‘The Four Agreements’

In the best selling book *The Four Agreements* Don Miguel Ruiz gives four principles to practice in order to create love and happiness in your life. Adopting and committing to these agreements is simple. Actually living and keeping these Four Agreements can be one of the hardest things you will ever do. It can also be one of the most life changing things you will ever do.

As you practice living these four practices your life will dramatically change. In the beginning these new habits will be challenging and you will lapse countless times. With practice these agreements become integrated into your being and every area of your life and become easy habits to keep.

The Four Agreements are:

1. *Be Impeccable with your Word*
   
   Speak with integrity. Say only what you mean. Avoid using the Word to speak against yourself or to gossip about others. Use the power of your Word in the direction of truth and love.

2. *Don’t Take Anything Personally*
   
   Nothing others do is because of you. What others say and do is a projection of their own reality, their own dream. When you are immune to the opinions and actions of others, you won’t be the victim of needless suffering.

3. *Don’t Make Assumptions*
   
   Find the courage to ask questions and to express what you really want. Communicate with others as clearly as you can to avoid misunderstandings, sadness and drama. With just this one agreement, you can completely transform your life.

4. *Always Do Your Best*
   
   Your best is going to change from moment to moment; it will be different when you are healthy as opposed to sick. Under any circumstance, simply do your best, and you will avoid self-judgment, self-abuse, and regret.

   —Gary van Warmerdam


Another Angle

Speaking Up About What Matters

Andy liked beer. When he knew he was dying, he asked if he could go outside to the garden one more time, drink a beer and share a private moment with his wife.

This was not going to be easy.

Read more in my note on page 22.

Clareen Wiencek
AACN President

*The role of the undisputed leader is to speak up about what matters and say it in a way that can be heard.*

—“AACN Standards for Establishing and Sustaining Healthy Work Environments”
The American Association of Critical-Care Nurses is the world’s largest specialty nursing organization. AACN is committed to creating 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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AACN Certification Corporation, the credentialing arm of the American Association of Critical-Care Nurses, maintains professional practice excellence through certification and certification renewal of nurses who care for or influence the care delivered to acutely and critically ill patients and their families. AACN Certification Corporation offers CCRN, CCRN-K, CCRN-E, PCCN, PCCN-K, CCRN, ACCNS-AG, ACCNS-P, ACCNS-N, ACCNP and ACNPC-AO certification programs in acute, progressive and critical care; and CMC and CSC subspecialty certification in cardiac medicine and cardiac surgery.

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AACN Collaborates to Address Moral Distress

The two-day symposium culminated in a consensus on recommendations for practice, education, research and policy areas to address moral distress and build moral resilience.

Earlier this year, AACN participated in a two-day symposium, “State of the Science Symposium: Transforming Moral Distress to Moral Resiliency in Nursing,” focused on the best ways to address moral distress.

The event — held in Baltimore and part of a four-year collaborative effort with Johns Hopkins School of Nursing and Berman Institute of Ethics, American Journal of Nursing, Journal of Christian Nursing, the American Nurses Association and AACN — featured opportunities for participants to hear from experts what is known about moral distress, what's still being debated, potential avenues for study and promising practices for dealing with it.

The symposium culminated in a consensus on recommendations for practice, education, research and policy areas to address moral distress and build moral resilience. The group plans to release a full report next February.

We spoke with Karen Stutzer, assistant professor, College of Saint Elizabeth in Morristown, New Jersey, who served as AACN liaison at the symposium.

What was the purpose of this meeting?

The meeting brought together thought leaders from a variety of backgrounds to examine strategies to transform the experience of moral distress and affirm moral integrity.

How would you describe the experience?

Hopeful, grateful and energized. Over 30 years ago, Andrew Jameton gave a name to moral distress. Since then, vast research has described and measured the phenomenon. Many of the researchers and ethicists who pioneered this work attended the symposium. What gave me great hope and was especially energizing was that this dialogue was about how to intervene and prevent the demeaning impact that moral distress has on nurses. I am grateful the conversation is being moved to this level. Symposium participants were passionate about addressing moral distress, and the group came to a consensus on priorities in the areas of clinical practice, research, policy and education.

Moral distress is a term we hear a lot, but moral resilience is a newer idea. How would you define moral resilience?

When I think of resilience, I think about a person’s ability to bounce back. There is a body of work in nursing that has furthered our understanding of resilience as not a trait that a person innately has, but something that can be developed.

