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AMERICAN ASSOCIATION of CRITICAL-CARE NURSES
Live From the National Office: CATs

Live from the AACN National Office, it’s Megan and the CATs! Among the many things AACN President Megan Brunson is known for are her love for chapters and social media. It’s only fitting that one of the first acts of her term was participating in a Facebook Live Stream with some Chapter Advisory Team (CAT) members. Here’s a peek at Megan with the CATs during their annual orientation meeting. ▼
Isn’t it incredible that each shift we conquer the unpredictable so we can consistently meet the needs of our patients. How is that possible? Despite thinking I am good in the kitchen, I still tend to catch myself watching cooking shows when I have some downtime. I especially am intrigued by those competition shows that have unpredictable items in a basket or behind a door. You know which ones I’m talking about. The shows where contestants are given a basket of cotton candy, peanut butter, lamb, fennel and crushed pineapple and are challenged to make a delicious entrée in 20 minutes.

I actually wince when they list the items, but I also have confidence they will succeed with a creative and delicious dish in the end. Using all the tools and equipment in the kitchen, they bring the best of themselves knowing the clock is ticking. Presenting the dish with pride and trust in their abilities they still recognize at times where they could have improved or enhanced the dish. And I watch in complete bewilderment. How did they do that with such ease — knowing they still have two more segments of the show remaining? I gravitate to watching these shows because nurses work like this. When we became nurses, we knew — and perhaps were even drawn to — the unpredictability of the profession. Each day, as we walk into work we know we will be greeting unpredictability. We recognize we are there to provide care with excellence, despite the unknown. Each day and night is drastically different. It is conceivable that any of us could be faced mid-shift with a co-worker going home sick, a code, a grieving family or a visit from a regulatory team — all while knowing one of the highest priorities that day might be shaving a patient, because you promised his wife that you would. We come with our clinical knowledge, instincts, ability to prioritize and, most importantly, compassion.

Unlike those shows, we are not in isolation with our basket of unpredictable items. We know we have a team who will fill in the gaps and see where we need support. Many times, I have clocked out and thought “We somehow got it done”; we made the impossible, possible. We gave exceptional care again despite being caught off-guard or interrupted with the unthinkable.

Typically walking out together with colleagues, we debrief where we could perhaps do things differently but give assurances to each other. Not all of us know how to make a great dish with Brussels sprouts, sweetbreads and bananas, but we know how to overcome the unforeseeable with excellence. And we’re ready to do it again tomorrow.

Share a story at unstoppable@aacn.org about when you were in an unpredictable situation and you or your team showed excellence.
Nov. 1 Deadline to Apply for AACN Research Grants

AACN will award up to $160,000 in research funding this year, including three Impact Research Grants up to $50,000 each, to support inquiry that drives change in high-acuity and critical care nursing practice.

Since launching the grants program in 2011, AACN has awarded more than $1 million and 22 Impact Research Grants to ensure a pipeline for evidence-based resources in support of a wide range of priorities.

Research teams with current funding are studying ICU recovery in critical illness survivors; mitochondrial bioenergetics and fatigue in critically ill adults weaning from mechanical ventilation; and virtual reality simulation for onboarding.

Priority projects address gaps in clinical research at the organization or system level and translation of these findings to bedside clinicians. Projects include use of technology to assess patients and manage outcomes; ways to create a healing and humane environment; and processes and systems to optimize high-acuity and critical care nursing.

AACN continues to offer the annual AACN-Sigma Theta Tau International (STTI) Critical Care Grant, up to $10,000.

**AACN will award up to $160,000 in research funding this year.**

Principal investigators must have a master’s degree and be current AACN members. Sigma members are also eligible to apply for the AACN-STTI grant.

All research grant applications must be submitted online by Nov. 1.

For more information, including award criteria and supporting documents, visit www.aacn.org/grants, or email research@aacn.org. ▼

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Revitalizing Pediatric and Neonatal Clinical Nurse Specialist Roles

CNS pediatric and neonatal university programs are seeing a resurgence.

Did you know that the clinical nurse specialist (CNS) role has been referred to as the “invisible champion”? It’s a fitting designation, because the reach of the CNS role is extensive and its influence wide. Yet, despite the impact CNSs have on patients, nurses, nursing practice and hospital organizational systems in the delivery of high-quality nursing care, the role is often seen as “leading from behind the scenes.”

Now, the CNS role is enjoying increased visibility thanks in part to institutions such as Rush University College of Nursing, in Chicago, and California State University Sacramento (CSUS) School of Nursing and their resurgent pediatric and neonatal CNS programs, whose curricula have been verified by AACN Certification Corporation.

California State University Sacramento School of Nursing

CSUS recently finalized a pilot pediatric and neonatal CNS program, graduating four students. Currently, they are in the midst of the university approval process to elevate the pilot to a full-fledged program. Just a few years ago, they had stopped admitting students to their CNS program for lack of both qualified preceptors and local jobs for graduates.

But then representatives from two local hospital systems implored CSUS to renew their CNS track to help fill the hospitals’ need for qualified CNSs.

“Our first step was to ensure hospitals would provide clinical experiences,” recalls Tanya K. Altmann, chair and professor of CSUS School of Nursing. “The second step was to revisit our curriculum to ensure we had the content required for a CNS in today’s healthcare environment.”

The pilot was a success. Although they limited the program to four students, most of the school’s Master of Nursing students expressed interest in participating in the pilot. All four graduates were hired by local hospitals.

“It is extremely helpful for graduates to earn national recognition for their education through AACN certification,” Altmann notes. “It helps secure employment and allows mobility for their practice.”

Rush University College of Nursing, Chicago

At Rush, Lynn D. Mohr, program director, pediatric and neonatal CNS programs, believes that the CNS role is in a good place.

“Over the past five years, I’ve witnessed a resurgence of the CNS role in pediatric and neonatal settings,” Mohr says. “Our program applications have increased dramatically.”

