I have a friend, a chemotherapy nurse in a children’s cancer ward, whose job it is to pry for any available vein in an often emaciated arm to give infusions of chemicals that sometimes last as long as twelve hours and which are often quite discomforting to the child. He is probably the greatest pain-giver the children meet in their stay in the hospital. Because he has worked so much with his own pain, his heart is very open. He works with his responsibilities in the hospital as a “laying on of hands with love and acceptance.” There is little in him that causes him to withdraw, that reinforces the painfulness of the experience for the children. He is a warm, open space which encourages them to trust whatever they feel. And it is he whom the children most often ask for at the time they are dying. Although he is the main pain-giver, he is also the main love-giver.

—Stephen and Ondrea Levine


The Courage to Care

So many of you have responded to my call to send stories about when you provided Courageous Care. They all speak to why many of us became nurses — to care for patients and their families at their most vulnerable times.

Read more in my note on page 22.

Karen McQuillan
AACN President

From caring comes courage.

—Lao Tzu
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.

Board of Directors

President
Karen McQuillan, RN, MS, CNS-BC, CCRN, CNRN, FAAN
Clinical Nurse Specialist
R Adams Cowley Shock Trauma Center
University of Maryland Medical Center
Baltimore, MD

President-elect
Clareen Wieneck, RN, PhD, ACHPN, ACNP
Associate Professor
ACNP Program Coordinator
University of Virginia School of Nursing
Charlottesville, VA

Secretary
Deborah Klein, RN, MSN, ACNS-BC, CCRN, CHFN, FAHA
Clinical Nurse Specialist
Coronary ICU, Heart Failure ICU
Cardiac Short Stay/PACU/CARI
Cleveland Clinic
Cleveland, OH

Treasurer
Paula S. McCauley, DNP, APRN, ACNP-BC, CNE
Associate Dean for Academic Affairs, Associate Professor
University of Connecticut School of Nursing
Storrs, CT

Directors
Megan E. Brunson, RN, MSN, CNE, CCRN-CSC
CICU Night RN Supervisor
Medical City Dallas Hospital
Dallas, TX

Kimberly Curtin,
DNP, APRN, ACNS-BC, CCRN, CEN, CNL
Associate Director, Clinical Nurse Leader Program
University of Texas, MD Anderson Cancer Center
Houston, TX

Nancy Freeland, RN, MS, CCRN
Senior Nurse Educator for Critical Care
University of Rochester Medical Center
Strong Memorial Hospital
Rochester, NY

Wendi Froedge, RN-BC, MSN, CCRN RN IV, Critical Care Services
Houston Methodist Willowbrook Hospital
Houston, TX

Karen L. Johnson, RN, PhD
Director of Nursing Research
Banner Healthcare System
Phoenix, AZ

Michelle Kidd, RN, MS, ACNS-BC, CCRN-K
Clinical Nurse Specialist for Critical Care
Indiana University Health Ball Memorial Hospital
Muncie, IN

Lisa Riggs, MSN, APRN-BC, CCRN-K
System Director, Regulatory Readiness
Saint Luke’s Health System
Kansas City, MO

Louise Saladino, RN, DNP, MHA, CCRN
Director of Nursing
Ochsner Medical Center
New Orleans, LA

Christine S. Schulman, RN, MS, CNS, CCRN
Critical Care Clinical Nurse Specialist
Legacy Health System
Portland, OR

Chief Executive Officer
Dana Woods

AACN CERTIFICATION CORPORATION

AACN Certification Corporation, the credentialing arm of the American Association of Critical-Care Nurses, maintains professional practice excellence through certification and recertification renewal of nurses who care for acutely and critically ill patients and their families. AACN Certification Corporation develops and administers the CCRN, PCCN, CCRN-E, CCRN-K, ACNS, ACCNS-AG, ACCNS-P, ACCNS-N, ACNPC and ACNPC-AG specialty exams in acute, progressive and critical care; CMC and CSC subspecialty exams in cardiac medicine and surgery; and, in partnership with the AONE Credentialing Center, the CNML exam for nurse managers and leaders.

Board of Directors

Chair
Mary Frances Pate, PhD, RN, CNS
Assistant Professor
East Carolina University College of Nursing
Greenville, North Carolina

Chair-Elect
Karen S. Kesten,
RN, DNP, APRN, CCRN-K, CCNS, CNE
Director of Educational Innovations
American Association of Colleges of Nursing
Washington, DC

Secretary/Treasurer
Lisa A. Falcon, RN, MS, NE-BC
Director, Trauma and Injury Prevention
Robert Wood Johnson University Hospital
New Brunswick, NJ

Directors
Sonia Axle, RN, MS, CCRN, CNRN, CCNS
Clinical Nurse Specialist
Inova Fairfax Hospital
Falls Church, VA

Denise Buonocore,
RN, MSN, ACNPC, CCNS, CCRN, CHFN
Acute Care Nurse Practitioner,
Heart Failure Services
St. Vincent’s Multispecialty Group
Bridgeport, CT

Nancy Freeland, RN, MS, CCRN
Senior Nurse Educator for Critical Care
University of Rochester Medical Center
Strong Memorial Hospital
Rochester, NY

Milisa Manojlovich, RN, PhD, CCRN
Associate Professor
Strong Memorial Hospital
Rochester, NY

Deborah Klein,
RN, MSN, CCRN
RVICU Night RN Supervisor
Medical City Dallas Hospital
Dallas, TX

Lisa Riggs,
MSN, APRN-BC, CCRN-K
System Director, Regulatory Readiness
Saint Luke’s Health System
Kansas City, MO

Editors
Marty Trujillo; Managing Editor: Judy Wilkinson; Contributing Editors: Connie Barden; Clinical Adviser: Julie Miller, RN, BSN, CCRN; Contributing Writer: Vroomen Durning; Jim Kerr, Neal Lorenzini, Dennis Nishi, Jason Winston; Art and Production Director: LeRoy Hintz; Design: Brian Burton Design Inc., Matthew Edens; Web Editor: Paul Taylor; Publishing Manager: Michael Musiel; Senior Director: Liz Bear

Advertising Sales Office
SLACK Incorporated
6900 Grove Road, Thorofare, NJ 08086
800-257-8290 856-848-1000

National Account Manager: Nicole Rutter, nrutter@slackinc.com;
Recruitment Sales Representative: Bernadette Hamilton, bhame@slackinc.com; Administrator: Ashley Seigfried

AACN BOLD VOICES is an official publication of AACN. No part of this publication or its digital edition may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage retrieval system, without permission of AACN. Copyright 2016 by AACN. All rights reserved. AACN BOLD VOICES is an official publication of AACN. No part of this publication or its digital edition may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage retrieval system, without permission of AACN. All rights reserved. AACN BOLD VOICES is an official publication of AACN. No part of this publication or its digital edition may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage retrieval system, without permission of AACN. For all permission requests, please contact Sam Marsella, AACN, 101 Columbia, Aliso Viejo, CA 92656. Telephone: 844-362-2000. Fax: 949-362-2049. Email: sam.marsella@aacn.org. Prices on bulk reprints of articles available on request from AACN at 800-859-1712. AACN BOLD VOICES is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL).

