.org/beacon. The study also recommends adoption of AACN’s standards for a healthy work environment (HWE), because they are essential to create a work environment that promotes collegial nurse-physician relationships. Learn more at www.aacn.org/hwe.

Nurse Gives Clothing to Discharged Homeless Patients

Oliver Castellanos was concerned when homeless patients were released from his hospital without basic necessities, so he decided to do something about it.

“Homeless Patients Were Being Discharged in Hospital Gowns. So This Miami Nurse Found Them Clothes,” on CNN, explains that Castellanos, a nurse for 30 years at Jackson Health System in Miami, thought of a way to help these patients. He brought some clothing and shoes to work that he had planned to give away and offered it to them instead.

One patient received a pair of shoes to replace the ones he misplaced. “The man smiled and explained that the shoes he was receiving were far better than the ones he had walked in with,” Castellanos notes in the article.

As word of his efforts spreads, so does the inventory of clothing, shoes and accessories. Donations from co-workers, members of his church and others keep being added to a fully stocked hospital closet. “My mission resonates with others,” he says. “People contribute because it means they have a hand in bettering the community. They feel like they are doing something tangible to help others.”

Castellanos adds, “We are all human beings, all brothers and sisters. We have to help each other out.”

As word of his efforts spreads, so does the inventory of clothing, shoes and accessories.
Demanding work schedules are associated with nurse fatigue, a crisis in many healthcare workplaces.

“Position Statement: Reducing Fatigue Associated With Sleep Deficiency and Work Hours in Nurses,” in Nursing Outlook, acknowledges that shift work and long hours can take a toll on nurses’ health and affect patient safety.

The risk extends beyond the workplace to errors at home and drowsy driving. The AAA Foundation for Traffic Safety notes that less than four hours of sleep within 24 hours increases the risk of a crash 11.5 times.

Employers need to recognize the role of nurse fatigue on patient safety, turnover, absenteeism and related costs. The position statement, from the American Academy of Nursing, adds that accountability falls on everyone, including nurse managers, who need to consider scheduling practices, provide education that promotes sleep health and adjust demands that can contribute to nurses having unhealthy schedules. Nurses should also try to avoid long shifts and overtime, if possible.

“As a supervisor, I will not hesitate to adjust a schedule within 24 hours out when a nurse confides in me she is struggling,” says Megan Brunson in a related article on americanmobile.com. Manager of the cardiovascular ICU and night shift supervisor at Medical City Dallas Hospital, Brunson understands the risks associated with nurse fatigue. “Being responsible for the night shift schedule, I will contact them after reviewing their requests, if I see they signed up for too many shifts or shifts every other night. This will bring the conversation forward and allow me to chat about their concerns and mine.”

Besides adjusting work and travel schedules as needed, paying attention to signals that your body gives you is important. The related article references further research noting that 20-minute naps can improve alertness. For more information, read “How to Sleep Better: 10 Tips for Nurses,” on travelnursing.com.


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Animal-assisted intervention (AAI), and other nonpharmacological intervention programs, may help patients feel better and take an active role in their recovery.

“Animal-Assisted Intervention in the ICU: A Tool for Humanization,” in Critical Care, notes several factors for a successful AAI program:

- Have a champion consistently present in the ICU
- Develop program goals with milestones and measurable outcomes
- Include stakeholders who can help identify and overcome any barriers to implementation
- Partner animal teams with organizations that have experience training teams for the hospital environment
- Establish a policy with goals, roles/responsibilities and the logistics for animal visits
- Launch “the program with patients who have a high likelihood of success”

A related article in NIH News in Health notes that the National Institutes of Health (NIH) partnered with Mars Corp.’s WALTHAM Centre for Pet Nutrition to determine how pets can decrease people’s stress, improve heart health, and help children with their emotional and social skills.

Now in its 10th year, the NIH/Mars Partnership funds studies that examine people’s relationships with animals. For example, studies are examining how animals may influence child development, including interactions with children who have autism, attention deficit hyperactivity disorder or other conditions.

“There’s not one answer about how a pet can help somebody with a specific condition,” explains Layla Esposito, who oversees NIH’s Human-Animal Interaction Research Program. “Is your goal to increase physical activity? Then you might benefit from owning a dog ... If your goal is reducing stress, sometimes watching fish swim can result in a feeling of calmness. So there’s no one type fits all.”

AACN CSI Academy at NTI — Empowering Nurses as Leaders

Attendees at this month’s NTI in Boston have the opportunity to experience essential program content and key learnings from AACN CSI Academy, the nurse leadership and innovation training program. Sessions are relevant for direct care nurses and nurse managers/educators.

Preconference

“AACN CSI Academy: Creating and Sustaining Change on Your Unit”

This all-day session led by CSI Academy faculty and alumni teaches key concepts from the CSI program using real-world quality-improvement methods and tools to further elevate staff nurses’ knowledge and expertise — enabling successful implementation of patient care improvement initiatives and true influence at the bedside.