That trend, Mohr adds, is in part spurred by title protection in some states that recognize the CNS role as an advanced practice registered nurse (APRN) role. To work in that role, education requirements for certification and licensure must be met, and AACN Certification Corporation is the only credentialing organization to offer Consensus Model-based CNS certification in all three patient populations — adult-gerontology, pediatric and neonatal.

“AACN’s certification exams are critical for having certified pediatric and neonatal CNSs licensed as APRNs,” Mohr says.

Although there are fewer CNS programs available than before, Mohr sees an increased demand for CNSs because healthcare settings are aware of the organizational value of the role.
“If you look at highly functional institutions with great quality outcomes, you will find at least one CNS if not a group of CNSs contributing to that success,” Mohr says.

Unfortunately, Mohr says there are more positions available than qualified CNSs. Because of this, institutions may fill those CNS positions with other roles and “may not benefit from the full effect that a qualified CNS can bring to the institution.”

AACN and NACNS: Facing CNS Challenges

Although the pediatric and neonatal CNS roles face many challenges, including lack of role clarity or familiarity, a limited number of nursing school programs, lack of preceptors and variations in state nursing board requirements, Altmann and Mohr both cite the National Association of Clinical Nurse Specialists (NACNS) as a leading advocate to help the role thrive.

“The single greatest challenge of the CNS role continues to be visibility of the role within healthcare organizations and among C-suite leaders,” NACNS president Tracy B. Chamblee tells us. “Improving the visibility of this important role is a priority.”

Chamblee says that NACNS advocates for the CNS role to engrain high-quality, evidence-based practice for all nurses. And Chamblee adds that reports indicate chief nursing officers at Magnet® hospitals say that CNSs were instrumental in achieving and maintaining that designation.

She also says that CNSs facilitate the implementation of evidence-based practice, research and quality initiatives.

“AACN is a huge supporter and advocate of the CNS role, and I’m grateful that AACN prioritized the pediatric and neonatal exams,” Chamblee adds. “If there were no certification exams, then pediatric and neonatal CNS practice would not continue to exist, and that would be a travesty for patients and families.”

New CNS Practice Statement Coming Soon

Exciting things are on the horizon for CNSs.

Chamblee says that NACNS will soon release the third edition of “CNS Statement on Practice and Education.” The document outlines CNS practice, including education and licensure requirements. Chamblee tells us the statement will also feature revised CNS competencies and an update of the conceptual model of CNS practice.

The role remains important today, because CNSs are master’s-prepared experts with the flexibility and expertise to care for complex and vulnerable patient populations in a variety of settings. Specialty experience is a hallmark of the CNS role.

In addition to direct patient care, CNSs engage in teaching, mentoring, consulting, research, management, advocacy and systems improvement — typically collaborating with front-line nurses and multidisciplinary teams to improve patient care, change practice and stimulate research.

Find more information and resources related to CNS certification on AACN’s website: www.aacn.org > Certification > Advanced Practice.

Happy National CNS Week 2019

Did you know that the first CNS program emerged in the 1950s? That makes CNS the oldest advanced practice role in nursing.

At AACN, we celebrate CNSs for their ongoing commitment to excellence, devotion to patients and families, and dedication to the nurses, units and facilities they serve. We honor the vision of one nurse — Hildegard Peplau — who created the CNS role in 1956, when she established the first master’s degree nursing program with an exclusive focus on advanced clinical practice. Since then, CNSs have been bringing together and optimizing diverse aspects of healthcare, positively impacting patient care at every level and contributing to healthy work environments.

Here are some other CNS facts and milestones:

- In 1974, the American Nurses Association more formally defined the CNS role.
- In 1995, NACNS was formed.
- In 1999, AACN Certification Corporation launched its Adult, Pediatric and Neonatal CCNS certification programs, designed for nurses educated at the graduate level to provide care to acutely/critically ill patients.
- “The 2017 National Nursing Workforce Survey” reported that there are nearly 80,000 practicing CNSs in the United States.
- According to the unpublished NACNS 2018 census, approximately 10% of CNSs practice in pediatric and neonatal specialties.

Happy National CNS Week, Sept. 1-7. And thank you for the advanced skill, knowledge and inspiration you share to improve nursing practice, keep patients safe and lead change for healthier lives across the healthcare spectrum.
What resources can we deploy to improve patient outcomes?

In this month’s AJCC, Bass et al. retrospectively find that in adults with acute respiratory distress syndrome receiving neuromuscular blocking agents, adjusting sedation and analgesia on the basis of bispectal index monitoring leads to more dose adjustments but no difference in patient outcomes over titration based on traditional monitoring.

In contrast, Smith et al., in an observational study of 216 patients in three medical-surgical ICUs find that using exercise physiologists safely and effectively increased or maintained patient mobility.

In a randomized trial of 268 mechanically ventilated patients undergoing spontaneous breathing trials (SBTs), Qian et al. find that patients placed on high-flow oxygen during their SBT had shorter weaning times than patients placed on pressure support ventilation or T-tube during the SBT.

Do you wonder about the care patients require after discharge?

In a grounded-theory analysis of interviews with 10 mothers of infants who underwent surgery for congenital heart disease, Imperial-Perez et al. describe the mothers’ experiences providing the extra care their children required at home.

In a prospective study, McPeake et al. report that adults entering a post-ICU rehabilitation program had diverse goals for recovery and that co-creating goals was feasible. Three themes emerged from an analysis of the goals set by 43 patients: health-related quality of life, goal expectations and self-management, and family and social engagement.

A high priority in managing critically ill patients is preventing complications.

Perreault et al. find that a tool used in children is not valid in predicting iatrogenic opioid withdrawal in adults; more research is needed.

Pittman et al. established the validity of a tool for distinguishing avoidable from unavoidable hospital-acquired pressure injury (HAPI). In their study, 41% of patients developed HAPI despite documentation and implementation of preventive care.

Read the full text of these articles and more in September’s AJCC. ▼

www.ajcconline.org
Free On-Demand Webinars: From National Experts to You

Back-to-school season is a great time to catch up on professional learning — especially when it’s available anytime, anyplace … and it’s free!