The statements and opinions contained in AACN BOLD VOICES do not necessarily represent the views or policies of the American Association of Critical-Care Nurses, except where explicitly stated. Advertisements in this publication or its digital edition are not a warranty, endorsement or approval of the products or services by AACN or the editor and content contributors of AACN BOLD VOICES, who disclaim all responsibility for any injury to persons or property resulting from any ideas or products referred to in the articles or advertisements. Individual subscriptions by request: Institutional subscriptions: $20. Printed in the USA.
SuperSession Speakers Will Deliver Big Ideas and Laughter at NTI 2016

Join us to experience the magic of NTI and the rich history and culture of New Orleans.

The National Teaching Institute & Critical Care Exposition (NTI) is May 16-19, 2016, (preconferences May 15) at the Ernest N. Morial Convention Center in New Orleans. Our popular SuperSessions will set the tone for days filled with learning and inspiration. This year’s SuperSession lineup is sure to deliver the entertainment and motivation that NTI attendees love.

On Monday, Dan Harris will kick off our celebration. Harris is co-anchor of “Nightline” and the weekend edition of “Good Morning America” on ABC. He regularly contributes stories for “20/20,” “World News Tonight With David Muir,” and the weekday edition of “Good Morning America.” He is also the author of “10% Happier,” a New York Times best-selling book on meditation.

AACN President Karen McQuillan will follow with insights she has learned during her presidential year, building on the theme, “Courageous Care.” She is a clinical nurse specialist at R Adams Cowley Shock Trauma Center, University of Maryland Medical Center, Baltimore.

Tuesday’s SuperSession will be rich with motivation and humor. Mel Robbins, an expert on human behavior and motivation, is a popular on-air commentator and opinion writer. Her book on the brain and productivity, “Stop Saying You’re Fine,” is a business best-seller. She has shared her fiery advice with millions through appearances on “Good Morning America,” “Dr. Phil,” “The Dr. Oz Show” and “Oprah.”

On Wednesday, we’ll hear BJ Miller’s amazing story. An electrical shock sustained when he was a Princeton undergraduate nearly cost him his life. Through this lens, Miller has developed an extraordinary sense of presence and understanding that he shares with others. As executive director of the Zen Hospice Project, Miller oversees the pioneering integration of social and medical services grounded in spirituality and humanity, helping to make empathy-driven end-of-life care available to all.

Then, AACN President-elect Clareen Wiencek will inspire us when she reveals AACN’s new theme for the year ahead. Associate professor of nursing at the University of Virginia School of Nursing, Charlottesville, and ACNP program coordinator, Wiencek has almost 40 years of experience as a nurse manager, educator, researcher and bedside nurse in critical care.

Please join us to experience the magic of NTI and the rich history and culture of New Orleans. The vibrant culinary and music scene adds to the atmosphere as we welcome our community of exceptional nurses to NOLA. See you there!

Registration opens in early February.

Engage, Connect, Participate at 2016 LDW at NTI

Chapter Leadership Development Workshop features techniques and competencies for successful chapter management.

The 2016 Chapter Leadership Development Workshop (LDW), at the National Teaching Institute & Critical Care Exposition (NTI) in New Orleans, is an excellent learning opportunity for current and future chapter leaders. Be a part of this preconference, featuring techniques and competencies for successful chapter management.

LDW will take place Sunday, May 15, from 8 a.m. to 5 p.m. at the Sheraton Hotel, Grand Ballroom, class code PC125. Sign up when you register for NTI. To add LDW after you register for NTI, call Customer Care at 800-899-2226. Each AACN chapter that sends one person to LDW automatically receives a one-time $435 grant to help defray attendance costs.

Discuss the workshop at your next chapter meeting to ensure your chapter is represented. There is no limit to the number of additional chapter leaders or members who may participate for $85 each. Contact your chapter advisor or email chapters@aacn.org with your questions.
Volume Discount Programs Support Excellence Through Certification

Two volume discount options can help nurses become certified.

To support nursing excellence through certification, AACN Certification Corporation offers two volume discount programs. These programs — Certification Value Program and Certification Group Discount — provide significant savings on eligible credentials to groups of nurses or to employers with multiple certification candidates.

The Certification Value Program enables employers to purchase 30 or more prepaid exam vouchers at a discount for eligible credentials (CCRN, CCRN-E, CCRN-K, PCCN, CMC and CSC). The Certification Group Discount provides groups of 10 or more nurses applying together with a $20 savings per exam.

“Certification benefits nurses and their patients,” says Kelli Lockhart, certification director, “and our two volume discount options can help to get more nurses certified.”

The Certification Value Program offers substantial savings to hospital-based employers through a prepaid exam voucher program. It also provides access to a world-class certification review course for each exam type purchased, enhancing clinical knowledge and building test-taking confidence.

Through the program, employers purchase a minimum of 30 certification exam vouchers, valid for three years from the date of purchase. This makes it easy for nurse managers, nurse educators and nursing leaders to provide the vouchers to their employees to apply for the certification exam. Candidates have 90 days to sit for their exam after receiving notification of application approval.

A second option, the Certification Group Discount, allows 10 or more certification exam candidates to receive $20 off the regular price of each exam. Each candidate completes a special Certification Group Discount exam application and gives it to a designated group coordinator along with applicable exam fees. The coordinator then submits all applications, documentation and fees together in one package to AACN. Once the applications are processed, candidates have 90 days to sit for their exam.

“As an industry leader and your partner in certification for acute and critical care nurses, AACN understands your certification needs,” Lockhart says. “We hope these programs enable you to have as many of your nurses certified as possible.”

