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83% of unit leaders saw an increase in recognition of stability changes in their patients after their new nurses completed ECCO

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‘Turning people blue with the food coloring in tube feeds’

AACN’s Facebook community weighs in on a recent poll question: What’s the biggest change in technology you’ve seen in your career?

**Gail Pike Boston** So many things that I feel like we were in the dark ages. I remember letting people infarct under supervised care. The advancement of cardiac interventions amazes me! Still is amazing me!

**Lora Porter** Manually wrapping an IABP in heparin solution at the bedside, using first generation balloon catheters to using 1st generation stents. Literally holding up OR to perform a PTCA with everyone on standby. Wow! Lots of changes!

**Becky Potapa Gallinger** Sitting in a patient’s dark room on the night shift with a flashlight and the chart trying to decipher the handwriting of progress notes. Having an order sheet on the bedside table and adding interventions to it and the docs would sign it when they rounded in the morning (oops, we kinda practiced medicine). Mixing our own K+ replacements using the little vials that were stored near the saline and sterile water vials! Working with and learning from some of the most amazing senior nurses on earth (like some who have posted their memories here). Their experience was respected and sought after. I miss those days.

**Ruth Walton** Monitors. When I started in 1972, screens had little green blips bouncing across them. To determine the number of PVC’s/minute, you had to run a minute strip and count by hand. If the pt had >6/min, they would receive a 75mg bonus of Lido and be put on a drip. Ah ... the good old days ... NOT.

**Cristall Short** ICU had one nurse in a room with 4 rotobeds, each patient with a ventilator. The nurse sat in the middle of the room SMOKING while she cared for them and wrote on the 4 huge paper charts.

**Rocky LaRochelle** Placing Cantor tubes with a weighted bag of mercury on the end to help advance the tube through the GI system. Yikes!

**Sonya Moreau** The size of the air compressor used for SCD stockings. They used to be the size of a tool box, and were kept on the floor! I can remember having to be careful when lowering the bed, not to land on it and crack the housing LOL.

**Dawn Blake Holmes** The intraaortic balloon pump that looked like a ping game. Who remembers the big green kontron?

**Jennifer Peters** Yes ... I remember. I started ICU in 1973. Wow … things have Certainly Changed!!!!

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Let me tell you something I know: Patients need nurses. OK, I know a few other things. Our healthcare system also needs nurses. It needs us not only to care for patients, but also for something nearly as important. It needs us to shape the future of healthcare.

Now these two things seem obvious to me. Yet I think we can sometimes fall into a trap of believing what we have to offer isn’t valued. We’re overwhelmed with the chaos of our day-to-day reality. Hospital mergers. Staff cutbacks. Nursing shortages. It seems like that’s all we hear about these days. I recently read a survey that said 48% of RNs — just about half — believe the nursing shortage is worse today than it was five years ago. Almost as many — nearly 40% — believe they don’t have enough one-on-one time in their shift to spend with patients.

Aren’t you tired of these daunting statistics about our profession? I am. I think we need to hear some good news. We are the largest workforce in healthcare today. There are an estimated 4 million registered nurses in the United States. We are the fifth largest profession in the nation.

In this country, it’s estimated that there are over 500,000 acute and critical care nurses — and nearly 125,000 are members of our AACN community. 

Talk about Our Voice, Our Strength! Think about the strength of half a million acute and critical care nurses.

Through my travels this year, I heard many great stories of nurses. Powerful stories where nurses are using their voice to change the future of their practice — and the future of healthcare. Our words and actions radiate possibility.

As I reflect, I realize that I learned so much from all of you. Here are four important lessons you taught me that I think we can leverage as we use Our Voice, Our Strength to reinvent our future.

First, we must be united in our efforts. Together, nurses are nearly 30 million globally — and almost 4 million here in the United States. We are strong and fearless — and our voice is proud and courageous.

Next, we need to be clear about our unique contribution. Nurses consider all aspects of the patient: body, mind and spirit. We assess, analyze and intervene with large and subtle changes in condition. We educate the patient and their family. We are the orchestrators of the care they receive. Let’s strive to be fierce and diligent in protecting our role in the healthcare system.

Third, we need to engage and collaborate with our partners and colleagues in healthcare. Very little gets done in our work without the collaboration of many others on our teams.

Last, and I think most importantly, we must never forget our true north: the needs of patients and families. We are the voice for the voiceless — and creating the future is in our power.

Let me know how you are creating the future at OurStrength@aacn.org.
AACN’s Scope and Standards for Progressive and Critical Care Nursing Practice

This new publication includes advances in scientific knowledge, clinical practice and technology for progressive and critical care nurses.

“AACN Scope and Standards for Progressive and Critical Nursing Practice” is now available in AACN’s online store. A free downloadable PDF is also available, after you sign in.

The new scope and standards incorporate advances in scientific knowledge, clinical practice, technology and other changes in the dynamic healthcare environment.

“Nursing care reflects an integration of knowledge, skills, abilities, experience and attitudes to meet the needs of patients and their families,” says Julie Miller, AACN clinical practice specialist. “Healthcare reform and the Affordable Care Act, the national emphasis on the provision of safe and quality care, and pay-for-performance incentives all contribute to the ever-changing healthcare environment, affecting the climate in which nurses work. The challenge to nursing is to remain flexible in response to the increasingly complex needs of our patients.”

The scope and standards describe and measure the expected level of practice and professional performance for progressive and critical care registered nurses and articulate the contributions of progressive and critical care nursing to a patient- and family-centered healthcare system.

Among the features are exemplars written by task force members to demonstrate how the standards guide practice in real-life scenarios. Factors contributing to an unhealthy work environment and strategies to make work environments healthier are also discussed.

A must-have resource for all nurses practicing in any progressive or critical care setting, this up-to-date guide offers a practical tool for students, faculty, nurses in practice, members of the interprofessional team and other nursing colleagues.
Celebrating 15 Years of Progressive Care Nursing

Today and over the last decade-and-a-half, certification validates progressive care nursing practice.

This year marks the 15th anniversary of progressive care specialty certification. Progressive care has come a long way during that time.

“I was at the National Teaching Institute in Orlando in 2004, the first year they offered PCCN certification,” says Paula Staples, an RN on a cardiovascular stepdown unit. “It was a pencil-and-paper test — best $50 I ever spent.”