AACN offers a substantial library of on-demand webinars addressing a variety of timely clinical and professional nursing topics to help you stay up-to-date. Presented by nationally recognized subject matter experts, these educational sessions provide knowledge and tools to enhance patient outcomes and nurse well-being.

The webinars are free to view and feature the latest insights and evidence-based practices on subjects such as:

- The latest sepsis, heart failure, and pain, agitation, delirium, immobility and sleep (PADIS) guidelines
- Palliative care, pain management and acute respiratory distress syndrome
- Creating positive change, overcoming barriers and optimizing communication

Each webinar offers up to 1.0 CE contact hour and many offer downloadable application tools — both are free to AACN members and available to nonmembers for a nominal fee.

Start your learning at www.aacn.org/webinarseries.

AACN offers a substantial library of on-demand webinars to help you stay up-to-date.
Continuing the Fight: Sepsis Awareness Month

The annual observance raises awareness of the third leading cause of death in the U.S.

Every two minutes, someone in the United States dies from sepsis. At least 1.7 million adults develop sepsis each year, and nearly 270,000 die as a result — more than from prostate cancer, breast cancer and opioid overdoses combined — which makes sepsis the third leading cause of death in the country (Sepsis Alliance, August 2019). Globally, sepsis affects an estimated 30 million people annually, potentially leading to 6 million deaths (World Health Organization, August 2019).

By designating September as Sepsis Awareness Month, the national healthcare community strives to promote greater awareness of this insidious, often-fatal condition — and its antidote of early detection and treatment. Each September, you’ll find many healthcare organizations across the country, including AACN, supporting this effort through sharing the latest knowledge and tools to combat sepsis.

Battling Sepsis: What You Can Do

As the first line of defense for patients with sepsis, nurses are critical to improving outcomes.

Despite advances in the fight against sepsis, this deadly condition persists as one of healthcare’s most pernicious challenges. The latest research, guidelines and bundles continue to emphasize early detection and rapid treatment of patients with sepsis as key to increasing survival rates.

As front-line care providers, nurses are uniquely positioned to help patients win the fight against sepsis. Your ability to recognize the signs and deliver timely, effective care can mean the difference between life and death.

We’ve previously shared specific ways we as nurses can prepare ourselves for early awareness and intervention — and they still hold true, so we’re providing them again.

1. **Stay current** with definitions, guidelines, bundle recommendations and nursing care for patients with sepsis and septic shock.
   - Access updates on research and nursing care in AACN’s Continuing Education Activities library; www.aacn.org > Education > Continuing Education Activities
   - Review current medical management guidelines; www.survivingsepsis.org

2. **Discuss** sepsis recommendations, updates, bundles and questions with your colleagues and providers.
   - Use available educational forums such as unit newsletters, emails, team huddles, grand rounds, case debriefs and journal clubs to talk about changes and research.
   - Consider how current guidelines, updates and bundles may impact nursing assessment and priority interventions.

3. **Share resources** with your colleagues to help all of you stay up-to-date on sepsis.
   - Identify materials available to share from the Surviving Sepsis Campaign.
   - Work with your educator, manager or clinical leaders on your unit to develop an information-sharing process.

4. **Think through** your assessments, and use data to guide your decision-making and patient care priorities.
   - When in doubt, validate your assessments and clinical decisions with a colleague (peer, APRN, other healthcare provider).
   - Actively develop your instincts for a high index of suspicion when caring for patients at risk for sepsis/septic shock.

5. **Volunteer** for a unit-based committee or team, and work to promote early recognition and management of patients with suspected sepsis/septic shock.

6. **Educate** patients and families about their role in the prevention and early recognition of potential sepsis/septic shock.
   - Remember: handwashing, handwashing, handwashing!
   - Review sepsis information for patients and families; www.cdc.gov/sepsis
SEPSIS AWARENESS

Sepsis Resources From AACN
To help you translate and apply current thinking about sepsis to your practice, AACN offers nurse-focused resources on our dedicated sepsis webpage, www.aacn.org/sepsiscare, where you'll discover an array of clinical materials, including:
• Journal articles
• Webinars
• Recorded NTI conference sessions

Among these resources are materials from national sepsis expert Maureen Seckel, lead critical care clinical nurse specialist and sepsis coordinator at Christiana Care Health Services, in Newark, Delaware.

“One of the biggest changes in managing patients with sepsis is the surge of research looking at early identification and really trying to apply the science — how we can get sepsis care to the right patient at the right time,” says Seckel, who also served as AACN representative and co-author for the updated 2017 Surviving Sepsis Guidelines.

“People are interested in finding out what that right tool is. Many tools have been studied, such as NEWS, SOFA, qSOFA and eSOFA, Red Sepsis Flag and many others. People are becoming more educated about sepsis, looking at it and evaluating it in their facilities.”

Hot Topic in Sepsis: Biologics
In a recent interview, Seckel also discussed what she perceives as an up-and-coming area of focus in managing sepsis.

“My personal opinion — and I think it bears out in the research — is that the next hot topic for sepsis is biologics. We really don’t know what triggers that dysregulated host response in the patient. In 10 patients who have the identical infection of cellulitis, why does only one come down with septic shock? Having a biologic that could identify sepsis would be wonderful.

“The other issue is treating the sepsis. There have been some intriguing studies looking at biologic agents other than antibiotics to target therapy to stop that whole progression into sepsis.”

Discover more of Seckel’s insights on AACN’s sepsis resources page; www.aacn.org/sepsiscare.

Additional Sepsis Resources
Explore these websites for more information on sepsis detection and treatment.