CSI Faculty-led Concurrent Sessions

For nurses seeking to initiate positive change on their unit, CSI Academy faculty will present four different concurrent sessions, one each day, focused on a distinct element of the change process. The innovation tools and skills gained enhance nurses’ leadership abilities and instill the confidence to successfully implement change.

• “AACN CSI Academy: Creating a Foundation for Change”
• “AACN CSI Academy: Creating the Business Case for Quality”
• “AACN CSI Academy: Creating Buy-in for Change”
• “AACN CSI Academy: Sustaining and Spreading Change”

An additional session for those on the nurse manager track will be presented:

• “Nurse Manager Skills for Creating and Sustaining Change”

CSI Alumni-led Concurrent and Expo Ed Sessions

Learn more about unit-based quality-improvement initiatives and the benefits of empowering front-line nurses as leaders.

• “Advocating From Bedside to Capitol Hill: Nurse in Washington Internship” (ExpoEd)
• “CSI: Collaborative Participation From Area Hospitals to Decrease Delirium” (Concurrent)
• “CSI: Your Stay, Your Story” (concurrent)
• “Keep Calm and Stop the Clot” (concurrent)

• “Massachusetts CSI Nursing Collaborative: Hospitals Working Together to Improve Patient Outcomes” (ExpoEd)
• “Oh the Places You Will Go: Developing, Sustaining and Scaling a Frontline Nurse-led Improvement Initiative” (ExpoEd)
• “Teamwork Leads to Dreamwork” (concurrent)

To learn more about these and other activities at NTI, visit www.aacn.org/nti.

Editorial Consults and Other Publishing Events at NTI 2018

If you’re curious about publishing opportunities with AACN, NTI sessions and events can help. Among them is the opportunity for one-on-one consultations with journal editors.

Sunday, May 20, 4-5 p.m., attend a focus group to share your opinions on AACN Advanced Critical Care (ACC), our symposium-based quarterly journal. Sign up by emailing aacnacc@aacn.org. Participation is available to the first 30 people who reply. Snacks and incentives will be provided.

Monday, May 21, 12:15-1:15 p.m. in room 151A, meet the editors of the American Journal of Critical Care (AJCC), Critical Care Nurse (CCN) and ACC for “Publishing in AACN Critical Care Journals,” a Q&A panel. They will introduce the journals and answer general publishing-related questions.

Tuesday, May 22, 10:45-11:45 a.m., Rich Savel, AJCC co-editor-in-chief
Tuesday, May 22, 11:45 a.m.-12:45 p.m., Grif Alspach, CCN editor
Wednesday, May 23, 10:45-11:45 a.m., Cindy Munro, AJCC co-editor-in-chief
Wednesday, May 23, 2:30-3:30 p.m., Mary Fran Tracy, ACC editor

If you’re interested in further consultation about your publishing ideas, a limited number of one-on-one consultations will be available. Sign up outside room 151A after Monday’s Q&A session or during exhibit hours at publishing booth #2115.
To remain at the forefront of expanding evidence-based practices in all aspects of critical care, facilities must include teleICUs.

In 2013, AACN first defined standards for the emerging telenursing practice in the ICU and has recently published an update, “AACN TeleICU Nursing Practice: An Expert Consensus Statement Supporting High Acuity, Progressive and Critical Care.”

The new consensus statement, which creates a framework for implementing and evaluating teleICU nursing practice, addresses the new findings in this fast-growing area of healthcare. It also establishes a model for achieving excellence and optimal patient care outcomes through the following:

- Shared knowledge and goals
- Mutual respect
- Skilled communication
- True collaboration
- Authentic leadership
- Optimized technology
- Practice excellence

A 12-person task force, including teleICU nurse leaders, contributed to the statement and brought a fresh perspective to this area of practice.

Task force co-chair Pat Herr, clinical integration director of eCARE ICU at Avera Health, says it was important to harness the energy and lessons learned from experienced teleICU leaders.

“TeleICUs continue to evolve to meet the needs of patients and health systems,” Herr adds. “New technology options and new partnership models are available, and nurse leaders play an important part in using these tools to improve patient care.”

Opportunities in teleICU are one way to retain knowledgeable nurses, who can bridge clinical expertise gaps and provide an additional layer of skilled critical care. TeleICU care ensures delivery of both optimal patient outcomes and timely knowledge to support the bedside care team.

Task force member Lisa-Mae Williams, operations director of telehealth and eICU at Baptist Health South Florida, says telemedicine doesn’t mean fewer jobs for bedside nurses; it’s an extra set of eyes to support a clinical workforce that may be stretched thin.

“At the bedside, when teleICU came to my unit I was very skeptical,” Williams recalls. “But after seeing for myself what those extra nurses brought to the table — the available technology and time they had to assess trends and really delve into what’s going on — it turned out to be the best tool to care for our patients.”

In addition to knowledge gaps, nurse turnover is on the rise, according to “2017 Survey of Registered Nurses: Viewpoints on Leadership, Nursing, Shortages and Their Profession,” from AMN Healthcare, San Diego. The survey also finds that more than one in four nurses plan to retire within a year, and 73 percent of baby boomers expect to retire in three years or less.