For more details and to see what price discounts apply, visit AACN’s certification discounts page.

Celebrate Certified Nurses Day 2016

Start planning for March 19, when hospitals and healthcare organizations across the country will celebrate Certified Nurses Day 2016. 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, and 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 the local media.
- Conduct a certification drive or fair to raise awareness about the various 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.
Patient Satisfaction Linked to Preparedness for Discharge

The analysis suggests the need for more investigation into the requirements for patients who are not ready for discharge, in order to increase their satisfaction.

Patients who feel prepared for hospital discharge are more apt to say they were satisfied with their care than those who are discharged before they feel ready.

“In general, the length of hospitalization is determined by the amount of time it takes for patients to return to a state of health that will allow the remainder of their recovery to be done safely outside the hospital,” notes analysis co-author Emily Winslow, University of Wisconsin School of Medicine and Public Health, Madison.

The analysis suggests the need for more investigation into the requirements for patients who are not ready for discharge, in order to increase their satisfaction.

REFERENCE:

Magnet Accreditation Leads to Greater Patient Satisfaction

Patients report higher levels of satisfaction when treated at Magnet hospitals, which are nationally accredited for nursing excellence.

A study in HSR: Health Services Research evaluated patients’ experiences from 212 Magnet hospitals and 212 non-Magnet hospitals. The results show higher levels of satisfaction from patients admitted to Magnet hospitals. Nurses at Magnet hospitals also receive more support from administration, which helps them give better quality care.

Hospital Consumer Assessment of Healthcare Providers and Systems survey results comprise 30 percent of a hospital’s total performance score for reimbursement by the Centers for Medicare & Medicaid Services.

REFERENCE:
Analysis Seeks Link Between Job Stress, Stroke Risk

People with high-stress jobs have a 58 percent greater likelihood of an ischemic stroke than those with low-stress jobs.

High-stress occupations can increase the risk of stroke, according to an analysis of several international studies, although the lack of research prevents confirming a direct link between the two.

“Association Between Job Strain and Risk of Incident Stroke: A Meta-Analysis,” in Neurology, reviews six studies with 138,782 participants and finds that people with high-stress jobs present a 22 percent greater stroke risk than people in low-stress jobs, with the risk for women at 33 percent.

“Many mechanisms may be involved in the association between high-stress jobs and the risk of stroke,” lead researcher Yuli Huang, from the Department of Cardiology at Southern Medical University in Guangzhou, China, says in a related article in HealthDay.

Using studies from the United States, Sweden, Japan and Finland, the analysis put occupations in four categories based on how hard the individuals work (including time pressure, mental demand and coordinating requirements) and the degree of control over their labor:

- Passive jobs (e.g., manual laborer) have little demand and little control
- Active jobs (e.g., doctor, engineer) have high demand and high control
- Low-stress jobs (e.g., scientist, architect) have low demand and high control
- High-stress jobs (e.g., nurse’s aide, service industry) have high demand and low control

Although nurse’s aides were included in the high-stress category, nurses were not mentioned in the analysis.

According to a news release from the American Academy of Neurology, passive and active jobs do not have increased stroke risk, but people with high-stress jobs have a 58 percent greater likelihood of an ischemic stroke than those with low-stress jobs. The six studies measured job stress but not other potential stroke risk factors such as high cholesterol and high blood pressure.

“Having a lot of job stress has been linked to heart disease, but studies on job stress and stroke have shown inconsistent results,” says Dingli Xu, with Southern Medical University in Guangzhou, in the release. “It’s possible that high stress jobs lead to more unhealthy behaviors, such as poor eating habits, smoking and a lack of exercise.”

The analysis suggests the need for research into whether reducing job stress can also reduce stroke risk, much as previous studies focused on the link between stress and heart disease. Research could also focus on ways job stress can be modified to reduce these risks.


New Heart Device Helps Patients With Kidney Failure

The S-ICD operates like a traditional ICD, which sends a shock to the heart to correct arrhythmia; however, it doesn’t access the vascular system.

New York Methodist (NYM) Hospital in Brooklyn has introduced a less-invasive treatment option for patients with heart conditions who have life-threatening cardiac arrhythmias and kidney failure.

“New Heart Device Also Benefits Patients Living With Kidney Failure,” in Advance for Nurses, explains that the subcutaneous implantable cardioverter defibrillator (S-ICD) is an innovative new heart device that operates like a traditional implantable cardioverter defibrillator (ICD), which sends a shock to the heart to correct arrhythmia. However, the S-ICD doesn’t require access to a patient’s vascular system.

Traditional ICDs have wire leads that extend directly into the heart chambers. Although ICDs have a completely separate process compared to kidney dialysis, complications arise when they are used at the same time as dialysis, which requires regular access to a patient’s vascular system. Both processes together can significantly increase the risk of clotting.

The S-ICD is implanted directly under the skin like a traditional ICD but uses a subcutaneous wire positioned over the heart. According to Lawrence Stam, associate chief of nephrology at NYM, the less-invasive nature of the S-ICD avoids the risk of complications altogether, while also making it easier to remove the wire, without having to go into the heart due to an infection or other complication.
Preventing Maternal Deaths From Sepsis

Consider maternal sepsis in critically ill women even in the absence of fever.

Preventing maternal deaths caused by sepsis may depend on three key factors — early recognition of sepsis, prompt use of appropriate antibiotics and proper escalation of care.

“Maternal Deaths Due to Sepsis in the State of Michigan, 1999-2006,” in Obstetrics & Gynecology, finds that 22 of 151 pregnancy-related deaths resulted from sepsis, based on an analysis of Maternal Mortality Surveillance records from the Michigan Department of Community Health. The deaths occurred during pregnancy and up to 42 days postpartum.

Of those 22 deaths, 13 women presented to the hospital with sepsis, two developed sepsis during hospitalization and seven developed sepsis at home without hospital admission, the study finds. Hospital records available for 15 cases reveal delays in appropriate antibiotic treatment for 11 women and delays in care escalation for eight others.

A related article in Medscape Medical News notes that study observations led to these suggestions:

- Consider maternal sepsis in critically ill women even in the absence of fever.
- Administer early appropriate antibiotic therapy and use consultation (maternal-fetal medicine, infectious disease, critical care) early, if there is marked derangement in vital signs or an inadequate response.
- Vital sign derangement should be investigated, closely monitored and, if severe, lead to prompt escalation of care.
- Vital signs should be taken at appropriate intervals consistent with the patient’s condition.

