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One of the most important things Emma imparted to her children was empathy for other people. In their family life it was often emphasized, and it’s something that Whoopi knows has guided her in her own life. She tells the following story as an example:

“When I was a kid, we went on a school outing, and my mother also went along. I was not the popular kid—there were sometimes a lot of tears for me because I didn’t understand why I wasn’t like everyone else. I wasn’t hip; I wasn’t cool. But every now and then the hip, cool people would look at me and befriend me; and on the day of the school trip, they did, and I was hanging with them. I had a friend who was like me, who also wasn’t cool, named Robert; and under normal circumstances, Robert and I would have hung out and laughed and kept each other company on the outing. This time, because I was in with the cool kids, I didn’t do that.”

Not only did Whoopi not hang out with her friend, she participated when the cool, hip kids started teasing Robert.

“At the end of the outing, I said to my mom, ‘Wasn’t that great? I had so much fun—I loved it.’

“And she went, ‘Oh, good.’ I could tell something was up by the way she was responding. Then she said, ‘Do you think Robert had a good time today?’

“I asked her what she meant, and she said again, ‘Do you think Robert had a good time today?’ I knew instantly what she was saying, and I really didn’t have an answer for her.

“She told me, ‘You know what that’s like, you’ve felt that, and you forgot. You just forgot. Try not to forget again.’ And I try not to. That’s how she taught me ethics. She’s an incredibly ethical woman; and that, I think, I get from her.”

The American Association of Critical-Care Nurses is the world's largest specialty nursing organization. AACN is committed to a healthcare system driven by the needs of patients and families where high acuity and critical care nurses make their optimal contribution.

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It’s rewarding to bring about positive change in your unit or facility. For Karen McQuillan, AACN president-elect and clinical nurse specialist at R Adams Cowley Shock Trauma Center (STC), University of Maryland Medical Center, Baltimore, satisfaction also comes from helping nurses half a world away improve patient care—especially when the improvements build upon the success of frontline nurses who participated in AACN Clinical Scene Investigator (CSI) Academy.

McQuillan first traveled to India in 2009 to teach at the Trauma International Congress and Annual Conference in New Delhi. She returned for each of the next three years committed to improving the quality of care. With colleagues from STC, she established an international infection-reduction collaborative with Jai Prakash Narayan Apex Trauma Center (JPNATC) to decrease central line-associated bloodstream infection rates.

Participants wanted to do more after the 18-month project accomplished its objectives, so McQuillan proposed a new initiative inspired by the achievements of AACN CSI Academy. Since patients rarely left their beds due to lack of room chairs, mobilization equipment and practice protocols, STC nurses and their JPNATC colleagues focused on early mobility to reduce mechanical ventilation, pressure ulcers and falls.

Earlier this year, several JPNATC nurses traveled to Baltimore and learned mobility and assessment techniques, performance improvement strategies and metrics analysis. With their American colleagues, the nurses developed an action plan to increase mobility based on a review of AACN CSI Academy projects and toolkits. Based on similarity of patient populations, they patterned the project on the early mobility initiative at Duke Raleigh Hospital, North Carolina.

JPNATC plans to purchase chairs and mobility resources, share mobility techniques with clinical team members and deepen interdisciplinary collaboration. As a result, the team expects to achieve significant gains in patient mobility and decrease complications of critical illness.

From this project, JPNATC nurses have experienced the pride of serving as leaders who spearheaded change that drives optimal outcomes in their facility.

“CSI Academy demonstrates the power of bedside nurses to create change that improves patient outcomes,” McQuillan says. “It’s exciting to realize that, as a beautiful unintended consequence of their success, nurses in North Carolina helped change clinical practice in India.”

Learn more about the nurse-driven initiatives that inspired the JPNATC nurses in the CSI Academy Innovation Database, at www.aacn.org/csiacademy.
Certified Nurses Day 2015

March 19 activities honor, recognize and celebrate certified nurses.

Start planning for March 19, when hospitals and healthcare organizations across the country will celebrate Certified Nurses Day 2015. Visit www.aacn.org/certnursesday to learn about the many resources to help you honor, recognize and celebrate certified nurses at your facility and chapter.

Some ideas to kick off your plans:

- Host a breakfast, lunch, afternoon reception or dinner for certified nurses.
- Display signs/banners celebrating Certified Nurses Day.
- Provide gifts/giveaways — such as logo/recognition products, lapel pins, pens, retractable name badges, lunch totes, etc. — with credentials on them for certified nurses.
- Hold a drawing for an AACN gift certificate.
- Start a traveling trophy awarded to a newly certified nurse that is later given to the next certified nurse.
- Give away buttons or ribbons with certification credentials.
- Send a card or email from your administrator or manager to recognize and honor certified nurses.
- Create a wall of honor, or take pictures of certified nurses in front of the wall.
- Write an article for your hospital newsletter recognizing certified nurses.
- Collaborate with your hospital’s communications team to promote recognition activities in local media.
- Conduct a certification drive or fair to raise awareness about the different certification programs.

- Purchase certification study materials.
- Send photos of your celebration to certification@aacn.org with “Celebrate Certified Nurses” in the subject line.
- Send testimonials about your pride in being certified to certification@aacn.org with “Cert Testimonials” in the subject line.

American Nurses Credentialing Center, Silver Spring, Maryland, designed this special day to honor the birthday of the late Margretta “Gretta” Madden Styles, an international pioneer in nursing certification and longtime friend of AACN and AACN Certification Corporation. Styles designed the first comprehensive study of nurse credentialing.