The concept of progressive care emerged in the 1970s — focusing on patients with myocardial infarction who needed cardiac monitoring — and has since expanded to describe acutely ill, moderately stable patients who require frequent monitoring and intervention, and have different acuity and care needs than patients admitted to ICUs and medical-surgical units.

By 2001, the number of progressive care units (PCUs) had skyrocketed. That year, AACN assembled a task force and advisory panel to collect data and better understand PCUs and PCU nurses.

Three years later, AACN Certification Corporation launched its adult PCCN specialty certification program, which continues to validate progressive care nurses’ knowledge against national standards of nursing excellence. The PCCN Test Plan, based on a study of practice, defines the progressive care patient population and related nursing competencies.

Ambassador for Progressive Care

Michele Trinka, assistant clinical professor at Texas Woman’s University, Denton, teaches a combination of critical care and progressive care to nursing students who train at Parkland Memorial Hospital in Dallas, and has volunteered as a PCCN exam item writer.

Fifteen years ago, she saw the new certification and knew it was a good fit. She still conveys that same enthusiasm for PCCN specialty certification to her students.

“They ask what my ‘letters’ mean, which starts a conversation about how great progressive care units are,” Trinka says. “I remind them that certification elevates them above the average nurse and shows dedication and commitment to the level of care they provide.”

Progressive Care Today

Today, progressive care refers to a specific level of care required by acutely ill patients based on factors including their acuity, stability and complexity. These high-acuity patients generally require an increased intensity of nursing care and surveillance. The unpredictability of a progressive care patient’s condition involves a specialized set of nursing skills.

PCU by Any Other Name

Although the progressive care population has similar high-acuity care needs, PCUs often go by different names, such as intermediate care unit or stepdown unit.

“I began my career over 30 years ago in a telemetry unit. We did not call...
Care Certification

It progressive care back then,” Orser recalls. “I quickly learned and developed my assessment skills, critical thinking and time management in that unit.”

PCCN-K Credential Debuts in 2016
Since the launch of the PCCN certification program, many progressive care nurses have transitioned to roles influencing patient outcomes by sharing their unique clinical knowledge and expertise rather than providing care directly.

In 2016, AACN Certification Corporation debuted the PCCN-K certification program, which recognizes nurses who practice as progressive care knowledge professionals influencing the care delivered to acutely ill adult patients, in roles such as educator, researcher, administrator, care coordinator or manager, in settings including hospitals, health networks and nursing schools.

“As a nursing educator, I tell my students that PCCN certification proves your knowledge and gives you recognition for it,” Trinka tells us. “And it doesn’t hurt on your resume.”

Today, nearly 20,000 nurses hold PCCN or PCCN-K certification. To learn more about AACN’s adult progressive care credentials and eligibility requirements, visit www.aacn.org/certification.

Prepare With Confidence: PCCN and PCCN-K Exam Prep Resources
Are you considering PCCN or PCCN-K certification? Is the prospect of where and how to begin preparing for your exam a bit overwhelming? To help you build a solid foundation for success, AACN offers a variety of resources to help you prepare for your exam.

• Test Plan
The test plan (or exam blueprint) breaks down content areas and assigns a percentage indicating how each topic area is weighted on the exam. Test plans are your go-to exam resource and should be reviewed thoroughly as part of your preparation process. Find the PCCN and PCCN-K test plans in the exam handbook for each program, available on AACN’s website at www.aacn.org/certification.

• Practice Questions
Use “Practice PCCN/PCCN-K Exam Questions” to gauge your exam readiness and boost your test-taking confidence. The booklet aligns with the current test plans and includes 120 questions with rationales for correct and incorrect answers.

• Self-Assessment Exam (SAE)
The online PCCN/PCCN-K Self-Assessment Exam includes 75 items, aligns with the current test plans and offers 90 days of access, plus rationales for correct and incorrect answers and score reporting by content area upon completion.

• Review Course
A PCCN/PCCN-K certification review course is available through the AACN online store. Presented by nationally recognized subject matter experts, the web-based course aligns with the current test plans, provides an in-depth review and includes test-taking tips.

• Exam Bibliography
The exam handbook for each credential includes a list of references used by the exam item writers to validate correct answers. You may find it helpful to review some of these sources as you prepare.
Three review articles in this month’s Critical Care Nurse (CCN) offer guidance that you can apply to your nursing practice.

DeKeyser Ganz addresses the challenge of providing end-of-life care during an ICU admission. A review of the literature suggests strategies such as increasing communication with families, offering bereavement care and ensuring that nurses have access to emotional and educational support.

Miller-Hoover reviews guidelines and recommendations for the assessment and management of sedation and pain in pediatric patients. This article emphasizes the nurse’s role in monitoring to ensure comfort and guard against adverse events.

Dirkes and Kozlowski review the multisystem consequences of immobility and describe strategies for making early immobility less cumbersome, including the use of assistive equipment and intraprofessional collaboration.

Knowing that immobility contributes to pressure injury and ICU outcomes, does the presence of a pressure injury on admission predict patient outcomes? McGee et al. retrospectively examined 2,723 ICU admissions, finding that the presence of a pressure injury on admission was associated with a longer length of stay and an increased risk of mortality. The authors conclude that pressure injury might be a factor to consider in patient prognosis.

Online-only articles include “Reversing Direct Oral Anticoagulants in Acute Intracranial Hemorrhage,” by Nestor and Boling, which provides information to care for patients who take direct oral anticoagulants, including strategies for reversal of anticoagulation in the event of acute intracranial hemorrhage.

Also online, learn more about the experiences of surrogate decision makers for chronically critically ill patients by reading a qualitative study by Moss et al.

The online article by Kenedi et al. reports on a randomized trial with 104 patients with stroke and trauma that examines the impact of access to water and ice on clinical outcomes. No significant differences were found between the control and intervention groups.

Read the full text of these articles and more in June’s CCN.
Although pulmonary arterial hypertension (PAH) remains chronic and incurable, advanced intensive care is warranted when recovery or lung transplantation is the goal.

“Intensive Care, Right Ventricular Support and Lung Transplantation in Patients With Pulmonary Hypertension,” a research article in European Respiratory Journal, explains that intensive care for these patients involves monitoring cardiac function and addressing factors associated with heart failure, carefully managing fluids and reducing ventricular afterload.