Sepsis Alliance; www.sepsis.org
• Monthly clinically based webinars for care providers
• Sepsis basics for patients/families and care providers
• Sepsis awareness materials for Sepsis Awareness Month and beyond

Centers for Disease Control and Prevention (CDC); www.cdc.gov/sepsis/clinicaltools
• Links to sepsis guidelines, education and resources
• NEW! “Hospital Toolkit for Adult Sepsis Surveillance”
  - Supports sepsis surveillance methodology to track facility-level sepsis incidents and outcomes
  - Uses objective definitions based on clinical data obtained directly from patients’ electronic health records or manual chart reviews
  - The definitions are not recommended for use in pediatric sepsis surveillance

Surviving Sepsis Campaign (Society of Critical Care Medicine); www.survivingsepsis.org
• “International Guidelines for Management of Sepsis and Septic Shock: 2016”
• Sepsis bundle and educational video
Although he’s currently serving as a medical informatics post-doctoral fellow funded by the U.S. Department of Veterans Affairs in Nashville, Tennessee, Alvin Jeffery’s background — he says he always likes to mention this — is as a pediatric ICU nurse at Cincinnati Children’s Hospital. Jeffery, who will soon be starting as an assistant professor at Vanderbilt School of Nursing in Nashville, was recently honored with an AACN Circle of Excellence award at NTI 2019 in Orlando, where he also presented a session. He spoke with us about his varied and interesting career.

Let’s start with something a little philosophical: Where do you think nursing, healthcare and AACN will be in the next 10, 20, 50 years?

I think the biggest challenge I see for acute and critical care nurses and opportunities where AACN could help partner is that there’s so much information coming our way. We have ventilators and IV pumps and monitors galore. And all of these things are providing us with data and information — it’s almost nonstop. We can call this alarm fatigue; we could call it being overwhelmed. I think there are opportunities to release the innovative with our technology solutions, bringing on informatics.

Whether it’s informatics experts, nurse specialists or researchers, we need to ask: “How could we summarize this better, display it in a different way or think about how we think and work as nurses?” And be really innovative in some of our solutions to try to make them more streamlined, so that information flows within our cognitive and physical workflows.

So what is nursing informatics, and how is it changing nursing practice?

I like to summarize it as briefly as possible — not even use the term “informatics.” And I say, we talk about how it is data and information and knowledge … and even wisdom. How do we manage that? How do we use that to improve care? It involves looking at people — whether that’s nurses, physicians or administrative staff. Looking at people and processes. What are the workflows? Where are we getting information? How are we caring for patients?

And then, finally, where does technology play a role in that? So how do people, processes and technology play a role in managing all of the data that we have, the information that surfaces from that, and the knowledge that we have about treating other patients, whether from research studies or expert opinion. All to get back to that individual clinician treating an individual unique patient. We get to that level of wisdom. So people, processes, technology. Managing and providing data information and knowledge to wisdom. That to me, in a nutshell, is informatics.
What’s the biggest change in technology you’ve seen in healthcare? Describe how that advancement intersected with your career.

I think the biggest change I’ve seen in healthcare is on the technology side — and this is probably what a lot of nurses would say — the transition to electronic health records, or EHRs. And it can be a huge source of frustration and a burden, but the potential I see can far outweigh that as we continue to advance.

I’m an informatics researcher, and I look at how we use all the data that nurses and other team members enter into the EHR, and I think there’s just a goldmine of information within that data that we could use to make better decisions for patients and families. And so I look forward to us getting there, and I think we’ll get there in the next few years.

You’ve presented at NTI for a number of years now. What keeps bringing you back?

The community of exceptional nurses. And I know that may be part of the tagline, but every year I come back the community feels a little closer to me. I feel more connected with the nurses. I especially love my peds nurses — we have so much fun in our sessions. I was just talking to a friend a few days ago, and he said, “I’ve never seen you get this excited getting ready for a conference.” Because I know we’re going to have fun. Nurses’ Night Out, Certification Celebration dinner, all these things. And just presenting in front of people and trying to inspire them and help improve their practice and their knowledge. It fuels me, it inspires me and so I absolutely love it.

What can nurses do to positively impact their work environment and the well-being of co-workers?

I remember when I became a nurse educator, one of the first books I read was “Crucial Conversations.” And I realized how flawed so much of my communication had been with my co-workers ... even personal relationships. And to just communicate freely and openly and respectfully, and to praise each other even in the small things to say, “That was an excellent job you did for that patient.” Or to say, “Hey, what can I do to help?” I think that would help us build this sense of community. It’s one of the things I love about AACN: the sense of community. And I feel a part of it. I think so many of the other healthy work environment standards would start to fall into place if we could really engage in civil discourse and respectful dialogue with our co-workers.

What advice do you have for nurses who want to innovate to improve patient care?

Nurses are natural innovators. They create what we sometimes call “workarounds.” I call it innovation. And I think we have an innate skill to innovate. So to grow that and to enhance that, I would say two things. One, learn as much as you possibly can, whether that’s going back to school, or reading or going to conferences. Second, network with other people. Communicate with other people, and share your ideas with other people.

What has your experience working with the Department of Veterans Affairs taught you?

My experience with the Department of Veterans Affairs, or the VA, has taught me a number of things. I’ll probably boil it down to two, to be succinct. One is that it’s really great that even though I have a background in pediatric critical care, and now I work in research with the VA, I can say that I’ve never worked with patients. I’ve worked with kids, and I’ve worked with vets. And that just makes it feel so much more connected to me and my purpose as a nurse.

So the second thing I would say is access to education and national data. The VA has been overwhelmingly supportive of my pursuit of a PhD and doing research and informatics, and they give me access to national data to identify and make discoveries that I wouldn’t be able to make at a single institution. And so it’s been a phenomenal place that’s really enriched me as a nurse, as a researcher and hopefully someone that’s going to make some discoveries that will change care across the country or maybe even around the world.

You were presented with an AACN Circle of Excellence award at NTI. What was the experience like?