NTI 2015: Registration Now Open

AACN’s National Teaching Institute & Critical Care Exposition (NTI) is May 18-21, 2015, in San Diego, with preconferences on Sunday, May 17. • The premier educational conference for high acuity and critical care nurses, NTI offers up to 35 continuing nursing education (CNE) contact hours through live sessions, including concurrents, preconferences, the Advanced Practice Institute, self-study and more. • Be sure to submit your request for reimbursement and time off, and book your hotel early for the best selection. • If you can register before the new year at www.aacn.org/register you may be able to take advantage of unspent professional development funds in your unit’s or hospital’s budget. • See you in San Diego! ☞
More Nurses Needed to Meet Future Demand

Better education and nurses in leadership roles can improve the healthcare system.

More nurses must enter the workforce to meet the future demand on American healthcare resources, according to an article in FierceHealthcare.

“The Future of Nursing: An Industry in Flux” states that unless new nurses are recruited, as older nurses get set to retire, the country will see a shortage of qualified staff both inside and outside traditional hospital settings.

Nursing qualifications must change to meet the system’s needs, Beverly Malone, CEO, National League for Nursing (NLN), Washington, says in the article. NLN recommends that by 2020, 80 percent of nurses have at least a bachelor’s degree. However, encouraging nurses to achieve higher degrees is hampered by a shortage of nursing instructors at those levels, Malone points out.

“It’s tough to recruit nurses to work in academia,” she adds in the article, “because they’re paid more in the clinical setting, and that area offers a more hands-on experience.”

Important considerations to increase the number of nurses include reaching out to high school students, so these potential nurses take the appropriate science courses. Interested students should be provided with support to further their education. Nurses who may be successful teachers should be identified and mentored. Hospitals must require adequate budgets to diversify their workforce, and more men should be recruited to become nurses.

Malone also emphasizes the importance of ensuring a diverse workforce that represents the country’s changing demographics. Better education and nurses in leadership roles can improve the healthcare system, the article concludes.

Four Nurses Named Top Leaders in Healthcare

Four national nurse leaders are among the year’s “100 Most Influential People in Healthcare” chosen by readers of Modern Healthcare.

“It’s great for nursing, because we do this together,” Marla Weston, chief executive officer of the American Nurses Association, says in a related article in NurseZone. “Nurses are stepping forward to be leaders, and people are understanding nurses are not just functional doers of things, but thoughtful strategists.”

Weston is on the list for the first time, joined by Marilyn Tavenner, Sister Carol Keehan and Maureen Bisognano. Tavenner is agency administrator for the Centers for Medicare and Medicaid Services, Washington. Keehan is president and CEO, Catholic Health Association, Washington, and Bisognano is president and CEO, Institute for Healthcare Improvement, Cambridge, Massachusetts.

“The four nurses on Modern Healthcare’s 100 Most Influential People list this year are transformative and visionary leaders, and some of the brightest lights in the nursing world,” Susan Hassmiller, Robert Wood Johnson Foundation senior adviser for nursing, adds in the article. “They are role models.”

Anyone can nominate a candidate for this annual list composed primarily of government officials, healthcare executives and physicians. The top 300 nominees from the 15,000 submissions received this year were presented to the magazine’s readers for voting. Readers selected half the candidates, and the magazine’s editors chose the other half.
Changes in Tubing Connectors Aim to Reduce Errors

Joint Commission sentinel event alert focuses on severe and fatal injuries to patients.

Connection-related injuries caused by tubing connectors can result in severe and even fatal injuries to patients, according to a sentinel event alert issued by The Joint Commission, Oakbrook Terrace, Illinois.

“Managing Risk During Transition to New ISO Tubing Connector Standards” offers an infographic that reviews risk management during this period of change. Reminders for clinicians and healthcare organizations include tracing the tubing or catheters from the patient to the point of origin.

The many causes of connector-related injuries include using luer connectors; forcing tubes to fit together with adapters; connection errors; and confusion when more than one tube is present.

To reduce the risk of errors, the industry developed a set of foundational standards in 2011. The product rollouts started with new nutrition end small-bore connectors, followed by the Stay Connected initiative, a communications program that helps facilitate a successful transition from medical device applications that allow connections between unrelated delivery systems to new, safer connectors. The next steps introduced new neuraxial connectors, enteral-specific syringes and enteral feeding tubes.

“Under the new ISO connector standards, small-bore (less than 8.5 mm inner diameter) connectors will be engineered to make it nearly impossible to connect one delivery system to another delivery system that serves a completely different function,” states the sentinel event alert. The chances of accidentally connecting two unrelated sets — such as a feeding administration set and an IV tube — will become less likely.

While the new standards are not legally binding in most of the country, except in California, the industry hopes the safety and utility of the new connectors will encourage their use.
Restraint Urged on Using Restraints

Some alternative interventions to the use of restraints do not require more time or money.

An internist’s first-person account in an ICU puts a spotlight on physical restraints and asks whether compassionate alternatives could be used more frequently.

In “Rethinking Hospital Restraints,” published in The Atlantic, Ravi Parikh, resident in internal medicine and primary care, Brigham and Women’s Hospital, Boston, explains that even though restraints are a last resort under Medicare guidelines, they can be overused as a practical short-term solution. “[W]hen caring for the sickest patients in the hospital,” he writes, “restraining a delirious patient might be the only way to devote time to other seriously ill patients.”