Taking that one step further, if we gain an understanding of how nurses bounce back from episodes of moral distress, if we understand how nurses are able to maintain their moral integrity, then we can begin to better understand this notion of moral resilience.

Can you tell us about AACN Board President Clareen Wiencek’s role at the symposium?

Clareen presented the Healthy Work Environment standards and discussed the Critical Care Societies Collaborative’s work on burnout. To successfully address moral distress, we must intervene not only with individual nurses but also with the systems in which nurses work. Attention to the work environment is essential to fostering moral resilience. Clareen pointed out that transforming moral distress to moral resilience will not happen overnight and will result from the shared work of clinical leaders, clinicians, educators, researchers and policymakers.

Is there anything else you want AACN members to know?

That AACN recognizes that moral distress is a devastating problem and is working with nursing leaders to identify priorities to transform this harmful experience, promote individual resilience and improve the environments in which moral distress flourishes. The symposium was a great start; we have a long way to go. I’m looking forward to the publication of the symposium findings and continuing this important work.
Healthcare Costs Vary Substantially Across the U.S.

The greatest variation in prices was observed for imaging, radiology and lab tests.

Some states pay twice as much for healthcare among the commercially insured, according to an analysis conducted by Health Care Cost Institute (HCCI), Washington.

“Some States Pay Twice the Price for Health Care, Finds New Report” is accompanied by HCCI’s “National Chartbook of Health Care Prices 2015,” which shows price differences among 240 common medical services in 41 states and the District of Columbia.

“Compared to the national average, Alaska has the highest average health care prices, followed by Wisconsin, North Dakota, New Hampshire and Minnesota. In New Hampshire and Wisconsin, over 20 percent of health care services are twice the national average price.” However, 90 percent of services in Arizona, Florida, Maryland and Tennessee cost less than the national average.

Prices can vary for some healthcare services more than for others. For instance, states have similar prices for acupuncture, but the cost for cataract removal differs considerably.

The greatest variation in prices was observed for imaging, radiology and lab tests.

Nine states were excluded from the analysis based on a lack of sufficient data or state statutes that discourage data sharing.

“Although revealing the extent of price variation is an important first step, more systematic and consistent research is necessary to identify the forces that drive prices,” notes “Prices for Common Medical Services Vary Substantially Among the Commercially Insured,” HCCI’s full analysis, which was published in Health Affairs. “The questions that remain for researchers, policy makers, and healthcare leaders are as follows: Why do prices for the same service differ markedly across distances of only a few miles, and what amount of that difference is justifiable?”

Out-of-Pocket Hospital Costs Increased From 2009 to 2013

Wide variability in out-of-pocket spending merits greater attention from policymakers.

Average out-of-pocket costs for hospitalization increased for insured patients in the U.S. between 2009 and 2013, largely due to rising deductibles and coinsurance.

“Out-of-Pocket Spending for Hospitalizations Among Nonelderly Adults,” in JAMA Internal Medicine, finds that total cost sharing per inpatient hospitalization increased 37 percent, from $738 in 2009 to $1,013 in 2013, after adjusting for inflation and case-mix differences.

This increase was driven primarily by the amount applied to deductibles, which grew 86 percent from 2009 to 2013, and by coinsurance, which rose 33 percent.

In 2013, total cost sharing was highest for enrollees in individual market plans ($1,875 per hospitalization) and consumer-directed health plans ($1,219). “Cost sharing varied substantially across regions, diagnoses, and procedures.”

The retrospective analysis reviewed “commercial claims data from 2009 to 2013 for 7.3 million hospitalizations of adults ages 18 to 64. The study subjects were covered by Aetna, UnitedHealthcare and Humana under employer sponsored or individually purchased plans,” notes a related article in Reuters.

“Wide variability in out-of-pocket spending merits greater attention from policymakers,” the analysis adds.

Cindy Bohmont, a CCRN for 40 years

“I love doing what I do. It is very satisfying to see my critical care education resulting in positive patient outcomes with a large touch of human kindness and caring.”

In 1976, AACN launched the CCRN credential. Since then, very few nurses have been certified all 40 years. Cindy Bohmont is one of them.

“The CCRN credential has validated that the bedside nurse is not just an underachiever," she says. “We are educated, credentialed beyond just RN, continuing to achieve higher levels of expertise and competency, and able to convert that knowledge and expertise into positive outcomes.