“If further studies reveal a similar rate of maternal deaths at home due to sepsis and postpartum deaths after discharge, there may be a role for improving patient education concerning when to seek medical attention, timing of postpartum visits and use of home visits,” the study explains.

Long Shifts Linked to Nurse Burnout, Job Dissatisfaction

Nurses working shifts of 12 hours or longer were more likely than nurses working fewer hours to experience burnout. Longer hours for hospital nurses are associated with adverse outcomes such as burnout, which may present safety risks for patients and nurses, according to a study in *BMJ Open*.

“Association of 12 h Shifts and Nurses’ Job Satisfaction, Burnout and Intention to Leave” included 31,627 RNs in 2,170 general medical/surgical units in 488 hospitals across 12 European countries. The survey was mailed or directly distributed between June 2009 and June 2010. Study results indicate that nurses working shifts of 12 hours or longer were more likely than nurses working fewer hours to experience burnout, in terms of emotional exhaustion, depersonalization and low personal accomplishment. Also, they were more likely to be dissatisfied with their job and work schedule flexibility, and decide to leave their job.

“Our results provide the basis for managers and nurses alike to question routine implementation of shifts longer than eight [hours], and the use of overtime that is associated with poor nurse outcomes under any shift length, suggesting that overtime may not be a useful strategy to cope with nursing shortages,” the study concludes.

The design of the study is cross-sectional, which “limits the ability to infer causal relationship between nurses’ shift length and nurse outcomes causality.” Study limitations also include lack of “control for other aspects of shift work, including weekly hours, length of hours overtime, the possibility of taking breaks during shifts and sleep patterns.”


Promoting Staff Resilience in Pediatric ICUs

Healthcare professionals experience workplace stress, which may lead to impaired physical and mental health, job turnover and burnout. Resilience allows people to handle stress positively. However, little research has been directed at finding interventions to improve resilience. To fill this gap, researchers at Medical College of Wisconsin, Milwaukee, sought to describe the availability, use and helpfulness of resilience-promoting resources and identify an intervention to implement across multiple pediatric ICUs.

“Promoting Staff Resilience in the Pediatric Intensive Care Unit,” in *American Journal of Critical Care*, collected data on availability, use and impact of resilience resources from leadership teams and staff members in pediatric ICUs, along with resilience scores and teamwork climate scores.

Leadership teams from 20 pediatric ICUs completed the leadership survey. Individual surveys were completed by 1,066 staff members (51 percent response rate).

The study concludes that hospitals could facilitate access to peer discussions and social interactions to promote resilience. The two most often used and impactful resources are one-on-one discussions with colleagues and informal social interactions with them out-of-hospital.

Other underused but highly impactful resources include taking a break from stressful patients, being temporarily relieved of duty after a patient’s death, palliative care support for staff and structured social activities out-of-hospital. The use and influence of resources differed significantly between professions, between those with higher versus lower resilience, and between individuals in units with low versus high teamwork.

“Our results demonstrate that it is unlikely for a single intervention to satisfy the professional and personal needs of all staff members in every unit. To make the greatest impact, a set of interventions targeted to local contexts may be more advisable than focusing resources on a single intervention or program,” the study concludes.

Staph Infections Pose Risk to Hospitalized Infants

Since infections and deaths from MSSA exceed those due to MRSA, consideration should be given to including MSSA as well as MRSA in hospital infection control efforts.

When she was a kid, Nhu Tran used to pretend she was Wonder Woman. Now that she’s older and no longer pretends — with apologies to Diana Prince — she must be the real deal. Nhu is a neonatal CCRN who works as a clinical research RN at Children’s Hospital Los Angeles (CHLA) in the Cardiothoracic Surgery Department. Before working as a research RN, she was a staff RN in the Neonatal and Infant Critical Care Unit at CHLA. Certified as a critical care nurse in the Neonatal ICU and a certified research professional, she’s currently working on her PhD at UCLA and is a Robert Wood Johnson Foundation Future of Nursing Scholar. And, oh yes, in her spare time she likes to do weird stuff … like climb Mt. Kilimanjaro, which she did for “fun.”

How did you get started in nursing?

I certainly didn’t want to be a nurse when I was a kid. I wanted to be Wonder Woman. Well, I enrolled at USC [University of Southern California] fully intending to become a pharmacist, like my parents, but something was pulling at me. I wanted to have a good career and be able to help people, and that [pharmacy] was something I thought I wanted to do. But I just found I wanted to do something else.
So you found nursing.
I found nursing — or maybe it found me — and I fell in love with it. I loved it from the beginning. I have been in the NICU for 12 years, and it’s incredible. There’s not much that you can compare it with.

Where did you go to school?
I graduated from USC in 2001, and then I stayed there to earn a master’s in nurse leadership and administration in 2003. But I knew I really didn’t want to do nursing administration. So I went to work, but going back to school was always in the back of my mind.

You knew you’d go back?
Yeah, I think I always knew I wanted to go back to school. I think I’m kind of a bookworm.

Kind of curious that, being a USC double-grad, you decided on cross-town-rival UCLA to continue your studies.
I know, I know. I got a lot of grief from friends — and I still do — with the whole USC-UCLA thing. I get so conflicted sometimes, and I still have clothes from both schools. I’m so conflicted sometimes on whom to root for when they play each other. But it’s been an incredible opportunity. I love research so much and helping care for people.

What do you love about nursing?
It’s pretty simple, really. I love seeing babies smile. I’m not at the bedside as much now as before, since I’m studying, but there is nothing to compare with it. It always makes my day to see that little grin.

Many nurses have an ‘aha’ moment that seems to confirm or validate their choice of nursing as a career.
Have you had one?
I have. We all [in her unit] called it our little Christmas miracle. There was a baby in the NICU. The pregnant mother had had a transplant and because of that had needed to take anti-rejection meds, which we knew would impact the baby’s health. So we delivered the baby. The poor thing had all kinds of defects — it was not very compatible with life, and we all knew it. This was right around Christmas. I can’t remember if it was Christmas Eve or Christmas Day, but it wasn’t going to last very long. And it smiled. It was incredible. We all kind of called that a Christmas miracle. It’s just little things like that.