Alternative interventions that do not require more time or money exist, Parikh adds, citing the example of a patient with delirium who improved with medication and a call to his wife “to provide a familiar, soothing voice.” Innovations include “devices, such as shields around IV or central line sites, to protect medical interventions without restricting patient movement” and ward designs that promote safe movement with mobility aids.

Recommendations released earlier in 2014 by the American Geriatrics Society, New York, call for restraints to “only be used as a very last resort and should be discontinued at the earliest possible time.” For most patients, a focus on the conditions causing delirium can lead to effective modifications; other options include medication adjustment or prescription.

Parikh expresses concern that restraints can have the opposite effect of their intent, describing three patients fighting against restraints whose delirium increased as a result. Studies show that immobilization can lead to higher rates of pressure ulcers, respiratory complications and death.

Despite their failings, a 2007 study reported restraints were being used on an average of 27,000 U.S. patients a day. Parikh cites an additional report that concludes hospitals fail to report more than 40 percent of restraint-caused patient deaths.

Manage Delirium With AACN Resources

- Delirium Assessment and Management - Aacen Practice Alert
- Management of Delirium in Critically Ill Older Adults - Critical Care Nurse, August 2012
- Delirium Assessment and Management - Critical Care Nurse, February 2012
- Implications of Objective vs Subjective Delirium Assessment in Surgical Intensive Care Patients - American Journal of Critical Care, January 2012
- Implementing the ABCDE Bundle at the Bedside - www.aacn.org/aacnpearl

Short Breaks Can Offset the Downside of Sitting

Five-minute walks, even at slow speeds, can reverse the negative effects of prolonged sitting, finds a new study in Medicine & Science in Sports & Exercise.

Five-minute walks can reverse the negative effects of prolonged sitting.

Sitting for long periods, which many people do at work or at home, has been linked to various chronic diseases. Even an hour of sitting can significantly reduce the endothelial function of arteries, which is an early marker of cardiovascular disease.

However, “Effect of Prolonged Sitting and Breaks in Sitting Time on Endothelial Function” finds that the normal arterial function of test subjects was maintained throughout the entire test when five-minute walks were taken to break up three hours of sitting.

The small study consisted of two randomized trials that involved 11 non-obese men between the ages of 20 and 35. In the first trial, participants sat for three hours without moving their legs. In the second trial, they sat for three hours but also walked on a treadmill for five minutes. The function of the femoral artery was measured periodically during both trials.
Atrial Fibrillation Outcomes Improve With Nurse-Led Teams

Nurse-led care teams make intuitive sense for a condition such as atrial fibrillation where both the disease and its treatment carry danger.

Nurse-led treatment for patients with atrial fibrillation (AF) achieves many improved outcomes compared with standard physician care, giving a boost to clinics that focus on the whole person.

Presentations at the European Society of Cardiology 2014 Congress emphasized approaches to AF treatment that recognize the interconnectedness of conditions and value teamwork, according to a report in Medscape: “Dedicated Atrial-Fibrillation Clinics: There Is No ‘I’ in TEAM.” Since both overtreatment and undertreatment of AF occur, presenters discouraged clinicians from thinking about AF in isolation, citing a recent white paper aimed at eliminating the term lone AF.

The report notes that “for a disease like AF, where danger lurks from both the disease and its treatment, teamwork makes intuitive sense.” A 712-patient clinical trial first published in 2011 found that nurse-led teams in The Netherlands produced fewer cardiovascular deaths (1.1 percent vs. 3.9 percent) and hospitalizations (13.5 percent vs. 19.1 percent) than traditional care, improved patient knowledge and reduced costs.

Receiving nurse-led care was associated with higher adherence to clinical guidelines in the trial, which is being expanded to a 1,700-patient follow-up. Patients in the AF clinics took anticoagulant drugs at a higher rate (99 percent vs. 83 percent), and rhythm control was applied appropriately in asymptomatic patients at a higher rate (95 percent vs. 85 percent).

Nurses in the trial used interviews and software that produced an electronic checklist and focused on the patient holistically. The strategy involved coordinated care, working closely with a supervising cardiologist and having patients actively participate in their care process.

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Enterovirus Causing Widespread Respiratory Illness in Children

Handwashing is paramount to defend against enterovirus. There are no vaccines or specific treatments.

The Centers for Disease Control and Prevention (CDC), Atlanta, is urging healthcare providers to consider enterovirus D68 (EV-D68) as a possible cause if they encounter widespread respiratory illness in children.

“Enteroviruses are associated with various clinical symptoms, including mild respiratory illness, febrile rash illness, and neurologic illness, such as aseptic meningitis and encephalitis,” notes “Severe Respiratory Illness Associated With Enterovirus D68 – Missouri and Illinois, 2014,” in the CDC’s MMWR: Morbidity and Mortality Weekly Report. “EV-D68, however, primarily causes respiratory illness, although the full spectrum of disease remains unclear.”

There are no vaccines or specific treatments for patients with EV-D68, and the CDC recommends that suspected outbreaks or clusters be reported to local or state health departments.

The first cases were diagnosed in August after children’s hospitals in Kansas City, Missouri, and Chicago reported rapid increases in patients hospitalized with severe respiratory illness. EV-D68 was identified in 19 of 22 specimens from Kansas City and 11 of 14 from Chicago.

In October, the CDC started using a new, faster lab test for detecting EV-D68 in specimens from people with respiratory illness. The test allowed the CDC to process a backlog of specimens more quickly, resulting in an increase in the number of confirmed cases.