So exciting. I would say my path to that actually started last year when I nominated someone who received the award. And so I feel — I keep going back to community and connectedness, that opportunity to be in a lineage of my friends and the colleagues that I respect — honored, humbled and excited ... so many things. But being a part of a community of exceptional nurses just gives me so much joy and pride in my profession. And it makes me realize that, yes, there’s going to be challenges and obstacles. We’re all facing those, but we’re all in this together, and we all have an opportunity to deliver excellent care and make a difference for patients.
Hospital Program Reduces NICU Infections and Costs

A Utah hospital finds that reducing the number of invasive procedures for neonatal intensive care unit (NICU) patients can decrease length of stay and operational costs. “How Intermountain Reduced NICU Infections, Pain, Blood Loss,” in HealthLeaders, notes that when Dixie Regional Medical Center (a service of Intermountain Healthcare) implemented an initiative to reduce harm associated with invasive procedures — such as pain, central line-associated bloodstream infections and sepsis — the NICU:

- Cut operational costs 28%
- Reduced length of stay 21%
- Avoided more than 11,000 “pokes”

Having a just culture is the foundation for everything.

R. Erick Ridout, a neonatalogist at Dixie Regional who was interviewed for the article, explains that one of the core principles of the POKE program (preventing pain and organisms from skin and catheter entry) is ensuring that all care is value-added, defining harm as “care that was not value-added.” The program gathered patient data, created a database to record care decisions and their implications, and differentiated between invasive procedures that added value and those that did not. For example, performing routine labs several times a week on a preterm baby who is progressing well can put the patient at unnecessary risk for infection.

“The most important thing is recognizing that just culture is the foundation for everything — that means folks are accountable for the care they provide, and they will support things we can improve. That builds a virtuous cycle that drives toward safety and zero instances of harm.” ▼

Risk of Functional Decline After Pediatric Acute Respiratory Failure

Morbidity in pediatric patients after a hospital stay for acute respiratory failure is common and associated with many factors. “Risk Factors for Functional Decline and Impaired Quality of Life After Pediatric Respiratory Failure,” in American Journal of Respiratory and Critical Care Medicine, concludes that post-discharge morbidity in these patients is associated with “admission factors, exposure to critical care therapies, and pain and sedation management.”

The trial enrolled 2,449 children at 31 hospitals who were mechanically ventilated for acute respiratory failure.

From 2009 to 2011, the trial enrolled 2,449 children ages 2 weeks to 17 years who were mechanically ventilated for acute respiratory failure at 31 U.S. hospitals. Assessments were conducted six months after the children’s discharge from pediatric ICUs. Parents and guardians were interviewed to assess the patients’ functional status and quality of life.

“Twenty percent of 949 children with baseline and post-discharge interview data experienced decline in functional status from baseline to follow-up,” notes a related report in Healio Pulmonology. “In univariate analyses, functional decline occurred more often in children with a history of prematurity or cancer, greater illness severity or a diagnosis of sepsis-related acute respiratory failure at hospital admission.”

The analyses also “demonstrated associations between decline in functional status and moderate or severe pediatric acute respiratory distress syndrome, 7 days or more of mechanical ventilation, and a stay of 14 days or more in the pediatric ICU and hospital.” ▼

X-Ray Best Method to Test Feeding Tube Placement

Several methods can test placement of nasogastric (NG) tubes, but an X-ray is the most accurate way to determine proper insertion in the esophagus rather than the trachea. “A Review of Guidelines to Distinguish Between Gastric and Pulmonary Placement of Nasogastric Tubes,” in Heart & Lung, notes that NG tube placement, often performed by nurses, can result in a catastrophic outcome if improper placement is not determined before administering food or medications.

The review, which involved 14 guidelines from Europe, Australia, China and the United States, including an AACN Practice Alert, identifies the best methods to test NG tube placement and summarizes factors affecting how methods are chosen for specific situations. The testing methods reviewed were “radiography, respiratory distress, aspirate appearance, aspirate pH, auscultation, carbon dioxide detection and enteral access devices.”

“The single area of agreement among the guidelines is that an X-ray, when properly performed and interpreted, is the most accurate method for distinguishing between gastric and pulmonary placement of a newly inserted NG tube,” the review concludes. “Of the nonradiographic methods, pH testing was most favored,” while auscultation was the least favored.

Power of Nurse Innovators Yet to Be Fully Realized

- Only 31% of surveyed clinical leaders have a nursing leader whose primary focus is innovation.
- However, 81% say that having nurses as decision-makers on strategic planning teams will be crucial by 2025.
- And 57% of health-industry business leaders say advanced leadership for nurse innovators will be important in their organizations by 2025.

Nurses have long been innovators in healthcare, but for full transformation to take place, industry stakeholders must extend the power of nursing beyond the bedside and into the boardroom.

In other words, nursing innovation has yet to be fully embraced at leadership levels, notes “Unleashing Nurse-Led Innovation,” on www.bdo.com, a study by the BDO Center for Healthcare Excellence & Innovation and the University of Pennsylvania School of Nursing.

The study asked 104 clinical leaders and 172 health-industry business leaders where they expect to find the most value from nursing by 2025.

“What we found is that organizations across the system are already looking to nurses for individual-level innovation and clinical acumen skills,” the study reports. “But they’re missing out on the opportunity — including improved patient outcomes — that comes from bringing nurses into innovation at the leadership level.”

According to the study, only 31% of clinical leaders have a designated nursing leader focused primarily on innovation, and just 46% of health-industry business leaders say their senior staff includes someone with a nursing background.

Looking toward 2025, however, 81% of clinical leaders say that having nurses as decision-makers on strategic planning teams will be crucial for healthcare organizations. In addition, 57% of health-industry business leaders say advanced leadership for nurse innovators will be important in their organizations.

“Roadblocks need to be removed, and systems must embrace nurses as leaders in innovation. Unleashing nurse innovators is a care imperative and a business imperative,” Karen Meador, managing director and senior physician executive at BDO, adds in a related news release.

Innovation will be crucial to meet the nation’s health challenges, which include an aging population, chronic care management, mental health issues, addiction and improving population health. “By 2025, clinical and business leaders agree that nurses have the most opportunity to transform and improve care in these critical areas,” the study adds.