Central venous oxygen saturation and central venous pressure measurements are recommended for monitoring patients with severe right ventricular failure. Patients with low cardiac output will require dobutamine and milrinone for inotropic support. Norepinephrine and vasopressin are recommended for patients with low systemic vascular resistance.

Extracorporeal membrane oxygenation or extracorporeal life support may be a bridge to lung transplantation or to recovery for patients with a reversible cause of right-sided heart failure. However, if treatment goals are not realistic, “advanced intensive care will be futile and should be replaced by best supportive care,” the article explains.

Acknowledging that the topics addressed lack scientific data from large clinical trials, the article notes that most statements and recommendations are based instead on clinical experience and expert consensus. It suggests that future studies should try to develop new drugs to improve PAH and find new ways to support the failing right ventricle.

“Future devices will allow an extended use of extracorporeal or intracorporeal support systems, even in outpatients, like the use of left ventricular assist devices in patients with left-sided heart failure,” the article suggests. It’s unknown whether these devices could someday eliminate the need for lung transplantation.

“For the time being, lung transplantation remains an important treatment option for patients with otherwise refractory PAH,” the article adds. ▼

Tips to De-escalate Dangerous Work Situations

Managing negative incidents in healthcare settings starts with understanding that violence and harassment should never be tolerated.

“Verbal De-escalation for Clinical Practice Safety,” in American Nurse Today, notes that many nurses face workplace violence from patients or families but don’t ask for help or report it, because they believe harassment is inherent in the job.

If nurses encounter violence or harassment at work, following are some of the strategies that can help de-escalate the situation:

• Take a deep breath. Maintain relaxed body language and a measured tone and volume of voice.
• Designate a primary communicator who is responsible for directing the conversation, so the patient is not overwhelmed by multiple staff members.
• “Offer the patient realistic choices when possible.”
• Repeat what the patient or family member says, so they know they’ve been heard, and be sure you understand the issues. “Tell me if I have this correct…”
• Avoid arguing but set boundaries. “I know you want to go home today, but please don’t yell at the staff. We want to help you.”
• Plan an escape route from the patient’s room.
• “Don’t hesitate to get help. Keep yourself safe.”

Several strategies can help nurses handle violence or harassment at work.

AACN Resources for Healthy Work Environments

In AACN’s 2018 Healthy Work Environment (HWE) National Workforce Survey, nurses reported experiencing a total of 198,340 negative or violent incidents within the year preceding the survey, mostly associated with patients and family members. Knowing effective de-escalation techniques can help protect nurses and patients. An AACN on-demand webinar, “Bullying in the Workplace: It Harms More Than the Bullied,” offers suggestions on improving lateral (staff-to-staff) behavior. And there are extensive resources on AACN’s HWE webpage, www.aacn.org/hwe, on how to establish and sustain an HWE.

Mupirocin applied to multiple body sites proved effective in short-term decolonization of Staphylococcus aureus (SA) in a study of infants in neonatal intensive care units (NICUs).

According to “Mupirocin for Staphylococcus aureus Decolonization of Infants in Neonatal Intensive Care Units,” in Pediatrics, topical application of the antibiotic cream achieved decolonization of SA in 94% of infants within eight days and remained effective in 46% of patients after 22 days. Mupirocin was “safe and efficacious in eradicating SA carriage among infants in the NICU; however, after 2 to 3 weeks, many infants who remained hospitalized became recolonized,” the study explains.

The infants (24 months or younger) across eight study sites were randomly selected for either five days of mupirocin applied in the nasal, umbilical and rectal areas, or no treatment. The treated infants’ main adverse effect was a much higher likelihood of mild rashes.

Whereas 62 of 66 treated infants achieved primary decolonization (as of day eight), only three of the 64 untreated infants (4.7%) did. Of the infants who were still hospitalized at day 22, 21 of the 46 treated infants achieved persistent decolonization, while only one of the 48 untreated infants (2.1%) did.

Mupirocin eradicated SA in NICU patients, but many hospitalized infants were recolonized within two to three weeks.

Mupirocin Effective Against Staphylococcus aureus for Many NICU Patients

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World Health Organization Says Challenges Demand Attention

This year, the World Health Organization (WHO) began a five-year strategic plan to ensure more people benefit from universal health coverage, are protected from health emergencies and have better health and well-being.

WHO’s plan, the 13th General Programme of Work, requires addressing numerous challenges, according to “Ten Threats to Global Health in 2019,” on www.who.int.

- **Air pollution and climate change.** Air pollution is considered the greatest environmental health risk, contributing to 7 million premature deaths annually.
- **Noncommunicable diseases.** Diseases such as diabetes, cancer and heart disease cause more than 70% of deaths worldwide.
- **Global influenza pandemic.** Another influenza pandemic is expected; the questions are where, when and how severe.
- **Fragile and vulnerable settings.** More than 1.6 billion people live in areas affected by drought, famine, conflict and weak health services.

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• Data reveals an overall 13% decline in HACs from 2014 to 2017.
• At 37%, *Clostridioides difficile* infections declined the most.
• CMS hopes for a 20% reduction in HACs from 2014 to 2019.
• This goal could result in 1.8 million fewer HACs — about 53,000 fewer deaths.

National patient-safety initiatives averted about 910,000 hospital-acquired conditions (HACs) from 2014 to 2017, preventing about 20,500 deaths and saving $7.7 billion in healthcare costs.

“AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014-2017,” from the Agency for Healthcare Research and Quality (AHRQ), reveals an overall 13% decline in HACs during that period. *Clostridioides difficile* infections declined the most at 37%.

Most other types of HACs also decreased, including adverse drug events (28%), postoperative venous thromboembolisms (17%) ventilator-associated pneumonias (13%), central line-associated bloodstream infections (6%), catheter-associated urinary tract infections (5%) and falls (5%). However, pressure ulcers/pressure injuries increased 6%, according to data released in conjunction with the Centers for Medicare & Medicaid Services (CMS).

“The updated estimates are a testament to the successes we’ve seen in continuing to reduce hospital-acquired conditions,” AHRQ Director Gopal Khanna notes in an AHRQ media release. “There’s no question that challenges still remain in addressing the problem of hospital-acquired conditions, such as pressure ulcers. But the gains highlighted today were made thanks to the persistent work of many stakeholders’ ongoing efforts to improve care for all patients.”