“Since these initial reports, admissions for severe respiratory illness have continued at both facilities at rates higher than expected for this time of year,” the CDC article states, adding that ongoing investigations are taking place in other regions.

From mid-August to early November, the CDC or state public health laboratories confirmed a total of 1,116 people in 47 states and the District of Columbia with respiratory illness caused by EV-D68. The CDC expects that, as with other enteroviruses, cases of EV-D68 will continue to decline this month.

Len Horovitz, a pulmonary specialist at Lenox Hill Hospital in New York City, tells HealthDay that hand washing is paramount to defend against the virus: “Any child or adult with flu-like symptoms or common cold symptoms should be seen, evaluated and followed by doctors for any respiratory complications.”

Rehabilitating Nurses Who Are Challenged by Substance Abuse

About 10 to 15 percent of U.S. nurses have a substance abuse disorder, but 41 states offer programs to help these nurses recover and also resume their career, according to an article in The Pulse.

“State-Run Programs Help Nurses Detox Together and Stay in Their Scrubs” notes the “access and risks that nurses who use may take on the job, and the kind of stigma they receive for seeking help, make this a special group of people in recovery.”

Although specific details vary from state to state, a related article in FierceHealthcare indicates the programs are strict and include “three to five years of mandatory drug testing … and weekly meetings. Participants suspend their nursing licenses and pay for the treatment with a fee to get it back.”

Many nurses would not seek help if they risked losing their employment, so programs that allow nurses to keep their job are safer for them and for their patients, the article reasons. In addition, there is a nationwide nursing shortage, and turnover can be challenging. It’s expensive for a hospital to replace even one nurse.
Simple Actions May Improve Patients’ Experiences

Healthcare professionals may increase patient satisfaction by encouraging patients to understand their care is important, notes an article in Global Healthcare. “9 Things Health Care Professionals Can Do to Improve Patient Satisfaction” reviews some actions that may make a difference in how patients perceive their care.

For healthcare facilities, the article recommends improving systems and procedures, such as scheduling, switching to automatic systems and reducing system delays when possible, freeing up employees to be more available to patients and reviewing the overall infrastructure of the facility. For example, is it difficult for patients to navigate the facility or to find where they are supposed to be?

The article also addresses how staff members can improve the patient experience. Smiling and apologies go a long way to soothe an upset patient, as can making direct eye contact. Patients who hear healthcare professionals talking loudly, or hear loud music or noise, may feel uncomfortable.

“You can’t be perfect at everything, but you can aim to do so,” the article concludes. “Your patients will take notice and their overall positive experience with your medical facility or organization will convince a patient to cut you slack in some areas that you may have fallen short in.”

Patients’ perceptions of care can change with improved systems and procedures.

The AACN Community Responds

With the unfolding developments related to the care of patients with Ebola, the AACN community bands together to seek accurate information, workable solutions and informed partners. As is always the case, the safety of nurses — who care for patients at the most vulnerable time of their lives — is of paramount concern.

A Message to the AACN Community

The Centers for Disease Control and Prevention (CDC) has called for every hospital to think about Ebola preparedness. As a nurse working in acute and critical care, you have no doubt been affected by reports of Ebola Virus Disease (EVD) cases in the U.S. and may be thinking of possible implications for you and your practice.

As a galvanized community of exceptional nurses, you play a vital role in:

- Being prepared
- Staying informed with accurate information
- Educating others
- Protecting the safety of your patients, their families, your co-workers and yourself

We are grateful for your knowledge, expertise and commitment to providing excellent care to acutely and critically ill patients. We know our community will show its strength once again in the care of the most vulnerable patients and their families.

This is a time for us, as members of the AACN community, to be leaders and a steady rudder as we navigate this storm.
Cloud-based Telehealth Apps Receive FDA Clearance

Cloud-based eCareCoordinator and eCareCompanion telehealth apps are designed to reduce hospital readmissions and healthcare costs.

The Food and Drug Administration (FDA), Silver Spring, Maryland, cleared two apps from Philips Healthcare — eCareCoordinator and eCareCompanion — that intend to reduce hospital readmissions and healthcare costs.

“Philips Receives FDA Clearance for Two Telehealth Apps,” on MobiHealthNews, notes that these apps are part of the Philips Transition to Ambulatory Care program, which provides patients with tools to improve their transition to home. “Connecting care from hospital to home,” they are the “first clinical applications to be available through the cloud-based digital health platform,” which Philips is collaborating on with Salesforce, according to a related statement.

With eCareCoordinator, clinicians access a daily review of each patient and adjust the plan of care or intervene, as needed. The app also gathers patient data from connected devices.

Available only on Android tablets for now, eCareCompanion is a patient portal that helps patients manage their health via questionnaires and communicating with their healthcare team. It also reminds them about healthcare tasks, such as taking medication.

“These applications address both clinician and patient needs, providing clinicians with better access and analysis around patient data while empowering patients to manage their own health with direct access to care teams. The deeper insights into patient conditions will help enable more efficient and cost-effective care for improved outcomes,” Jeroen Tas, CEO, Philips Healthcare Informatics Solutions and Services, adds in the statement.