AACN CSI Academy: Empowering Nurses to Lead Innovation

AACN Clinical Scene Investigator (CSI) Academy — a hospital-based nurse leadership and innovation training program — empowers direct care nurses as leaders and change agents whose initiatives measurably improve patient and fiscal outcomes.

CSI Academy builds on nurses’ clinical expertise, providing the additional knowledge, skills and support needed to lead their peers in creating unit-based change. The program’s results clearly show the return on investment of providing staff nurses with dedicated time to think, strategize, plan and collaborate.

AACN offers a 12-month CSI Academy program designed with flexibility to meet the needs of individual hospitals. We invite you to connect with our CSI program faculty to discuss your facility’s needs and how this program can help achieve your organizational objectives.

Explore CSI Innovation Projects, and refer to our FAQ to learn more or to contact us.
Nurse Understaffing Linked to Healthcare-Associated Infections

A study finds a correlation between nurse understaffing and healthcare-associated infections (HAIs) in patients. According to “Nurse Staffing and Healthcare-Associated Infection, Unit-Level Analysis,” in JONA: The Journal of Nursing Administration, when both the day and night shifts were understaffed with RNs, patients had a 15% greater likelihood of developing HAIs (pneumonia, urinary tract infections and bloodstream infections) two days later compared with patients cared for during fully staffed shifts.

The study, conducted by Columbia University School of Nursing, New York, involved data from more than 100,000 patients and determined a shift was understaffed when RN staff or nursing support staff (licensed practical nurses and nursing assistants) fell below 80% of the unit median. Approximately 19% of shifts in ICUs were understaffed for RNs, and 32% were understaffed for nursing support.

Results suggest that understaffing among RNs or nursing support staff increases the patients’ risk of developing HAIs. Larger workloads raise the likelihood of missed care; infection surveillance and prevention practices that could curb HAIs may not be performed.

“Being at the forefront of infection control and prevention is a unique responsibility and opportunity for nurses, and our study shows that hospital administrators should ensure adequate nurse staffing to provide the safest patient care,” lead study author Jingjing Shang, associate professor at Columbia, adds in a related news release.

For additional staffing resources, refer to the AACN webpage “Staffing in Acute & Critical Care,” www.aacn.org > clinical resources > staffing.


Safe Harbor When Faced With Potentially Unsafe Assignments

What should nurses do when they doubt they can provide safe care, yet their supervisors give them these assignments?

“A ‘Safe Harbor’ for Unsafe Nursing Assignments,” in Medscape, explains that two states — New Mexico and Texas — offer a “safe harbor” for nurses who face possibly unsafe assignments or orders. For example, a nurse who usually works with adult patients is asked to work in the neonatal ICU.

In New Mexico, nurses are now “protected from adverse action by a facility” when they make a “good faith request to be allowed to reject an assignment.” The Safe Harbor for Nurses Act allows nurses to reject an assignment based on their “education, knowledge, competence, or experience” and their immediate assessment of the risk to patient safety, or possible violation of the state nurse practice act or board of nursing rules.

“The law applies to entities having three or more nurses that are licensed by the Department of Health to provide healthcare on their premises,” the article adds.

In Texas, nurses may invoke safe harbor when they believe they have received an unsafe assignment, explains “The Texas Administrative Code,” on the Texas Board of Nursing website. They need to complete a form, and a peer review committee then makes a determination within 14 days. New Mexico’s law was inspired by the one in Texas.
**Inpatient Delirium and Hospital Readmission in Older Patients**

The study concludes that “delirium is a significant predictor of hospital readmission, ED visits, and discharge to a location other than home.” Patients with delirium “should be targeted to reduce post-discharge healthcare utilization.”

“Using an unweighted, multivariable logistic regression, delirium was determined to be significantly associated with the increased odds of readmission within 30 days of discharge.” In addition, delirium was significantly associated with visits to an emergency department (ED) within 30 days post-discharge and discharge to another facility.

The study concludes that “delirium is a significant predictor of hospital readmission, ED visits, and discharge to a location other than home.” Patients with delirium “should be targeted to reduce post-discharge healthcare utilization.”

“The research team plans to take these findings and conduct follow-up studies, as well as work with these patients on recovery options,” adds a related article from CTV News London.


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**Sleep Quality Predicts Success of Ventilator Removal**

Critically ill patients are more likely to be successfully removed from mechanical ventilation if testing reveals high levels of wakefulness and a good correlation of sleep depth between the brain’s hemispheres.

“Sleep and Pathological Wakefulness at the Time of Liberation From Mechanical Ventilation (SLEEWE). A Prospective Multicenter Physiological Study,” in American Journal of Respiratory and Critical Care Medicine, recorded brain activity in 37 patients at three Toronto-area sites a day before a spontaneous breathing trial (SBT). Sleep depth was measured by an odds ratio ranging from 2.5 for full wakefulness to 0 for deep sleep.

Eleven patients passed the SBT and were extubated, eight passed but were not clinically ready for extubation and 18 failed the SBT. Extubated patients experienced longer periods of wakefulness and better sleep-depth correlation than those who failed the SBT.

In a related article in Healio Pulmonology, study co-author Laurent Brochard, director of critical care medicine at the University of Toronto, notes that mechanically ventilated patients often exhibit severe sleep deprivation, which partly explains the frequent development of delirium.

“We wondered whether assessing a period of sleep and wakefulness in the hours before attempting a separation from the ventilator could predict the success of this process,” Brochard explains.