Looking ahead, CMS hopes for a 20% reduction in HACs from 2014 to 2019, a goal that could result in 1.8 million fewer HACs, about 53,000 fewer deaths and $19.2 billion in hospital savings, the release adds.

To help nurses and other front-line clinicians combat specific, frequently occurring HACs and other adverse events, AHRQ offers “AHRQ Tools to Reduce Healthcare-Acquired Conditions.” ▼
An AACN past president, professor emerita at the University of Alabama at Birmingham (UAB) School of Nursing, a nationally recognized expert in cardiovascular surgical nursing, and an award-winning researcher, Marguerite R. Kinney Handlin has been a guiding light of nursing throughout her career. She’s received the UAB President’s Award for Excellence in Teaching, was inducted into the Alabama Nursing Hall of Fame, was honored by the American Heart Association as one of four Pillars in the Field of Cardiovascular Nursing and presented with the Katharine A. Lembright Award for Excellence in Research. And, in 1997, AACN established the Marguerite Rodgers Kinney Award for a Distinguished Career to recognize outstanding careers in nursing.

What led you to become a nurse?

This question makes me take a really long look in my rearview mirror, but I can’t remember ever thinking I wanted to do anything other than nursing. My Aunt Marguerite — for whom I am named — was a leader in her hospital in St. Albans, Vermont, and I recall some of her stories that probably had a big influence on my thinking even at an early age.

What impact has nursing made on you and on the lives of others?

My mother was hospitalized many times while I was growing up, and I saw nurses in action and thought that was a special thing to do. I have loved hearing stories at NTI about the impact critical care nurses have had on so many lives, and you know those accounts have been lived over and over by so many people around the world. Nurses are the backbone of the healthcare system, and our impact cannot be underestimated.

How did critical care nursing come into the picture for you?

Critical care units were not part of the typical hospital structure when I became a nursing student in 1957. Therefore, there was no opportunity to have a clinical rotation there, and the closest we came was an assignment in the recovery room. I was very fortunate to arrive in Mobile, Alabama, in 1969, at the same time a cardiac surgical program was being planned, and I was asked to join the team and organize the nursing component. It was a game changer for me, and I was hooked!

I remember nurses at the hospital asking why I would want to take care of critically ill patients, and the answer was always easy: I could know everything (almost) about one or two patients instead of knowing very little about 10 or 20 patients on a typical nursing unit. Also, I recalled an assignment as a nursing student to care for a teenage boy who had been shot in the abdomen in a hunting accident and had a severe case of peritonitis. I was in his room all by myself with a thermometer, a blood pressure apparatus (the old-fashioned kind), my watch for checking his pulse and a urinary catheter. I realized then how little I could know about his condition with what I had to work with, and in our critical care unit we could do so much more than watch and pray.
How has critical care nursing remained unchanged, and what has endured?
While medical interventions and the technology have certainly become more sophisticated, nursing’s focus on the patient and family has remained steadfast. Providing safe, quality care is a goal that will never change.

How did you first learn about AACN?
My introduction to AACN was the 1974 NTI. I had just completed my doctoral studies at the Catholic University of America in Washington, D.C., and moved to Birmingham to join the faculty at UAB and coordinate the graduate program in cardiovascular nursing. Along with some of my students, I went to New Orleans and was literally blown away by being among 2,500 nurses eager to learn and amazing faculty eager to teach. The big topics were heart sounds, rhythm disturbances and lung sounds. Like every NTI I have attended since then, the atmosphere was electric and the opportunities for networking were endless. I knew then that AACN had much to offer me in my teaching and much to offer my students as well.

Was there a specific experience that cemented your relationship with AACN and led you to become actively involved in the association?
A former student nominated me for a position on the board of directors and, while I was very flattered, I never really thought I would be elected. Attending my first board meeting was a real eye-opener into what a special organization this is. I learned that a firm foundation had been put in place by the founders, and the current group of leaders thought the sky was the limit in what AACN could accomplish on behalf of critical care nurses. I certainly wanted to be a part of something with so much promise.

How has your involvement with AACN influenced your professional and personal lives?
My involvement with AACN brought many amazing opportunities that I would not otherwise have had. I traveled broadly both here in the United States and internationally, and learned a great deal from those I met. I was introduced to the world of book and journal publishing, which was a large part of my professional life for a long time.

But the best thing about being a part of AACN was and still is the people I met along the way who shared the passion about the association’s opportunities to impact how care is delivered to our patients. It makes me very proud that four of my graduate students found such a passion for AACN that they are now former presidents of the association, and three others were elected to the board of directors.

What values come to mind when you think of AACN?
AACN’s core values reflect its history, tradition and culture, and include ethical accountability in everything the association undertakes — grooming the next generation of leaders, collaboration with all its stakeholders and innovation in its approach to doing business. These values have served the association well over the past 50 years and will continue to guide AACN into the next 50 years.

Were you surprised to have an award named for you?
I remember as though it was yesterday receiving the phone call from my friend and colleague Ramón Lavandero telling me that the board of directors had just created an award to recognize outstanding careers in nursing and healthcare, and that the award would be named for me, and I was to be the first recipient. Overwhelmed would be a gross understatement. I am truly humbled by this recognition, especially as I have witnessed the incredible recipients of this award over the years and their considerable influence on the healthcare landscape.

Using your magic wand, what would you change about nursing today?
While I am not sure about what should change about nursing, I do think nursing is certainly doing something right, as a Gallup poll shows us to be the most trusted profession for the 18th year.

What message do you have for young nurses today?
I continue to say to young nurses what I have said for many years: “You have so much to offer in your professional and personal lives because of your preparation for becoming a nurse. You have developed skills in planning, critical thinking, communication, negotiation, leadership and so much more. Think about ways you can offer what you have learned, and you will be surprised how many opportunities you can think of.”

If you’re talking with a nursing student or a new nurse, what would you tell them about acute/critical care nursing and AACN?
I recently sat next to a nursing student at a luncheon here in Birmingham and had an opportunity to introduce her to AACN, and I encouraged her to put attending an NTI on her bucket list because of the incredible learning opportunities as well as the networking possibilities and the energy and enthusiasm she would take back home with her. I also encouraged her to join a chapter wherever her practice takes her to continue her professional development.