And then there is the flip side.
There is. It’s so frustrating when the prognosis is poor, the whole issue of prolonging life just to prolong life, as opposed to quality of life and suffering and all of those factors. These are all ethical dilemmas. I guess you’d say they are really hard to come to terms with. It’s never easy, and one of the greatest conflicts we have — when does it become futile? To me, those are the biggest challenges, and overcoming them is just reflecting again on what makes me happy as a nurse, what reminds me why I do this.

Considering the high level of stress in your career, how important is work-life balance?
Dealing with the stress we go through is extremely important, so finding a way to get some balance outside of work to recharge the batteries, I guess you could say, is crucial.

How do you deal with it?
I think I have the ‘balance’ thing down pretty well. I have always been pretty active. I love to travel. A group of girl-friends and I used to go all over. One year we went to Brazil, then another time we went down to South Africa.

Then we decided to do The Climb.

“I certainly didn’t want to be a nurse when I was a kid. I wanted to be Wonder Woman.”

The Climb?
Yeah, I don’t know how this started, but I was with some of my friends, and someone suggested that it would be fun to climb Mt. Kilimanjaro.

Yeah, it sounded pretty cool at first.
So when did it stop sounding pretty cool?
I’d always been active. I thought I was OK to do this. It was on my bucket list. But you don’t know how hard that is.

On the day of the ascent, we finished at 6 in the evening, ate dinner and then got up at 11 that night to go out again, because it’s much better to climb at night than during the day, because there are so many people climbing during the day.

It was crazy. First of all, it’s freezing. Then we’re getting rained on, hailed on. And then in the dark, it’s very scary. Yeah, I wasn’t feeling so brave at times. I felt crappy and started walking at the back of the group. But we had great guides helping us out.

It was an incredible experience. There were times I wasn’t sure it would ever end, I’m telling you. I think I slept for a week when I got back. But we did it.

What are your thoughts about AACN?
AACN has played a significant role in my career. Huge. I knew I wanted to become certified and how important it is. Since then, I have helped with different certification committees. We feel it’s very important to be certified, and those committees are the very best around. Really.

What else is on your bucket list?
The year I graduated from USC, 2001, the university began closing its nursing program. It’s sad. I can’t believe it. But I want to open it back up. It’s one of my future goals. It’s a really long-term one and will require a lot, but it’s one that’s on my bucket list.

Interview by Paul Taylor (paul.taylor@aacn.org)
**Very Premature Neonates Surviving at Higher Rates**

Babies born at 23 to 24 weeks had the largest increase in survival rates. Improvements in neonatal and maternal care have boosted the survival rates of extremely preterm neonates and reduced complications for an increasing percentage of the surviving babies. “Trends in Care Practices, Morbidity, and Mortality of Extremely Preterm Neonates, 1993-2012,” in JAMA: The Journal of the American Medical Association, reports that babies born at 23 to 24 weeks had the largest increase in survival rates, and those born between 25 and 28 weeks had the highest gains in survival without major health problems. The study covered 34,636 babies born at 26 Neonatal Research Network (NRN) centers (academic hospitals) in the U.S. from 1993 to 2012.

Significant changes in interventions include an increase from 24 percent of mothers receiving antenatal corticosteroids in 1993 to 87 percent in 2012, caesarean deliveries increasing from 44 percent to 65 percent, and intubation in the delivery room dropping from 80 percent to 65 percent. Rates of survival without major complications did not change for babies born at 22 to 24 weeks, who still require the most intense interventions, but improved 2 percent per year for babies in the 25- to 28-week range.

The one complication that did increase was rates of bronchopulmonary dysplasia from 2009 to 2012 among babies born at 26 to 27 weeks. “Our findings show that progress is being made and outcomes are improving,” lead study author Barbara Stoll, professor and chair of pediatrics, Emory University School of Medicine, Atlanta, says in a related news release. “This information should be valuable in counseling families and in developing new interventions to help prevent and treat significant health problems in these infants.”


---

**Light-Protected Parenteral Feedings Reduce Premature Infant Mortality**

The survival rate for premature infants increases when their intravenous (IV) nutrition is protected from light, notes a review in Journal of Parenteral & Enteral Nutrition. “Shielding Parenteral Nutrition From Light Improves Survival Rate in Premature Infants: A Meta-Analysis” states that light damages the cells of IV nutrition and produces oxidants, such as hydrogen peroxide, which are harmful to premature infants.

Four trials were assessed in this review, comprising 800 premature infants born between 26 and 31 weeks gestation. The mortality rate among infants with light-exposed feedings was 5 to 32 percent. This rate was halved in the light-protected group, the review notes; however, the mortality rate for males was twice as high as females in this group.

“If we can reduce the peroxide [in the feedings] then this is a winner,” review co-author Jean-Claude Lavoie of the University of Montreal says in an interview with CBC News. The review also finds that protecting the feedings from light may prevent future complications in the lungs and kidneys.

The findings are significant, considering it was almost 20 years ago when a treatment was discovered that caused such a dramatic reduction in mortality. That treatment involved giving infants surfactant for lung development, according to the interview with CBC News.

The review adds that Canadian hospitals do not routinely shield feedings from the light, a process that should begin from the time the solutions are prepared in the pharmacy, including withdrawal by syringe, up to and during delivery. More studies are needed to determine if these findings are similar for older children and adults who receive long-term home parenteral nutrition, and if shielding would help prevent complications, the review concludes.

Brain ‘Fingerprint’ Might Predict Mental Illness Risk

The study points to a distinct pattern of brain activity in each person, one that held true whether the individual was doing something or just sitting.

F unctional magnetic resonance imaging (fMRI) creates a brain “fingerprint” that can accurately identify individuals in a large group, possibly predicting risk of mental illness and measuring the effects of medical treatment.

“Functional Connectome Fingerprinting: Identifying Individuals Using Patterns of Brain Connectivity,” in Nature Neuroscience, also reveals that connectivity profiles can predict levels of fluid intelligence — quick thinking and problem solving — noting that the “same networks that were most discriminating of individuals were also most predictive of cognitive behavior.”

The Yale University study used data from multiple fMRI brain scans of 126 volunteers, reports a related article in NBC News. Participants were part of a larger study called the Human Connectome Project that seeks to determine how parts of the brain work together.

The study points to a distinct pattern of brain activity in each person, one that held true whether the individual was doing something or just sitting, the article states.

“Characteristic connectivity patterns were distributed throughout the brain, but the frontoparietal network emerged as most distinctive,” the study adds. Those are regions associated with fluid intelligence, explains study author Emily Finn, a Yale graduate student.