To the Ebola Outbreak

True Collaboration

To live our value of true partnership, AACN joins with the American Organization of Nurse Executives and the Emergency Nurses Association to commit to some shared principles in the fight against Ebola. Members of the three organizations have been called upon to:

- Pledge their commitment to collaborate in identifying resource and system gaps that have the potential to harm patients or caregivers
- Work together, with urgency, to put solutions in place that will prevent the spread of this disease
- Sustain this collaboration to fulfill our promise to patients and their families that they will receive excellent care

As part of the Nursing Community, we also join with 60 other nursing organizations to affirm our commitment to work together, supporting more than 3 million registered nurses in their frontline work to provide direct care and education to patients and the public regarding EVD. We released a statement that read, in part:

Today, as in every other day throughout history, nurses are at the patient’s side, delivering care tailored to each patient’s unique and most personal needs. Registered nurses, specialty-credentialed and advanced practice registered nurses are key to leading the real-time implementation of the evidence and analyzing outcome information to improve patient care and maximize the effectiveness of the healthcare team. As experts in communicable disease prevention and control strategies, public health nurses are well positioned to collaborate with other healthcare providers to share their knowledge and skills to manage the spread of diseases in communities nationwide.
Units With Experienced Nurses Have Better Patient Outcomes

Study confirms nurses’ experience plays a significant role in patient outcomes and length of stay.

Units with longer-term nurses provide better patient outcomes, indicates a review in *American Economic Journal: Applied Economics*.

“Human Capital and Productivity in a Team Environment: Evidence From the Healthcare Sector” contends that experience specific to nursing units leads to better patient care, which, in turn, improves outcomes.

The review of more than 900,000 admissions over a period of four years looked for unit-nurse experience and average length of stay for patients on the units. Factors that could contribute to less cohesion and decreased productivity in the unit included “the departure of experienced nurses, the absorption of new hires, and the inclusion of temporary contract nurses.”

The review worked on the premise that a shorter stay meant better patient care, and the results showed that, on average, for every one year of experience the nurses had on a unit, the length of stay decreased 1.3 percent.

The nurses’ skills were also important, notes a related article in *Science Daily*. “Length of stay decreased more in response to staffing by RNs than by unlicensed assistive personnel,” the article adds. “Furthermore, the study showed that length of stay increased when a team of RNs was disrupted by the absence of an experienced member or the addition of a new member.”

The review concludes that nurses’ tenure, in addition to overall experience, played a significant role in patient care, and that paying staff RNs overtime could be more cost-effective than hiring nurses from temporary staffing agencies.

How does your unit handle new nurses and promote retention of experienced nurses? Tell us at aacnboldvoices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.

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U.S. Will Need a Million New RNs

As more nurses prepare to retire, the United States will need 1.1 million RNs by 2022 to fill their shoes and meet the demands of our aging population, indicates a news release from the American Nurses Association (ANA), Silver Spring, Maryland.

To help prevent a serious shortage of RNs, the ANA recommends the following:

- Increase federal funding 12 percent in 2015 for Title VIII, which addresses nursing shortages, education, practice, retention and recruitment.
- Develop and recruit more nursing professors.
- Highlight the importance of the transition from education to practice for the nursing workforce.
Nearly One in Five New Nurses Leaves Position Within a Year

Analyze employee turnover to project the job market for nurses.

An estimated 17.5 percent of newly licensed RNs leave their first job within the first year, and 33.5 percent do so within two years, finds a new study in Policy, Politics, & Nursing Practice. Since there is no accepted standard definition of turnover, “What Does Nurse Turnover Rate Mean and What Is the Rate?” sought a more definitive measure for why nurses leave and in what cases staffing managers should be concerned. Employee turnover is a useful way to project the job market for nurses and determine whether a healthcare organization has a positive or negative work environment.

The study indicates there are different types of turnover. Functional turnover, which can be helpful, occurs when a poorly functioning employee leaves. A dysfunctional turnover occurs when a high-performing employee leaves. In all cases, the study recommends that healthcare organizations pay close attention to the specific kind of turnover, since each type can offer actionable insight.

The data for the 10-year longitudinal study come from surveys of three cohorts of newly licensed RNs conducted since 2006. The study included data from nurses in 34 states and covered 51 metropolitan areas and nine rural areas.

AACN Colleges Partners With CDC to Bolster Nursing Workforce

In partnership with the American Association of Colleges of Nursing (AACN Colleges), Washington, the Centers for Disease Control and Prevention (CDC), Atlanta, offers new funding opportunities to help increase workforce development, build faculty enrichment in nursing schools and increase student engagement.

According to the press release, “AACN’s Partnership With CDC Yields Opportunities in Population and Public Health,” two nurses have already been placed in one-year fellowship programs that will be hosted at CDC headquarters. Robin Wallin, a certified pediatric nurse practitioner, was selected as a Managing Chronic Conditions in Schools Nurse Fellow. Tessa Walker Linderman, an RN with board certification, was selected as a Medical Countermeasure Program Development Nurse for the CDC.

For more information about these AACN Colleges fellows and their projects at the CDC, visit www.aacn.nche.edu/public-health-nursing/fellowships.

Peer Pressure May Influence Hand Hygiene Compliance

Handwashing adherence rate was 7 percent lower when a healthcare worker was alone.

Hand hygiene compliance in hospitals may be influenced by peer pressure, specifically whether other healthcare personnel are nearby, according to a study in Infection Control & Hospital Epidemiology. “Do Peer Effects Improve Hand Hygiene Adherence Among Healthcare Workers?” explains the study used an automated hand-hygiene monitoring system to observe staff in a 20-bed medical ICU at a large university hospital. The system detected whether physicians and nurses washed their hands before entering a patient’s room and estimated the location of other healthcare staff in the vicinity.