What do you like to do in your spare time or as a hobby?
I have found new things to do in retirement that I enjoy very much. I belong to a garden club, assist with creating the altar flower arrangements at my church, belong to a knitting group fondly known as the Knit Wits, volunteer with community groups, enjoy my grandchildren and great-grandchildren, continue as a staunch supporter of Auburn football and basketball, and travel with my husband, Harry, who introduced me to the idea of mystery trips. Each year, we alternate planning a trip where the other one doesn’t know where we are going until we get there. It is a lot of fun, and we have enjoyed many great excursions both in the United States and abroad.
Improving Mobility for Patients Undergoing RRT

A stepwise mobility protocol increased mobility for patients undergoing renal replacement therapy (RRT).

According to “Early Mobilisation in Intensive Care During Renal Replacement Therapy: A Quality Improvement Project,” in Intensive and Critical Care Nursing, the use of explicit step-by-step instructions following a preliminary safety screen provides a safe structure to progressively increase mobility for all types of ICU patients. The protocol “can improve compliance to mobility orders for patients who historically have not been mobilised or were thought difficult to mobilise.”

The single-site quality-improvement study in a 24-bed surgical/trauma ICU in the southeastern United States involved 360 patients split into groups before and after introduction of the protocol, with 56 of them undergoing RRT. “Before introducing the protocol, compliance to mobility [for patients undergoing RRT] was 12.5%, compared to 62.5% after the protocol was introduced. There were no identified negative outcomes, such as catheter loss, filter loss or bleeding, associated with mobilising these patients following implementation of the protocol.”

Recommendations for future research include building on the protocol and expanding implementation in larger trials. “This is a small contribution to the process of enhancing the standard of care and the current process must undergo further evaluation to confidently promote a change of practice.”

The study adds, “Development of a daily mobility goal by the interprofessional team served as a positive influence in the promotion of safety while providing individual mobility therapy requirements.”


Mortality Risk Associated With Prehospital Mechanical Ventilation

A study of prehospital mechanical ventilation for patients in septic shock finds an association between mortality at 28 days and tidal volume indexed by ideal body weight.

According to “Pre-Hospital Mechanical Ventilation in Septic Shock Patients,” in The American Journal of Emergency Medicine, lower prehospital tidal volume (less than 8 mL/kg) was associated with a decreased likelihood of mortality at day 28, and higher prehospital tidal volume (greater than 8 mL/kg) was associated with an increase. Septic shock in the 59 studied patients was mainly associated with pulmonary infection (64%), and 42% of the patients died within 28 days.

The retrospective study notes that “septic shock was defined according to the international sepsis-3 consensus conference,” adding that patients “characteristics, interventions, prehospital ventilatory parameters and outcomes were retrieved from medical records.”

The study intended to understand the effects of prehospital mechanical ventilation in a mobile ICU, particularly because these patients are at risk for lung damage. A previous study from the National Board of Respiratory Care notes that patients on higher tidal volumes face an increased potential for lung damage, leading to the recommendation that tidal volume calculations use ideal body weight rather than actual body weight.

Despite progress in understanding sepsis-associated acute kidney injury (SA-AKI), it remains a common complication of critical illness, requiring aggressive screening of at-risk patients.

“Sepsis Associated Acute Kidney Injury,” a clinical review in BMJ, examines evidence published from 2000 to April 2018, focusing on SA-AKI risk factors, early recognition and diagnosis, treatment and long-term consequences. Although the ability to prevent, detect and treat patients with SA-AKI has advanced, data suggests that the disease is likely to increase with population changes and intensive medical interventions.

Vigilance in considering risk factors is essential to implement preventive strategies. “We must consider how the choices we make with the fundamental elements of our critical care practice (fluid, vasoactive, and ventilator management) affect the kidneys,” the review notes.

The review summarizes management strategies, including screening and diagnosis, supportive care, treatment and avoidance of further kidney injury. In pointing to the need for more research, it notes that “even perfect implementation of current best practice is unlikely to significantly ameliorate the burden of SA-AKI.”

Research topics include determining whether there is an ideal intravenous fluid and vasoactive drug to prevent or treat patients with early SA-AKI and finding the best way to identify AKI at its earliest stage.

“Novel translational animal models, the wealth of data available in modern electronic health records, and a myriad novel clinical biomarkers present a tremendous opportunity to refine our understanding of SA-AKI, and may allow us to set a new course for prevention, treatment, and renal recovery.”


Nurses at an acute care hospital created an escape room — an adventure game where healthcare participants are locked in a room and collaboratively solve puzzles to be released — to promote sepsis awareness.

Lauren McPeake, a nurse at Penn Presbyterian Medical Center, Philadelphia, brainstormed the geriatric unit’s first sepsis-focused escape room in 2017, explains “Nurses Create Escape Room to Increase Sepsis Awareness,” in HealthLeaders. The game was so successful that nurses Paula Gabriel and Casey Lieb, members of the Penn Medicine Sepsis Alliance education team, helped expand the game to the entire hospital.

They tasked teams of six to eight nurses, social workers, physicians, nursing assistants, nursing students, infection prevention professionals and quality team staff. “The teams had 25 minutes to detect and treat sepsis in a mock patient before they could escape the room. They did this by solving four puzzles and responding to clues.”

In one hands-on puzzle, team members were faced with an intravenous (IV) pump containing four antibiotics and two functioning IVs. They needed to determine how to administer the proper series of antibiotics while navigating environmental distractions. After completing their challenges, each team reported back to the three nurses.

“The escape room format allows different types of learning, so you have people that are auditory, visual, or kinesthetic learners [and] they can touch things and talk through things. You have to use your critical-thinking skills and think outside the box,” Gabriel adds in the article.

Many participants said they were more knowledgeable about diagnosing and treating patients with sepsis after their experience. The three organizers also claim to have seen some healthcare teams using the sepsis treatment methods they learned during the escape room game in their clinical practice — a sign that the interactive experience could produce positive outcomes.

Nurse Empowerment Can Reduce Patients’ Sleep Disruption

A prospective study aimed at reducing inpatient sleep deprivation achieved a 44% decrease in overnight room entries.

According to “Effectiveness of SIESTA on Objective and Subjective Metrics of Nighttime Hospital Sleep Disruptors,” in Journal of Hospital Medicine, physician education is associated with decreased sleep disruption for patients, but “creating a sleep-friendly environment likely depends on the unit-based nurses championing this cause.”