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**AACN Resources for ABCDEF Bundle, Mobility and PADIS**

- On-demand webinars, www.aacn.org/webinars
  - “Guideline Update: Bundle Up for Pain, Agitation and Delirium [PAD]”
  - “Guideline Update: Addressing Immobility and Sleep Disruption [IS]”
  - “Adding F: Integrating Family Throughout the ABCDE Bundle”

- CSI projects, www.aacn.org/csidatabase
  - “Collaborate to Extubate: A Needs Assessment and Educational Program on the ABCDEF Bundle”
  - “Rise and Shine: Implementing the ABCDE Bundle”
  - “Keep the Beat, Move Your Feet Early: Progressive Mobility for Cardiac Surgery Patients”

- Articles in Critical Care Nurse, ccn.aacnjournals.org
  - “Letter to the Editor: Nurses’ Role in Implementing the ABCDEF Bundle,” June 2019
  - “Implementing the ADCDEF Bundle: Top 8 Questions Asked During the ICU Liberation ADCDEF Bundle Improvement Collaborative,” February 2019
  - “Common Challenges to Effective ADCDEF Bundle Implementation: The ICU Liberation Campaign Experience,” February 2019
  - “Factors Influencing Patients’ Sleep in the Intensive Care Unit: Perceptions of Patients and Clinical Staff,” July 2017, American Journal of Critical Care, ajcc.aacnjournals.org
The Food and Drug Administration (FDA) approved the first generic naloxone hydrochloride nasal spray designed to stop or reverse the effects of an opioid overdose.

According to “FDA Approves First Generic Naloxone Nasal Spray to Treat Opioid Overdose,” on www.fda.gov, the generic spray:

- Does not require assembly
- Delivers a consistent, measured dose when used as instructed
- Can be used on adults and children
- Can be administered by anyone, even those without medical training
- Is administered by spraying into one nostril while the patient is lying on their back
- Can be given more than once if necessary (effects typically seen within a few minutes)
- Is not a substitute for timely medical attention; patients should also receive immediate medical care

The medication is designed to treat patients with narcotic overdose effects, including shallow or interrupted breathing. However, administering naloxone to patients who are opioid-dependent can cause severe opioid withdrawal, which may present as tachycardia, nausea or vomiting, diarrhea, fever or increased blood pressure, among other symptoms.

“We’re taking many steps to improve availability of naloxone products, and we’re committed to working with other federal, state and local officials as well as health care providers, patients and communities across the country to combat the staggering human and economic toll created by opioid abuse and addiction,” adds Douglas Throckmorton, deputy director for regulatory programs at the FDA’s Center for Drug Evaluation and Research.

In April, the National Institutes of Health (NIH) announced funding for a study to reduce opioid-related deaths.

“NIH Funds Study in Four States to Reduce Opioid Related Deaths by 40 Percent Over Three Years,” on www.nih.gov, notes that grant awards totaling more than $350 million will fund the multiyear HEALing Communities Study, which focuses on testing and measuring the effects of integrating evidence-based prevention, treatment and recovery interventions. These interventions include:

- Reducing the incidence of opioid use disorder
- Promoting medication-based treatment for opioid use disorder
- Increasing the distribution of naloxone to reverse overdose effects
- Encouraging treatment retention beyond six months
- Providing recovery support

The research sites receiving grants are University of Kentucky, Lexington; Boston Medical Center; Columbia University, New York City; and The Ohio State University, Columbus. Each research site will partner with at least 15 communities to help reduce opioid-related deaths and create an evidence-based model that other communities can adopt.

When managing patients with diarrhea, it’s not a good idea for nurses to just roll the dice and hope for the best.

Unless they’re playing the Poopology Game, a board game created by nurses in England to raise staff awareness about a serious symptom of infection, reports “My Nursing Team Created Poopology – A Board Game About Diarrhoea,” in The Guardian.

Nurses at Newcastle upon Tyne Hospitals NHS Foundation Trust developed the game as an educational tool for managing patients with diarrhea, which can be a warning sign of gastrointestinal infections such as Clostridiodes difficile and norovirus.

Players roll the dice and move game pieces on a board designed with squares resembling pieces of toilet paper. Depending on where they land, players take a chance card or answer a question from another player.

“The board game is a more active learning experience, and people are much more likely to remember what they’ve learned,” the article adds.
8 Rules for Using Social Media

Social media communication can enhance the nursing profession, but nurses need to ensure personal and patient safety and privacy. “Social Media: New Communication Platform, but Old Rules Still Apply,” in American Nurse Today, notes that social media can present some risks to both nurses and patients. Author Mary E. Fortier, associate professor in the department of nursing at New Jersey City University, describes an example in which a nurse performs cardiopulmonary resuscitation on someone in a grocery store and then posts about it on social media.

Although the nurse doesn’t state the patient’s name, her social media connections know where she shops and may know the person she helped, which represents a breach of privacy. These types of violations can occur even when nurses try to obscure personal data. Fortier suggests following these eight rules of social media etiquette:

- Be aware of your facility’s social media policy, review your state’s nurse practice act and read “A Nurse’s Guide to the Use of Social Media” for tips on best practices.
- Follow organizational policies about checking email and social media profiles while at work. Don’t conduct personal business or expect privacy on work computers.
- Don’t take photos or videos of patients at work, even if there are no identifiers.
- Never share patient information in a public forum, including social media.
- Avoid disparaging posts. If you speak badly about patients, families, colleagues or employers online, it could constitute cyberbullying or professional misconduct.
- Don’t post if you’re angry or need to vent.
- Anything you post remains accessible even if you delete it later. The time, place and content of a social media post can be tracked and retrieved.
- Serve as a positive representative of the profession online.

“Mindful social media practices create a positive nursing presence,” Fortier adds. You might volunteer to serve on a policy-writing committee addressing electronic communication and patient privacy. “We need to set the standard for others who use these platforms and frame the guidelines.”


Ensure you know the proper use of social media platforms.

Drones Deliver Medical Supplies, Blood, Donor Kidney

Drone delivery of medical supplies, blood and donor organs is becoming a reality, according to two recent initiatives.

“N.C. Hospital Delivering Blood With Drones in Pioneering Medical Program,” on www.upi.com, explains that a drone recently began delivering blood samples between Raleigh, North Carolina’s WakeMed Hospital surgical center and the primary testing lab at its main campus. In the following weeks, the supplies made daily flights.

WakeMed Hospital’s medical drone delivery service is the first to be approved by the Federal Aviation Administration, it is part of a three-year pilot program testing the integration of drones into commercial airspace.