“The real potential in this is not predicting IQ per se, but things that are harder to predict in a test like who is going to go on to develop mental illness,” Finn adds in the article in NBC News. “Maybe we could find a way to predict it so we can intervene and prevent mental illness.”


Apple Invents a Wearable Biomedical Ring

The device can collect user data such as heart rate, temperature, motion, perspiration and galvanic skin response.

A pple recently filed a patent for a wearable ring with biometric sensors, microphones, motion sensors, cameras and a small display, to monitor the user’s health.

According to “Apple Is Developing an Electronic Ring Full of Biosensors,” in FierceMedicalDevices, the finger-mounted device will collect user data such as “heart rate, temperature, motion, perspiration and galvanic skin response” as well as record and transmit what the user writes. The device is controlled with voice, motion or a touch interface that controls features in the ring or in a separate paired computing device.

Although many features are already in, or planned for, the Apple Watch, this much smaller device will introduce unique capabilities such as inductive wireless charging. Data in the device also can be shared wirelessly with others, including trainers or health professionals in a clinical setting; providing a pulse reading from the user in the form of a heartbeat animation or haptic feedback, e.g., vibration as a response.

According to an article in AppleInsider, the device also could have non-healthcare applications, such as security. Biometric data could authenticate the user by comparing newly collected information against a database of known user signatures.
Propofol Reduces Risk of AKI When Sedating ICU Patients

In addition, fluid-related complications, the need for renal replacement therapy and the ICU mortality rate were lower among patients receiving propofol.

Propofol is safer than midazolam and can reduce the risk of adverse renal-related outcomes when sedating critically ill patients on mechanical ventilation.

“Renal Outcomes in Critically Ill Patients Receiving Propofol or Midazolam,” in CJASN: Clinical Journal of the American Society of Nephrology, notes that researchers from the Federal University of Ceará in Brazil compared 698 patients treated with propofol to the same number of patients given midazolam. The criteria for selection included patients in their first ICU admission, and all required mechanical ventilation.

Incidents of acute kidney injury (AKI) in the first seven days of ICU stay were more than 12 percent lower in patients given propofol compared to those treated with midazolam. Propofol was also associated with lower AKI incidents using both urine output and serum creatinine criteria. In addition, fluid-related complications, the need for renal replacement therapy and the ICU mortality rate were lower among patients receiving propofol.

The study drew from propensity-matched data in the Multiparameter Intelligent Monitoring in Intensive Care II database (Beth Israel Deaconess Medical Center, 2001-2008). The database is maintained by the Massachusetts Institute of Technology Laboratory for Computational Physiology, Boston.

A related article in Renal & Urology News notes the study’s limitations, including the retrospective nature of the study. The data was from one center, so more research is needed to determine the application of the findings in other settings.

REFERENCES:

A Call for Scent-Free Hospitals

Canadian healthcare facilities should be free of artificial scents, advises “Artificial Scents Have No Place in Our Hospitals,” an editorial in CMAJ: Canadian Medical Association Journal. “This is particularly concerning in hospitals, where vulnerable patients with asthma or other upper airway or skin sensitivities are concentrated.”

A previous article in Journal of Environmental Health, referenced in the editorial, states that 30 percent of the U.S. population claim some sensitivity to scents worn by others, and 27 percent of those with asthma say that artificial scents worsen their disease.

“These patients may be involuntarily exposed to artificial scents from staff, other patients and visitors, resulting in worsening of their clinical condition,” the editorial adds.

This stance has changed over past years, when the seriousness of scent-related triggers was not understood. Now, research shows that scents can cause irritant-triggered neutrophilic inflammation of the airways.

Artificial scents include perfumes and colognes, cleaning products, bleach and secondhand cigarette smoke, adds a related article in FierceHealthcare. “Experts also have noted that the toxins in common cleaners, disinfectants and sanitizers can trigger asthma and be hazardous to pregnant women,” the article notes. “Some experts recommend that hospitals buy environmentally friendly cleaning products with ‘Green Seal’ certification as part of an overall greening of healthcare facilities.”

The editorial adds that scent-free policies should include visitors and patients, not just staff. It concludes that Canadian hospitals must develop uniform policies banning artificial scents, and the directive should be part of the hospital accreditation process.

What is your hospital’s policy on artificial scents? 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/aacnfice.

REFERENCES:
Flegel K, Martin JG. Artificial scents have no place in our hospitals. CMAJ. 2015;187(16):1187.
Longer Ambulance Rides Increase One-Year Mortality

Patients with AMI admitted to the hospital following ambulance diversion had 9.8 percent higher one-year mortality compared to patients who were not diverted.

Patients with acute myocardial infarction (AMI) whose ambulances are sent to a farther hospital have poorer outcomes, according to a study in *Health Affairs*.

“Ambulance Diversion Associated With Reduced Access to Cardiac Technology and Increased One-Year Mortality” states that while ambulance diversion is not independently associated with treatment, patients with AMI admitted to the hospital following diversion had 9.8 percent higher one-year mortality compared to patients who were not diverted. Ambulances are diverted when hospital emergency departments temporarily don’t have the capacity to deal with certain emergencies.

The study included 28,683 patients with AMI in the main analysis and 22,058 in the readmission analysis for 26 California counties from 2001 to 2011. Fifty-one percent (14,628 patients) were not diverted, and the remaining patients were either diverted for less than six hours, between six and 12 hours, or 12 hours or more. The study also finds that people of color were more likely to be sent to a farther hospital.

“One smaller study in New York City also linked diversions with higher heart-attack death rates, while others have found that diversions can lead to delays in administering drug therapy to heart-attack patients,” adds a related article in *Kaiser Health News*.

Since this study was conducted for California hospitals, a limitation is the inability to generalize the findings to other states; however, state administrators are reducing diversion rates. The article explains, “B.J. Bartleson, vice president of nursing and clinical services for the California Hospital Association, said the state’s hospitals are working with local EMS agencies to make sure patients get to the right hospital at the right time.”

REFERENCE: Shen YC, Hsia RY. Ambulance diversion associated with reduced access to cardiac technology and increased one-year mortality. *Health Aff.* 2015;34(8):1273-1280.
Better Hospital Design Improves Patient Outcomes

Design amenities such as gardens, nature images and private ICU rooms increase patient satisfaction, speed healing and reduce stress for patients, families and hospital staff, reports an article in FierceHealthcare.