The SIESTA — Sleep for Inpatients: Empowering Staff to Act — program includes nudges in electronic health records to discourage nighttime checks of vital signs and issuing medications, combined with nurse education on the benefits of reducing nighttime care.

The study involved 1,083 awake patients in two 18-room general-medicine units at University of Chicago Medicine. “The SIESTA-enhanced unit underwent the full sleep intervention: nursing education and empowerment, physician education, and EHR changes. The standard unit did not receive nursing interventions but received all other forms of intervention. Because physicians simultaneously cared for patients on both units, all internal medicine residents and hospitalists received the same education.”

In addition to the decrease in overnight room entries, surveyed patients in the SIESTA unit were more likely to report they were not interrupted overnight for vital signs (70% to 41%) or to receive medications (84% to 57%) compared to the standard unit.

Because it was not a controlled environment and physician orders affected both units, the study primarily attributes improvements in the SIESTA unit to the effect of empowering the nurses. “While the initial decrease in nocturnal room entries post-SIESTA eventually faded, sustainable changes were observed only after SIESTA was added to nursing huddles, which illustrates the importance of using multiple methods to nudge staff,” the study concludes.


Antibiotics for Patients With Asthma Exacerbation

A retrospective, cohort study sought to determine the association of antibiotic therapy with outcomes for patients who were hospitalized for asthma exacerbation.

“Association of Antibiotic Treatment With Outcomes in Patients Hospitalized for an Asthma Exacerbation Treated With Systemic Corticosteroids,” in JAMA Internal Medicine, finds that antibiotic treatment may not be associated with better outcomes and should not be prescribed routinely in adult patients hospitalized for asthma and treated with corticosteroids.

The study examined the data of 19,811 adults hospitalized for this condition in 542 U.S. acute care hospitals from Jan. 1, 2015, through Dec. 31, 2016. A variety of scoring systems, as well as weighting and analysis tools, were used to assess the association of antibiotic treatment with outcomes.

Of the total number of patients, 8,788 (44.4%) received early antibiotic therapy during their first two days in the hospital. Compared with patients who did not receive antibiotics, the treated patients had a significantly longer hospital stay, a similar rate of treatment failure, and a higher risk of antibiotic-related diarrhea that was not statistically significant.

“There was no concurrent improvement in clinical outcomes or reductions in clinical deterioration,” adds a related article in 2 Minute Medicine, and “treatment with antibiotics was also linked with higher hospitalization costs.”

Consider Cardiotoxic Effects of Cancer Therapy

Patients who had cancer treatment can experience secondary cardiac events linked to that treatment, many years later. Radiation and chemotherapy can lead to several short- or long-term adverse effects, including hypotension, hypertension, unstable angina, pericardial fluid accumulation, cardiomyopathy and acute myocardial infarction, explains “Cardiotoxic Effects of Cancer Therapy,” in American Nurse Today. Recognizing potentially cardiotoxic cancer medications and symptoms helps nurses provide appropriate treatment for patients who had cancer therapy.

The following are signs and symptoms of cardiotoxicity:

- Arrhythmias
- Cardiac dysfunction
- Chest pain
- Dyspnea
- Electrocardiogram changes
- Edema
- Fatigue

Common cancer therapy medications that can cause short- or long-term cardiac abnormalities include alkylating agents, angiogenesis inhibitors, antimetabolites, anthracyclines, immune-checkpoint blocking antibodies, monoclonal antibodies and taxanes.

Patients who experience cardiac symptoms during or after cancer therapy should be referred to a cardio-oncologist or a cardiologist who is knowledgeable about treating oncology patients. Diagnostic testing, including electrocardiograms, echocardiograms and multigated acquisition scans, can help determine the cause of symptoms.

Nurses can also help educate patients about the potential cardiotoxic effects of cancer therapy, as well as positive lifestyle changes (such as a physical activity or a low-salt, low-fat diet) that could help protect cardiac health.

“Individual patient education and treatment, as well as community prevention strategies, are key to the success of stopping this epidemic,” the article adds.


Palliative care may be a cost-effective option for patients with multiple sclerosis (MS) when traditional clinical interventions are ineffective or do not improve quality of life.

“Ten-Year Trends of Palliative Care Utilization Associated With Multiple Sclerosis Patients in the United States From 2005 to 2014,” in Journal of Clinical Neuroscience, finds that palliative care for hospitalized patients with MS increased 120 times from 2005-2014. The study also reveals a significant increase from 2010 (1.5%) to 2011 (4.5%). The rate of palliative care for these patients who died in the hospital increased from 7.7% to 58.8% over 10 years. The national inpatient sample was used to identify patient and clinical characteristics associated with receiving palliative care.

Costs associated with hospitalization were lower for patients with MS receiving palliative care than for those not receiving such care. This result was true even though patients receiving palliative care spent slightly more time in the hospital and were more likely to die there.

“If clinical interventions are exhausted to improve patient outcomes and quality of life, the palliative care option may be better off for patients for symptom management and comfort,” study co-author Jay Shen, School of Community Health Sciences, University of Nevada, Las Vegas, adds in a related article in MD Magazine. “It could be suggested to patients and families as early as possible in these kinds of situations.”


If clinical interventions are exhausted, palliative care may be a better option for symptom management and comfort.
Mitigating Opioid Tolerance in the ICU

While opioids are a mainstay of pain control for ICU patients, long-term use requires strategies to mitigate tolerance and hyperalgesia.

“Opioid Tolerance in Critical Illness,” a clinical review in *The New England Journal of Medicine*, notes that opioid tolerance occurs in patients with all types of critical illnesses, due in part to higher and more frequent doses to achieve the same analgesic effect.

The review lists strategies to mitigate opioid tolerance based on the following topics:

- Appropriate use of opioids, including daily interruption of sedative infusions, intermittent opioid therapy (oral or intravenous) rather than continuous infusions and rotating opioids to mitigate tolerance
- “Coadministration of nonopioid analgesics as rescue therapy during procedures or to potentiate the effects of opioids”
- Using a catheter for continuous administration of neuraxial, regional or local nerve blocks
- Prevention or reversal of opioid-induced hyperalgesia and opioid-withdrawal symptoms, including tapering off the opioid dose when the pain score goal is achieved, and using adjuncts to opioids, such as ketamine, dexmedetomidine or gabapentinoids
- Reducing inflammation, with scheduled acetaminophen therapy or short-term use of ketorolac

Translational application of pain therapies targeting the body’s opioid and nonopioid receptors is being studied, providing a “road map for strategies to mitigate opioid tolerance in persons with critical illnesses.”