Over a period of 10 days, the observational study identified 47,694 hand-hygiene opportunities. When a healthcare worker was alone, the observed adherence rate was 20.85 percent. In contrast, when other healthcare personnel were nearby, the rate was 27.9 percent.

However, compliance may have been higher, because the automated system did not record dispensing events inside patients’ rooms, reports an article in FierceHealthcare.
In Our Journals

Hot topics from this month’s AACN journal

Providing adequate nutrition may help halt the development or worsening of pressure ulcers. Prevention and healing can be especially challenging because of comorbidities and the degree of physiological compromise. Practical solutions to improve the nutritional status of critical care patients include appropriate screenings for nutritional status and risk for pressure ulcers and early collaboration with a registered dietician. Solutions also include administration of appropriate feeding formulations and micronutrient and macronutrient supplementation to promote wound healing. Nutritional management and enteral feeding protocols may provide vital elements to augment nutrition and ultimately result in improved clinical outcomes. (Cox et al., CCN, Dec 2014)

“What method is better for measuring real-world patient outcomes – quality improvement or clinical research?” Critical care nurses are constantly challenged to provide safe, high-quality care using the latest evidence while challenged by increasingly scarce resources. This first article in a four-part series reviews how quality improvement and clinical research are different. A checklist helps to differentiate between the attributes of each process, and a quick quiz of studies recently published in Critical Care Nurse tests knowledge between quality improvement and research. (Stausmire, CCN, Dec 2014)

Since 2004, the Adam Williams Initiative (AWI) at Mission Hospital, Mission Viejo, California, has offered clinical team members at 37 hospitals an immersion experience during which they receive didactic and hands-on education in the care of traumatic brain injury (TBI). AWI began as a conversation between nurses and a family member. It was established specifically to provide education and resources to encourage culture change leading to application of the Brain Trauma Foundation’s treatment guidelines for TBI. The initiative’s 10-year experience may serve as a template for hospitals and nurses seeking to engage in long-term improvement collaborations with foundations and/or industry. (Bader et al., CCN, Dec 2014)

Attend National Nursing Ethics Conference With AACN Scholarship

AACN Continuing Professional Development Scholarships support members to enrich their career and acquire knowledge and skills beyond traditional academic learning.

For the first time, these scholarships will help nurses attend the National Nursing Ethics Conference (NNEC), March 19-20, 2015, in Los Angeles. The conference theme is Conversations in Ethics, highlighting the importance of communication in supporting ethics in clinical practice.

Conference participants can join national experts to learn together how nurses can improve communication to establish caring relationships with patients, families and each other. Visit the NNEC website, www.ethicsofcaring.org, for more information.

When applying for an AACN Continuing Professional Development Scholarship to attend the conference, you need to assess gaps in your knowledge and skills in ethics, identify what you want to learn and explain how you will evaluate and apply your learning. You will also want to show how attending NNEC furthers your professional development.

AACN members may apply for a scholarship to attend NNEC at www.aacn.org/scholarships by Jan. 19, 2015. Email scholarships@aacn.org with your questions.
Top Medical Device Challenges

Medical device challenges are complex, long-term issues that evade easy solutions.

A survey of healthcare technology management (HTM) professionals uncovers their challenges in trying to provide safe work environments.

Results appeared in “And the Survey Says … AAMI Members Report Top Medical Device Challenges,” in Biomedical Instrumentation & Technology, the bimonthly journal of the Association for the Advancement of Medical Instrumentation (AAMI), Arlington, Virginia, which supports the healthcare community in development, management and use of safe and effective medical technology.

HTM professionals from 195 U.S. hospitals rate “ensuring networked devices and systems work properly” highest on the list of medical device challenges. Sixty-two percent of those surveyed consider the networking issue challenging or extremely challenging. “Integrating data into electronic health records” was the next concern, with “maintaining infusion pump systems” third.

“The top challenges reported in the 2014 survey reflected those seen in previous years, indicating that these are complex, long-term issues that evade easy solutions,” explains survey author Joseph Sheffer, AAMI production specialist. “Many of the problems, such as managing the interconnectivity of devices on the IT network, underscore the need for systems-level solutions,” he adds in the article.

Additional challenges noted in the survey are cybersecurity, device incident reporting, product recalls, spectrum and wireless management, battery management, endoscope management and nonhospital devices brought in by patients.

Respondents rated the “biggest mistakes made by organizations when investing in new technology.” The top five responses: (1) Not including all relevant staff in decisions; (2) Basing decisions solely on price; (3) Not investigating the cost of ownership thoroughly enough; (4) Not doing a proper technology assessment up-front; and (5) Making purchase decisions based on the preference of one clinician.

Most survey respondents (78.5 percent) work in hospitals, with two-thirds (67 percent) describing their facility as general/medical surgical.

Watch Your Health!

Apple Watch measures workout intensity with sensors that track distance covered and type of exercise.

Apple recently introduced its new smartwatch, which can collect and share health data via the HealthKit app, available with the new iOS operating system.

“Apple Rolls Out the Health-Enabled Apple Watch,” in Modern Healthcare, explains that the device can track medical and fitness data, including pulse. Apple CEO Tim Cook says the watch “can pick up pulse rate to measure intensity of workout with sensors to measure distance covered and type of exercise.”

John Halamka, chief information officer at Beth Israel Deaconess Medical Center, Boston, believes the combination of the app and the wearable device will help hospitals achieve continuous wellness, he says in the article.