The shortfall is already more pronounced in rural hospitals facing staffing challenges and in specialty areas where additional education, training and experience are critical to improve patient safety and outcomes.

The expertise and dynamic, front-line viewpoint of teleICU experts has resulted in a comprehensive, patient-centric update. Their experience delivering both bedside and remote care was instrumental in developing valuable clinical scenarios. The scenarios in the statement are genuine examples of how each key recommendation is implemented to provide continuity of care; identify high-risk patients; and decrease mortality rates by filling gaps in monitoring and staff expertise.

As a leader in the delivery of evidence-based practices, AACN offers CCRN-E specialty certification for nurses who primarily provide acute or critical care for adult patients in a teleICU setting, which is connected to the bedside via audio-visual communication and computer systems. Learn more at www.aacn.org > Certification > Get Certified > CCRN-E (Adult).

The consensus statement is available for AACN members to download or to purchase a hard copy at www.aacn.org/nursing-excellence/standards/aacn-teleicu-nursing-consensus-statement. Nonmembers can receive a free download by signing onto the website with their name and email address.
An Insider’s Guide to a Healthier, More Delicious NTI Boston

With the National Teaching Institute & Critical Care Exposition (NTI) back in Boston this month, we turned to a local for insider tips on how to make your conference downtime fun, healthier and more delicious.

Who better to act as our guide than the only 2018 AACN Circle of Excellence awardee from Massachusetts — Jason Thornton.

Jason, director of nursing and patient services for the Cardiac ICU and Cardiovascular Operating Room at Boston Children’s Hospital, earned the award in part for his DNP capstone project to develop a specialty benchmark for healthy work environment scoring in pediatric cardiovascular operating rooms. His work is based on the AACN Healthy Work Environment Assessment Tool. He’s also a member of a Boston CrossFit gym and fitness team. So, he knows the importance of work-life balance and has some wicked-cool insider recommendations for attractions to see, exercising in town and dining options beyond convention center food.

“It’s always such a hard thing to eat healthy and work out when you travel and go to conferences,” says Jason, a six-time NTI veteran.

Here are his picks to share with NTI 2018 Boston attendees; all sites are located in Boston (sorry, sitcom fans — the Cheers bar didn’t make the cut).

### Best Fine Dining
- Del Frisco’s Double Eagle Steakhouse (Seaport District on Liberty Wharf — 0.3 mile from the convention center) 250 Northern Ave., Suite 200
- Ocean Prime (Seaport District — 0.6 mile) 250 Northern Ave., Suite 200
- Strega Waterfront (Seaport District on Fan Pier — 0.9 mile) 1 Marina Park Drive

### Best Family Dining
- Durgin-Park Market Dining Room (downtown at Faneuil Hall Marketplace — 1.3 miles) 340 Faneuil Hall
- Best Bar With a View
  - Top of the Hub (top of the Prudential building in the Back Bay — 2.5 miles) 800 Boylston St.
- Best Casual Seafood
  - Legal Sea Foods – Harborside (Seaport District on Liberty Wharf — 0.4 mile) 270 Northern Ave.

### Best Clam Chowder
- Legal Sea Foods – Copley Place (Copley Place in the Back Bay — 1.9 miles) 100 Huntington Ave.

### Best Hot Dog/Sausage
- The Sausage Guy (Fenway Park — 3.8 miles) 49 Lansdowne St.

### Best Lobster Roll
- Row 34 (Seaport District/Fort Point — 0.4 mile) 383 Congress St.

### Best Farmers and Public Markets
- Boston Public Market (downtown, indoors year-round — 1.4 miles) and the seasonal Dewey Square Farmers Market (Rose Kennedy Greenway, outdoors Tuesdays and Thursdays) 100 Hanover St.
- Quincy Market & Food Colonnade (downtown at Faneuil Hall Marketplace — 1.3 miles) 206 S. Market St.

### Best Latin Food
- La Casa de Pedro (Seaport District — 0.5 mile) 505 Congress St.

### Best Sweet Treat
- The Boston Chipyard cookies (downtown at Faneuil Hall Marketplace — 1.3 miles) 257 Faneuil Hall
- Best Place to Fill Your Fridge, Cooler or Lunch Box
  - Whole Foods market (South End — 1.4 miles) 348 Harrison Ave.

### Best Places to Walk, Jog or Run
- Boston Waterfront/Harborwalk (Seaport District — 0.5 mile). Start at Seaport Blvd. to Atlantic Avenue and the Wharf District for an approximate 2.5-mile loop.
  - Charles River paths (Back Bay and Cambridge — 2.5 miles). Start at the Museum of Science, and take the Massachusetts Avenue Bridge on the paved sidewalk around the Charles River for a 3.5-mile loop.

### Best Tourist Experiences
- Fenway Park Tour (2.9 miles) 4 Yawkey Way
- Boston Duck Boat Tours (Prudential Center — 2.2 miles) 53 Huntington Ave.
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