The review adds that “a more nuanced understanding of the way critical illness and inflammation affect the body’s response to opioids could lead to tremendous reduction in morbidity among critically ill patients.”


Addressing Opioid Use Disorder With Medication-Assisted Treatment

To address opioid addiction in patients, nurses need to identify the symptoms of OUD and provide evidence-based intervention options such as medication-assisted treatment (MAT). Once they are familiar with the diagnostic criteria, nurses can identify OUD or opioid dependency in patients using a variety of tools, such as the Drug Abuse Screening Test, an assessment of past and current substance abuse and a comprehensive physical, medical and emotional exam.

For patients who experience OUD, MAT provides an evidence-based care plan that combines medication with counseling and behavioral therapies. Nurses should first evaluate patients for withdrawal symptoms using the Objective Opioid Withdrawal Scale, Subjective Opioid Withdrawal Scale or Clinical Opioid Withdrawal Scale. Then, they can educate patients about MAT and develop individualized plans that involve patient input.

These plans can include medications such as methadone to manage patients with opioid overdose or withdrawal symptoms and prevent relapses. Nurse practitioners can also prescribe buprenorphine until Oct. 1, 2021, after they would complete training and obtain a Drug Addiction Treatment Act (DATA) 2000 waiver to prescribe it for up to 30 patients.

Learn more about the DATA 2000 waiver on the Substance Abuse and Mental Health Services Administration website, www.samhsa.gov.

Opioid Effectiveness Questioned for Patients With Noncancer Pain

Although opioids offer significant pain relief for patients without cancer, improvements are often minor, reduced after six months and likely treatable with nonopioid alternatives.

According to “Opioids for Chronic Noncancer Pain: A Systematic Review and Meta-Analysis,” in JAMA: The Journal of the American Medical Association, a review of 96 clinical trials does not show conclusively that the benefits of opioid treatments outweigh the negative effects associated with rising addiction rates. “The effects of opioids on chronic pain are uncertain, whereas the harms found to be associated with prescription opioids include diversion, addiction, overdose, and death.”

The analysis of 26,169 patients finds that those receiving opioids in randomized trials had less pain and improved physical functioning compared with placebo, but opioid use was also associated with significantly increased vomiting.

Limited data shows similar minimal pain reduction with opioids compared with nonsteroidal anti-inflammatory medications but only in studies with treatment lasting up to six months.

In longer trials, however, the analysis finds less association between opioids and pain relief. This could be because of increased tolerance, which can lead to prescriptions at higher doses, usually without clinical evidence of the benefit and with a greatly increased risk of addiction and abuse.

With opioid overdoses skyrocketing, a related commentary in JAMA indicates, “There are many options to consider when offering treatment for chronic pain that go beyond pharmacological management such as physical therapy, cognitive behavioral therapy, mindful meditation, yoga, and tai chi.”

Costs and Risks of Opioid Overdoses

Total care for patients with an opioid overdose reached $1.94 billion in annual hospital costs in 647 U.S. healthcare facilities.

According to “Opioid Overdoses Costing U.S. Hospitals an Estimated $11 Billion Annually,” a news release from Premier Inc., “these costs were concentrated among nearly 100,000 opioid overdose patients with 430,000 total visits across emergency department (ED), inpatient and other care settings. Sixty-six percent of the patients were insured by public programs (33 percent Medicare and 33 percent Medicaid), 16 percent used a commercial payer, 14 percent were uninsured and 3 percent were covered under other programs, such as workers’ compensation.”

Caring for all overdose patients treated in the ED led to $632 million in hospital costs.

According to the analysis, about “47 percent of patients were treated and released, and 53 percent were treated and admitted.” Of those who were admitted, nearly “40 percent experienced organ failure. The average cost for an overdose patient who was treated and released totaled $504, but the average rose to $11,731 for those that were treated and admitted and to $20,500” for an ICU stay.

Consider the treatment options for chronic pain that go beyond pharmacological management.

Total added costs to the U.S. healthcare system are estimated at $11.3 billion annually, or 1 percent of hospital expenditures.

“If the payer mix remained constant, $7.4 billion of the expense would be borne by the federal Medicare and Medicaid programs,” the analysis shows.

Patients with an opioid overdose who present to the ED are at “high risk for multiple organ failure, hospitalization, increased costs due to ICU stays and unplanned readmissions following discharge.”

According to the analysis, about “47 percent of patients were treated and released, and 53 percent were treated and admitted.” Of those who were admitted, nearly “40 percent experienced organ failure. The average cost for an overdose patient who was treated and released totaled $504, but the average rose to $11,731 for those that were treated and admitted and to $20,500” for an ICU stay.
With adolescent use of e-cigarettes at epidemic levels, the Food and Drug Administration (FDA) is considering enhanced regulations and taking the products off the market.

“FDA Threatens to Remove e-Cigarettes From Market as Teen Use Surges,” in Medscape, notes that then-FDA Commissioner Scott Gottlieb told medical, consumer and industry representatives at a public hearing, “If the youth use continues to rise, and we see significant increases in use in 2019, on top of what we found in 2018, I believe this entire category will face an existential threat.”

The hearing also addressed marketing regulation options, possible bans on flavored products and preventing children from starting use.

According to a national 2018 survey, regular use of e-cigarettes rose 78% from 2017, and use by middle-school children increased 48%. The U.S. Surgeon General declared the situation an epidemic in December 2018, in part because youth do not understand the addictive nature of e-cigarettes and advertising specifically targets them.

“When we look at data going back to 1975, we have never seen a jump in youth use of any substances even close to the order of magnitude of this increase,” Surgeon General Jerome Adams says in a video interview in Medscape. While e-cigarettes have the potential to help adults stop smoking, the nicotine in e-cigarettes is known to be harmful to developing brains and is likely to create a new generation of nicotine addicts, Adams notes.