“If this device has a lot of functionality for monitoring health and it’s so easy to use that we can just ship it to people, and it connects with the iPhone that they already own, that might be compelling for us,” adds Joseph Kvedar, founder of the Center for Connected Health, Boston.

However, a survey of 500 people referenced in the article indicates that health and fitness ranks very low as a reason to buy the watch. “Some question whether the Apple Watch can truly nudge consumers into better health.”
A recent string of closure announcements indicates that rural hospitals are struggling financially because of declining inpatient volume, falling reimbursement rates and insufficient revenue.

The closures reported in “Rural Hospitals Struggle to Keep Doors Open,” published in FierceHealthFinance, include East Texas Medical Center Regional Healthcare System, Tyler, which did not renew leases with two affiliates and will phase out the inpatient emergency department at a third rural hospital.

Crittenden Regional Hospital in West Memphis, Arkansas, recently closed its doors after a fire crippled the struggling hospital, affecting 400 employees whom hospital leaders are trying to place at other facilities.

In a related article in FierceHealthFinance, University of North Carolina Professor Mark Holmes, who studied the economic impact of rural hospital closures, suggests that these closures have major implications for the communities. Three years out, he adds, losing a hospital costs a community, on average, “about 1.6 percentage points in unemployment [and] about $700 in per capita income [in year 2000 dollars, which adjusted for inflation is closer to $1,000 today.]”

Attempting to reverse this trend, more rural hospitals are considering giving up their independent status to align with larger entities. For example, another related article in FierceHealthFinance notes that Community Memorial Healthcenter, South Hill, Virginia, will join Virginia Commonwealth University Health System to improve its bottom line and maintain access to quality care throughout the region.

At the same time, some rural hospitals are seeking ways to stay viable in a difficult financial environment. For instance, an article on the WALB News website says the Rural Hospital Stabilization Committee, Cordele, Georgia, is considering whether freestanding emergency departments could work in rural hospitals.
AACN Scholarships: They’re Not Just for School

AACN Continuing Professional Development Scholarships are a unique member benefit that supports much more than academic education. Scholarships enrich the AACN community and help members achieve their professional learning goals. Members use scholarships for a variety of purposes — such as sessions on evidence-based practice, leadership events and classes on improving communication with colleagues.

Enrich your career. Apply for an AACN scholarship at www.aacn.org/scholarships.
NTI 2015: See You in San Diego!

How will you make your NTI dreams come true this year?

The National Teaching Institute & Critical Care Exposition (NTI) is May 18-21, 2015, in San Diego with preconferences on Sunday, May 17. To experience the value of attending this year, start by downloading AACN’s ActionPak planning tools. After that, you might follow the example of Mary Young, an AACN member from Evansville, Indiana, who found creative ways to obtain funding to support her NTI experience.

“I made it my goal to attend NTI,” Young says. “I requested a scholarship through my manager, but I was too new to be considered. Then I submitted a scholarship essay to the local AACN chapter, but mine wasn’t selected,” she recalls. Young thought she could work additional hours and earn the money. But when she did the math it turned out she couldn’t work enough extra shifts in time to cover her costs.

She asked her manager again, but this time she was well prepared. AACN’s online worksheets and template letter helped Young make a strong case, guiding her through the steps to organize and optimize her NTI learning experience. Download tools to justify your attendance at www.aacn.org/nti.

“I used the template and linked it to my hospital’s specific needs with information about sessions I would attend. Three days before my birthday my manager said, ‘Your letter did the trick. You’re going to NTI!’”

Young’s participation at NTI benefited her unit and other staff. After the conference, she presented on fever management to her hospital’s interdisciplinary critical care core team, sharing her learning.

How will you make your NTI dreams come true this year? Let us know and share with others on our Facebook page, facebook.com/aacnface.

AACN Launches Updated Online Pharmacology Course

Updated course developed with American Society of Health-System Pharmacists expands its focus on safe medication administration.

Nursing practice, like time, doesn’t stand still. To help nurses keep their medication-related knowledge and skills current, AACN and education partner Elsevier Inc. have launched an updated pharmacology e-learning course.

“AACN: Acute and Critical Care Pharmacology” expands the original course by providing comprehensive education in safe medication administration for both critical care and acute care staff nurses. The course further develops competencies leading to enhanced patient safety and optimal outcomes, and is relevant for nurses new to critical care and experienced nurses looking to maintain their edge.

Created in consultation with the American Society of Health-System Pharmacists (ASHP), Bethesda, Maryland, the interactive course guides learners in applying new clinical knowledge to real-world patient scenarios, sharpening bedside clinicians’ critical thinking skills and building confidence. It helps healthcare institutions comply with The Joint Commission National Patient Safety Goals’ education requirements.

Encompassing eight lessons and one final exam, the course features approximately 30 percent new content, including updated drug monographs used by practicing pharmacists. The latest evidence-based practices, standards for safe drug administration and patient management recommendations are included.

Learners earn up to 12.0 CNE contact hours, depending on the number of lessons completed. CNE can be obtained for individual lessons or the entire course.

Individuals and organizations can purchase “AACN: Acute and Critical Care Pharmacology” at www.aacn.org/pharmacourse.
**HOSPITAL WINE BAR**

*Re: Page 7 in November AACN Bold Voices*

I think the idea of a wine bar is wonderful. If a patient nearing death is able to swallow, why not let them continue to enjoy something they have enjoyed their whole life? Two days before my father died, he had his last drink of bourbon. We all drank with him. Kudos to our French colleagues for this innovation.