Design elements also help prevent the spread of hospital-acquired infections (HAIs) and shorten patient stays, according to an article in Harvard Business Review (HBR).

“Innovative new hospital designs have changed patients’ experiences and expectations of what a hospital should be.”

As evidence-based hospital design evolves, nurses have an increasingly important role in developing these designs, FierceHealthcare previously reported. In fact, architectural firms often hire nurses to help designers understand the needs of the healthcare environment.

The article in HBR highlights the following benefits of proper hospital design:

- **Fewer infections.** After redesigning its ICU from shared to private rooms, one McGill University hospital in Montreal reduced its HAI rate 50 percent and shortened hospitals stays 10 percent.

- **Therapeutic benefits.** Hospital gardens — outside or indoors — provide a calming effect that speeds healing, lowers blood pressure and boosts pain tolerance. Gardens reduce stress for patients, their families and hospital employees.

- **Reduced pain.** After surgery, children who listened to 30 minutes of music or a story reduced their pain score one point. In addition, nature images in an acute psychiatric clinic saved a hospital more than $30,000 for injections that would have been used to calm agitated patients.

- **Shorter hospital stays.** By redesigning its maternity and neonatal units to allow mothers to hold their babies next to their skin, a hospital in Sweden shortened hospital stays 10 days for premature infants and also reduced morbidity rates and ventilator assistance.

Design Award Honors Innovation

Combining functional design with humanitarian delivery of critical care is the basis for the ICU Design Citation, a national award recognizing the critical care unit that best achieves that standard.

Units are judged on how well they uphold their commitment to a healing environment, efficiency, security and safety, while demonstrating innovative, unique, aesthetic and creative designs.

The Society of Critical Care Medicine, Mount Prospect, Illinois, co-sponsors the annual award with the American Association of Critical-Care Nurses and the American Institute of Architects Academy on Architecture for Health.

Applications must be received by Aug. 15 for the following year’s award. Access more information at www.sccm.org.

Job Market for RNs Continues to Improve

Nearly 25 percent of hospitals reported a vacancy rate of 10 percent or higher in 2015, compared to 5 percent in 2012.

Whether a nurse is starting a career or considering a different role after many years in the field, the job market should continue to be strong.

“Nursing Job Market Heating Up,” on nurse.com, includes a Bureau of Labor Statistics’ projection that employment for RNs would increase 19 percent from 2012 to 2022, “faster than the average for all other occupations.” A survey of 141 U.S. hospitals finds that nearly 25 percent reported a vacancy rate of 10 percent or higher in 2015, compared to 5 percent in 2012. The turnover rate for bedside nurses increased from 11 percent in 2011 to 16 percent in 2015.

In addition, the demand for experienced acute care nurses has increased during the last six to nine months in rural areas (where there are fewer candidates) and in urban communities, according to the article. Alternative nursing positions are also opening, as experienced RNs move into new roles such as nursing informatics, clinical documentation and community care.

Because experienced nurses have an advantage when competing for jobs in acute care settings, some staffing agencies recommend that new graduates build their experience by working in outpatient clinics or group homes, the article adds.
Advance Directives Not Only for Refusing Care

Many people give a document to someone who may be involved in their future care decisions, but they don’t discuss what the document truly means to them.

About one-third of people with an advance directive request common end-of-life medical interventions, with patients younger than 50 most likely to make that choice, according to a study in *Journal of Clinical Ethics*. “Assessing Advance Care Planning: Examining Autonomous Selections in an Advance Directive” also reveals the proportion of patients requesting interventions is higher than previous studies show, reports a related article in *FierceHealthcare*. “Contrary to common beliefs in the healthcare community, advance directives are used for more than refusing care,” study co-author Craig Klugman, chair of the Department of Health Sciences at DePaul University in Chicago, says in a news release. The study of 491 patients, ages 19 to 94, finds that nearly one-third requested interventions as part of end-of-life care, and younger patients were more likely than those over 50 to request that care, including antibiotics and breathing assistance. While many people give their advance directive to a lawyer or physician, the study reveals that far fewer talk about it with loved ones.

“It appears that many people hand a document to a person who may be involved in their future care decisions, but they don’t discuss what the document means or what their wishes or values are,” Klugman says in the release. “Having the document is important, but having the conversation is essential.”

That result differs from a 2013 study in *JAMA Internal Medicine* that finds most older patients at high risk of dying discuss their wishes with a family member but not necessarily with physicians, notes the article in *FierceHealthcare*.

REFERENCES:
Seven Dishes to Try in New Orleans During NTI 2016

The city’s justifiably famous cuisine remains a draw for tourists from around the world.

There is no other American city blessed with cuisine as unique and diverse as New Orleans. Its food — a delicious mixture of styles and influences, including Creole, Cajun, French, Italian, Spanish, German and African — is justifiably famous and a draw for tourists from around the world. Mark Twain said, “New Orleans food is as delicious as the less criminal forms of sin.” Here’s your proof:

1. **Gumbo.** No dish better exemplifies the melting pot of exotic flavors that is New Orleans than gumbo. A rich stew typically served over rice, popular varieties include chicken (or duck); a local sausage called andouille thickened with roux; chicken and smoked sausage thickened with the fragrant spice filé; and seafood with okra.

2. **Red beans and rice.** Red beans and rice proves the adage that simple things satisfy the most. Spicy and filling, a bowl of red beans and rice will set you back about $5 nearly anywhere in town and just might be the best thing you eat all week at NTI. A traditional Monday dinner, red beans and rice is on menus throughout the Crescent City in customary (simmered with a hambone) and meatless varieties.

3. **Po-boy.** It’s hard to believe that some people will venture all the way to New Orleans to eat a sandwich, but a po-boy is no ordinary sandwich. Although stylistically similar to a hoagie or a sub, po-boys are in a class by themselves. Served on French bread with a variety of absurdly delectable toppings (such as fried shrimp or oysters, hot roast beef or cold cuts), po-boys are true fast food — inexpensive, delicious and satisfying in every way.

4. **Muffuletta.** Speaking of delicious and satisfying sandwiches, you can’t leave the Big Easy without trying a muffuletta. One of the world’s most distinctive sandwiches, muffulettas must be experienced to be believed. The hefty sandwich is served on a large, round loaf of bread, which is sliced in half and stuffed with all manner of fillings, including salami, mortadella, capicola, provolone and swiss cheese, and then topped with the world’s most delicious olive salad and liberally doused with olive oil. We like to purchase ours from Central Grocery in the French Quarter, where the sandwich was developed early in the last century.