In addition, “Drone Delivers Kidney for Transplant at U of Maryland,” in Becker’s Healthcare, notes that a drone recently flew 2.8 miles to deliver a donor kidney to University of Maryland Medical Center, Baltimore, for a woman who spent eight years on a transplant list to undergo transplant surgery. “The drone was custom-built to monitor the organ in real time while in the air and to send updates to personnel handling the transplant.”

Before the delivery, the medical team “developed and tested the drone system by transporting saline, blood tubes and other materials as well as a healthy, but nonviable, human kidney.”

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Building Resilient Nurse Leaders

Psychological resilience can help nurse leaders endure challenges and turn them into opportunities for growth.

“Rising Strong From Our Setbacks,” in Emerging RN Leader, explains that nurse leaders will likely experience stressful situations in their personal and professional lives, such as a job loss, illness, financial issues or the death of a loved one. A resilient attitude can help them survive these challenges and become stronger.


- Reckoning: Understand the emotions involved in a challenging situation
- Rumble: Analyze the facts and determine what to change
- Revolution: Leverage the challenge to become stronger and more resilient

Sherman adds that nurse leaders can use the following tactics to build personal and professional resilience:

- Exercise self-care.
- Have confidence in personal strengths and abilities.
- Stay optimistic during tough times.
- Redirect any negative thoughts.
- Develop a sense of purpose at work and at home.
- Cultivate a personal and professional support system.
- Accept that change is inevitable; differentiate between what can and cannot be controlled.
- Practice problem-solving.
- Set manageable, realistic goals.
- “Maintain perspective — don’t blow a setback out of proportion — instead, learn from it.”

Reach Out to Nursing Peers in Emotional Distress

What if all nurses had colleagues to turn to in times of emotional stress? Would they find healing?

“Nurse Suicides: Talk to a Colleague,” in MedPage Today, the third article in a series on suicide among nurses, focuses on ways nurses can help peers who have emotional problems.

“Feeling alone and disjointed from your team is one risk factor for suicide,” Judy Davidson, a nurse scientist at the University of California San Diego (UCSD), notes in the article. “Just recognizing somebody is having a bad day is a suicide prevention technique.”

The university is a leader in recognizing the problem, the article contends, adding that UCSD has initiated peer-related programs to address depression, burnout and suicide.

In an initiative called Code Lavender, nurses can share simple kindnesses with colleagues who are showing signs of distress. Code Lavender packets contain chocolate, lavender oil, a comforting message, a card for the employee assistance program and a small lavender starfish sticker.

Another UCSD program, the Caregiver Support Team, trained 100 volunteers to spot depression and other suicide risk factors and guide their peers for treatment if necessary. The program was piloted in four high-intensity, high-stress units and will be implemented system-wide.

“You need to be able to shift your culture so people care and take action,” Davidson explains in the article. “You need to have people who recognize other people that they trust to go to, and then you need real ways to get people into treatment.”

The other articles in the MedPage Today series describe factors contributing to suicide and how UCSD connects troubled nurses to counseling services.
New Editors Shape AJCC and CCN, Encourage Reader Engagement

They bring vision and energy while maintaining AACN’s tradition of publication excellence.

Even before AACN began celebrating its 50th anniversary this year, we welcomed two new editors to Critical Care Nurse (CCN) and American Journal of Critical Care (AJCC).

Annette Bourgault joined CCN as associate editor in July 2018, becoming editor in April, when she succeeded Grif Alspach after the latter’s 34 years at the helm. Aluko A. Hope became co-editor-in-chief of AJCC in August 2018, partnering with Cindy Munro, the journal’s other co-editor-in-chief, on AACN’s flagship research journal.

(For more background on these new editors, see AACN Bold Voices July 2018 and September 2018, pages 14 and 22, respectively.)

As editors, Bourgault and Hope collaborate with colleagues, contributors, reviewers and staff to review manuscripts and publish the best clinical and research content, underscoring the importance of interprofessional collaboration. “As a physician and epidemiologist,” Hope says, “I don’t want to replicate the sometimes hierarchical nature of physician-nurse relations. I keep a posture of listening and prioritize nurse stakeholders.”

The editors bring vision and energy while maintaining AACN’s tradition of publication excellence. Along the way, they hope to shatter a few myths.

“Articles in CCN are not written by ‘other people,’” Bourgault says. “They’re written by nurses who are passionate about a clinical topic or experience.” Nurses should be encouraged to start writing, she adds, to work with experienced authors with similar interests, and to reach out to journal editors when they have questions.

Hope has launched a Junior Peer Reviewer program to mentor the next generation of reviewers for AJCC. (For more about the program, see AJCC July 2019, pages 244-245.)

With her finger always on the pulse of clinical practice, Bourgault remembers what it’s like to be a novice nurse. “Readers who want to engage with CCN content can start a journal club, seek experienced colleagues for group projects or join a unit practice council.”

Hope resists hierarchies and pigeonholing. “I want to make sure people aren’t afraid of research,” he says. “It’s foundational to the history of nursing. Think of Florence Nightingale, a profoundly good epidemiologist.” Hope keeps up-to-date on the latest studies, learning more about the science and history of nursing from Munro, his new mentor. And he hopes to push himself to write AJCC editorials on topics outside his comfort zone.

Bourgault enjoys learning about new projects on bedside care and practice. Her immediate tasks are to revise CCN author guidelines and to work with a new editorial board, tapping into their talent while revisiting the contributing editor program.

Hope is working closely with Munro to enhance the already-rigorous AJCC peer-review process and enrich observational articles with implementation, qualitative and pilot/feasibility studies to reach a wider audience.

The future looks bright. “Our contributors give me hope that we have excellent clinicians striving to provide the best care to patients and families,” Bourgault says. Both she and Hope strongly encourage interested readers to inquire about becoming journal manuscript reviewers.

To learn more about the journals, visit AJCC, www.ajcconline.org, and CCN, www.ccnonline.org, where you can also read author guidelines.
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