Michelle Jonkiert  
Newark, Delaware

Should we ask instead why patients are required to quit drinking when they’re admitted to a U.S. hospital? I worked with a leading surgeon who would ask patients if they would have a problem not drinking after open heart surgery. Whoever said yes would come from the operating room with an alcohol drip. These patients were never drunk. We discharged them in three to four days like those who didn’t drink. When I asked the surgeon why he did this he said, “Well, son, in 15 years of doing open heart surgery, I never had a patient say ‘Hey, doc, can you fix my heart and make me quit drinking?’” We spend so many nursing hours charting about restraints and giving Ativan to patients who could be discharged if we hadn’t cut them off. Why do we assume that we know best by tying someone to a bed and medicating them, also adding thousands of dollars to their hospital stay? This assumption needs to change.

Vincent Kent  
California

**CHAPTER ENGAGES STUDENT LEADERS**

In response to a lack of student members, the Greater Washington Area Chapter has developed an engagement program to encourage lifelong learning and develop future leaders for the chapter and critical care nursing. Actively recruiting students and getting them involved in chapter activities benefits the students by exposing them to nurses who understand the importance of professional organizations. The students become involved with a chapter activity and grow professionally. The chapter benefits from fresh ideas, help in planning activities and the opportunity to develop future chapter leaders. In 2012, one student attended our annual conference; two years later, 21 attended. In 2012, our chapter had two student members; two years later we have 12. Please contact me at brettdodd@msn.com for more information.

Brett A. Dodd  
Washington, D.C.

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**Letters**

**HOSPITAL WINE BAR**

*Re: Page 7 in November AACN Bold Voices*

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Brett A. Dodd  
Washington, D.C.

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**Transitions**

Events in the lives of members and friends in the AACN community. Please visit [www.aacn.org/transitions](http://www.aacn.org/transitions) for more information about each one.

Send new entries to aacnboldvoices@aacn.org. Honor or remember your colleagues with a gift to AACN at www.aacn.org/gifts.

Claudia Barone, appointment  
Elaine Casavant, council  
Sean Clarke, new position  
Kathleen Dracup, award  
Sharon Irving, publication  
Bernadette Melnyk, appointment  
Ann O’Sullivan, award  
Cynda Hylton Rushton, fellow  
Deborah Shields, award  
Jeanne Widener, recognition

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**‘I Am a Critical Care Nurse’**

Daisy Ann Fabian says her nursing journey has been phenomenal, moving from her home country to the U.S. and finding her comfort zone in critical care. She finds caring for the sickest patients and helping them recover most rewarding. It’s the positive feedback given by co-workers, patients and their families that makes her happiest at work. Fabian enjoys cooking and often shares the results with her co-workers. She competed three times in the U.S. Open for table tennis and still plays in tournaments when she’s not painting with oil pastels. Read more about Fabian’s journey as a staff nurse when you open December’s *Critical Care Nurse* from the back.
Do you ever wonder if it will matter that you were here?

It was the late Denise Thornby who compelled me to answer that question. NTI 2001. Anaheim, California. Her president’s address.

Denise reached into the audience and tapped me on the shoulder. She challenged me to influence my practice and the decisions that affect my work environment. To be courageous in protecting patients, their families and ourselves, no matter how complex the situation.

I clearly took Denise’s message seriously because here I am, president of AACN, challenging our community to let the F-I-R-E light the way on our journey of making a difference with our optimal contributions. F-I-R-E because we are indeed Fearless. We Inquire. We’re Resilient. And, above all, we’re Engaged.

What happened between 2001 and now?
Denise helped us find courage. The kind that propels you to take action, because it is the right thing to do. Then she charged us with using that courage to make waves. Waves that make it matter we were here. Waves of influence to effect positive change through the kind of true collaboration that harnesses an ocean of possibilities.

Influential nurses are those with a dream and a vision of how healthcare should be, she said. A vision of healthcare with nursing’s rightful place at the center. How could I not be inspired to want to matter?

Always practical, Denise also gave us a map. She pointed us to Robert Staub’s “The 7 Acts of Courage,” so we could learn how to up our personal courage quotient.

We matter. Individually and collectively. As individuals, even our small acts have an effect that matters. Collectively, as the world’s largest specialty nursing organization, AACN matters.
Recently, we mattered on a national scale when our laser-like focus on patients and their families kept us above the panic that accompanied much of the initial response to the Ebola outbreak.

One way to help others engage and realize that what they do matters is to reach out and tap them on the shoulder. Invite them to join in the action however they want to and can. It’s what I do at home and when I’m on the road. It’s what Denise did for me.

Denise, it mattered that you were here. Your message is as relevant now as it was in 2001. Because of you I rarely allow a day to go by without making a wave, even if just a small ripple as I focus my flame on courageous actions that continue making AACN’s vision a reality.

Have you been tapped on the shoulder? How are you focusing your flame and igniting your F-I-R-E? What are you doing so it matters that you are here?

Please drop me a note at focustheflame@aacn.org, or post a message on my wall at facebook.com/aacnterikiss and share your story.

Teri Lynn Kiss

I want it to matter that I was here.

— Denise Thornby
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Now, many acute/critical care nurses transitioning to roles away from the bedside* have a certification option … CCRN-K.

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Why CCRN-K? This new credential enables a broader spectrum of qualified acute/critical care nurses to maintain or pursue certification.

Learn more about CCRN-K certification today!

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