E-cigarettes May Increase Risk of Stroke, Myocardial Infarction

Survey data reveals that compared with nonusers, those who smoke e-cigarettes may have:

- Twice the rate of smoking traditional cigarettes.
- 71% higher risk of stroke.
- 59% higher risk of myocardial infarction or angina.
- 40% higher risk of heart disease.

“Vaping Tied to Rise in Stroke, Heart Attack Risk,” in HealthDay News, notes that after controlling for other risk factors, e-cigarettes present a much higher risk of adverse effects.

Researcher Paul Ndunda, assistant professor at University of Kansas School of Medicine, Wichita, suggests that the chemicals in e-cigarettes “could increase inflammation of the lining of the blood vessels … [which] could lead to clot formation, clogging the artery and causing a stroke.”

The article notes that 66,800 respondents — of the more than 400,000 people surveyed in 2016 — are regular e-cigarette users, but direct connections cannot be drawn from the data. “Because this is survey data, it cannot draw a direct cause-and-effect relationship between vaping and stroke or heart attack,” Ndunda explains, adding that “this study has some limitations that do not allow us to make very firm conclusions and be able to change policy around e-cigarettes. I would look at this as a call for larger and longer studies into this issue.

The findings were presented at the American Stroke Association’s annual meeting, but the study has not yet been published.
Heart Monitoring With a Watch

Advances in healthcare apps and digital devices are helping consumers control their health information, including monitoring heart rhythms with a watch.

Examples include two apps for the Apple Watch, one that creates an electrocardiogram (ECG) to detect atrial fibrillation and regular heart rhythm, and another that analyzes pulse-rate data to identify irregular heart rhythm, according to “Statement From [then] FDA Commissioner Scott Gottlieb, M.D., and Center for Devices and Radiological Health Director Jeff Shuren, M.D., J.D., on Agency Efforts to Work With Tech Industry to Spur Innovation in Digital Health.

Apple’s Series 4 model also detects falls by analyzing wrist trajectory and impact, then sends an alert to the user, notes a related article in FierceBiotech. If there’s no motion for 60 seconds, the watch automatically calls emergency services.

“The completely redesigned Apple Watch Series 4 continues to be an indispensable communication and fitness companion, and now with the addition of groundbreaking features, like fall detection and the first-ever ECG app offered directly to consumers, it also becomes an intelligent guardian for your health,” Jeff Williams, Apple’s chief operating officer, notes in the related article.

A recent report attests to the watch’s ability to detect atrial fibrillation, explains WMUR-TV in Manchester, New Hampshire. An alert prompted a local resident to go to the hospital, where the emergency department confirmed the diagnosis. The man was treated, and his heart returned to a normal rhythm. “It would’ve probably taken me longer had I not had something actually telling me that something’s not right,” he adds in the report.

Robots Can Perform Useful Tasks in Hospitals

Can robots perform useful tasks in busy hospitals? According to two recent reports, the answer is “yes.”

“Baylor Scott & White Brings Robot to ICU,” in The Eagle, notes that the medical center, in College Station, Texas, recently welcomed a robot-like platform named Dr. Stan to its ICU team.

Dr. Stan has a docking station and can wheel itself to a specific room, as needed.

A large screen displays the physician’s face to help him engage with patients, and a zoom function can provide a closer look at wounds. In addition, “specialists at other Baylor Scott & White facilities can more quickly see a patient virtually, allowing critical medical decision-making to rapidly occur,” the article notes.

“Nurse Robot Moxi Gets Schooled by Texas Nurses,” on ZDNet, explains that a robot named Moxi was specifically designed to help nurses. The first real-world trial, which recently concluded at Texas Health Dallas, was “designed to test a collaborative automation integration in a working hospital.”

During the trial, Moxi delivered admission kits and lab specimens. One nurse adds in the article, “Almost thirty percent of our tasks during our shift is to fetch things. But at this time all you need to do is press your voice button and call for Moxi; it responds.”

Robots that deliver supplies are considered one possible tool to help nurses.
Significant Increase in Number of Nurse Practitioners

The number of nurse practitioners (NPs) increased 9% from 2018 to an estimated 270,000 as of January, according to the National Nurse Practitioner Sample Survey.

“Nurse Practitioner Role Grows to More Than 270,000,” a news release from the American Association of Nurse Practitioners (AANP), notes an estimated 72.6% of survey respondents describe primary care as their main clinical setting, and 66.9% report certification as a family NP. “The faith patients have in NP-provided health care is evidenced by the estimated 1.06 billion patient visits made to NPs in 2018,” AANP president Joyce Knestrick notes in the release.

The number of NPs has increased significantly from an estimated 120,000 in 2007 to 248,000 in 2018 before jumping again in 2019. AANP data comes from 4,350 respondents to an electronic survey aiming to provide a national snapshot of the profession.

NP graduates increased from 23,698 in 2015-2016 to more than 26,000 in 2016-2017, and AANP’s survey estimates that 87% have been educated in primary care. Over 42% of respondents have been practicing for less than five years, up from 22% in 2016.

According to the survey, the most common work settings for NPs are private practice (24.2%), outpatient hospital clinics (14.5%) and inpatient hospital units (12.1%). More than 95% have graduate degrees, with an estimated 17.8% holding doctorates, and about one third have a professional- or executive-level leadership role in their workplace.

“Patients are benefiting now more than ever before from the high quality, comprehensive, patient-centered health care services provided by nurse practitioners,” the release adds. ▼

National numbers are 270,000 NPs as of January, an increase from 248,000 in 2018.

Legislative Updates: Prescribing Controlled Substances, APRN Practice Authority

Prescribing controlled substances and legal definitions of practice authority are among the main issues in an annual review of legislative updates that impacts advanced practice registered nurses (APRNs).

“31st Annual APRN Legislative Update: Improving State Practice Authority and Access to Care,” in The Nurse Practitioner, reviews legislative and regulatory changes in more than 20 states, with a focus on prescriptive and practice authority. Changes in six states expanded signature authority for APRNs, 18 states now have 100% implementation of the APRN Consensus Model recommendations, and survey respondents indicate additional states are now permitting home health service authorization.

All APRNs authorized to prescribe controlled substances will be affected by changes to the laws in 11 states restricting certain substances in response to the opioid crisis. APRNs should review the regulatory requirements in their state, which may include new requirements to review and monitor their state’s prescription-drug monitoring program.

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