5. **Crawfish.** A freshwater crustacean from the swamps of southern Louisiana and farmed in the state’s rice fields, crawfish are served in a variety of ways. From being simply boiled in an almost unbearably spicy sauce and piled on a plate, to being folded into a rich and spicy stew called crawfish étouffée, to being baked in a pie — the crawfish pie that Hank Williams sang about in “Jambalaya” — there is a crawfish dish in NOLA to satisfy every taste.

6. **Jambalaya.** And speaking of jambalaya, be sure to try some. A traditional, boldly spiced rice dish, Jambalaya is made from a wealth of ingredients, including chicken, sausage and seafood, or any combination of the three.

7. **Beignets.** After all that rich, spicy and exotic fare, you might want something sweet. Nothing satisfies that craving better than a beignet. Pronounced “BANE-yay,” these crispy pillows of fried deliciousness are sometimes referred to as “French doughnuts,” although to us they seem more like individual funnel cakes. You’ll want to enjoy yours with a café au lait at world-famous Café du Monde. Go ahead and stand in line. It will be worth it.

*Bon appetit!*
Hospital-acquired pressure ulcers are a costly and largely preventable complication that occurs in acute care settings. A quality improvement study funded by the American Association of Critical-Care Nurses Clinical Scene Investigator Academy demonstrates that a comprehensive, collaborative ulcer prevention program based on staff education with a focus on adherence to protocols for patient care can be an effective way to reduce pressure ulcer incidents in ICUs. Program components include use of Braden scores, a revised skin care protocol, fluidized repositioners and silicone gel adhesive dressings. (Swafford et al. AJCC, January 2016) www.ajcconline.org

Information on the impact of tele-intensive care (tele-ICU) on nursing is limited. A survey of 1,213 nurses who work in or interface with a tele-ICU indicates that using telemedicine results in enhanced patient care, improved productivity and collaboration, and makes their jobs easier. When the researchers asked 60 nurses to rank the skills needed for optimal tele-ICU nursing practice, the top-rated competencies were skillful communication and mutual respect for tele-ICU and bedside staff. They also pointed to critical thinking skills and expert clinical ICU experience as important abilities. (Kleinpell et al., AJCC, January 2016) www.ajcconline.org

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

**Janice Gasaway**, an AACN member since 1974, past president of three AACN chapters and a member of the Circle of Excellence Society, becomes executive director of Health Care Analytics in Greensboro, North Carolina. She will establish the analytics team and develop processes that enhance understanding and use of data, and promote knowledge-driven decision making.

**Sandra Hanneman**, Jerold B. Katz professor for nursing research, University of Texas Health Science Center, Houston, joins the Physician-Patient Alliance for Health & Safety. She is a past recipient of AACN’s Distinguished Research Lectureship.

**Tonja Hartjes**, clinical associate professor, University of Florida College of Nursing, Gainesville, is named coordinator of the adult-gerontology acute care doctor of nursing practice track. She is also a peer reviewer for several nursing and critical care journals.

**Rebecca Kuhn**, executive vice president for community delivery at Banner Health, and an AACN member since 1974, is named the 2015 Alumna of the Year for the University of Arizona College of Nursing.

**Rose Labriola**, previously chief nursing officer at The George Washington University Hospital, Washington, becomes CNO at University of Miami Hospital (UMH). CEO David Zambrana says in the release, “With her leadership skills and passion for nursing, she will help our executive team bring UMH patient care to new heights.”

**Betty Sadaniantz**, a full-time faculty member at St. Joseph School of Nursing, North Providence, Rhode Island, and an AACN member since 1985, becomes the school’s dean. She earned a doctor of nursing practice from University of Rhode Island and a Master of Science in Nursing from Medical University of South Carolina.

Send new entries to aacnboldvoices@aacn.org. You may also honor or remember a colleague by making a gift to AACN at www.aacn.org/gifts.
So many of you have responded to my call to send stories about when you provided Courageous Care. They all speak to why many of us became nurses — to care for patients and their families at their most vulnerable times.

Most of you shared experiences that occurred at or near the end of a patient’s life. Jami writes that she “wiped the final tear of a dying man she cared for while his wife was en route to the emergency room and then witnessed the presentation of the handkerchief with his tear to his wife.”

One nurse describes “sitting with a patient, holding his hand, as he was terminally extubated. He had neither family nor friends — no one to be with him as he passed on. I simply held his hand and whispered words and prayers.”

Another nurse submitted this poignant message: “I admitted you to the SICU, afraid and in pain. I comforted you and advocated for you. I sat with you and your family and discussed the surgical options that had been presented and answered your questions. We built a rapport of trust and laughed together. On your last day, I was honored to be your nurse. I reminisced with your wife as she made the difficult decision to withdraw care. Your family and I held your hand and prayed as you passed peacefully.”

Others stories simply describe how you advocate for patients so they are able to experience death the way they desire.

BJ Miller, a palliative care physician and executive director of Zen Hospice Project, notes that at the end of life many simply wish to have “comfort, respect and love.” Atul Gawande, author of “Being Mortal,” encourages better communication with patients and families to determine understanding of the patients’ health condition, goals if their health deteriorates, fears they have and trade-offs they are either willing or unwilling to make, so that end-of-life decisions support their desires.

Nurses have the unique opportunity to strongly encourage patients and healthcare providers to participate in end-of-life planning in advance and to advocate for the patient’s preferences as death nears. It is a time that most patients and their families fear, but because we are so often the ones who are present with them as decisions are made, we are a critical resource. We provide a knowing and compassionate presence as life draws to an end.

And we are in key positions to participate in the redesign of units’ and health systems’ approaches to end-of-life experiences to ensure they are based on what is most meaningful to the patient. These are important responsibilities, but I believe there are few more qualified than critical care nurses to make a difference for individuals and their families as well as to impact the entire system, so that death experiences are as respectful and peaceful as possible.

As nurses, we have the courage to care when it matters most. What a privilege to provide courageous care that makes a lasting difference for patients and families.

Please email me at courageous@aacn.org to share your stories of how you provided Courageous Care that made a difference in the lives of others.

Note: We apologize if you tried to contact Karen through courageous@aacn.org and your message was returned as undeliverable. The email address is now back online, so please share your stories with us.