“I don’t want to be in management, etc. I love doing what I do. It is very satisfying to see my critical care education resulting in positive patient outcomes with a large touch of human kindness and caring. All of the components of obtaining and maintaining the CCRN credential help me to have the confidence, knowledge and skills to be the best nurse that I can be, caring for the sickest of the sick, and validates that I’m still on the cutting edge of my profession even after 40 years!”

Bohmont is profiled in this month’s Nurse Voices, pages 12 and 13.
New CMC and CSC Subspecialty Certification Exams Effective in December

The new exams are based on revised test plans, which were updated as a result of national studies of practice conducted in 2015.

On Dec. 1, AACN Certification Corporation will launch new exams for cardiac medicine (CMC) and cardiac surgery (CSC) subspecialty certifications.

The new CMC and CSC exams are based on revised test plans, which were updated as a result of national studies of practice conducted in 2015. These periodic studies and resulting test plan changes ensure that certification exams are evidence-based and tied directly to relevant practice.

What does this mean for CMC and CSC certification exam candidates?

- CMC and CSC candidates planning to sit for an exam on or after Dec. 1 should reference the new test plans available at www.aacn.org/cmccscnewdocs.
- Candidates testing now through Nov. 30 will take the exam based on the current test plans in the CMC and CSC exam handbooks.

Certification Fast Fact: Displaying Subspecialty Credentials

To properly display CMC and CSC subspecialty credentials, candidates must link the credential to a nationally accredited clinical nursing specialty certification with a hyphen, e.g., PCCN-CMC, CCRN-CSC. Nurses holding both subspecialty certifications should attach them to the same clinical nursing specialty credential with hyphens, e.g., CCRN-CMC-CSC.

Initial Eligibility: CMC and CSC

Following is a brief summary of eligibility for CMC and CSC certification. The main difference between CMC and CSC exam eligibility is that the CSC credential requires a majority of time spent caring for cardiac surgery patients within the first 48 hours postoperatively.

For detailed eligibility information, please see the certification exam handbook for your desired credential, available online at www.aacn.org/certification.

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Tackling Post-Intensive Care Syndrome

A series of articles in *AACN Advanced Critical Care (ACC)* examines post-intensive care syndrome (PICS), the effect on families (PICS-F) and how hospitals are addressing these conditions.

“Millions of ICU survivors are being discharged into the community, unprepared and uneducated about what to expect and how to adjust,” lead author Mark Mikkelsen, assistant professor at the University of Pennsylvania, Philadelphia, says in “Need for Improved Care in and Out of ICU to Treat Patients With PICS, PICS-F,” a related article in *News Medical*.

The articles in *ACC*, which focus on new and innovative solutions being tested to counter the combination of mental and physical problems patients experience following ICU stays, are as follows:

“Implementing a Mobility Program to Minimize Post-Intensive Care Syndrome” reviews the success factors in early mobility-based rehabilitation, including interdisciplinary teamwork, leadership and championing, and focusing on performance and outcome measurement, safety and quality improvement. Effective programs shorten ICU stays, reduce readmissions and return patients to physical functioning more quickly.

“A Clinic Model: Post-Intensive Care Syndrome and Post-Intensive Care Syndrome-Family” assesses one of the country’s first interprofessional clinics designed to fit the needs of post-ICU patients and families.

“Developing a Diary Program to Minimize Post-Intensive Care Syndrome” reviews the effectiveness of programs that introduce intensive care diaries and educational pamphlets as support tools.

“Peer Support as a Novel Strategy to Mitigate Post-Intensive Care Syndrome” discusses a care strategy tested in six hospitals as a pilot program. In-person peer support groups offer their collective knowledge and experience to post-ICU patients.

“Innovative strategies are urgently needed to meet [patient] needs, and peer support groups can do more than help individual survivors,” Mikkelsen adds. “They position the survivors themselves as experts key to finding solutions.”

**REFERENCES:**


FDA Approves Dissolving Coronary Stent

The device would allow cleared arteries to return to their natural shape and function after dissolving.

The Food and Drug Administration (FDA) approved a stent for patients with angioplasty that dissolves inside the artery after three years and is a long-range alternative to metallic stents.

As noted in “The FDA Approves First Absorbable Stent for Coronary Artery Disease,” on the FDA website, the Absorb GT1 Bioresorbable Vascular Scaffold System, manufactured by Abbott Vascular and previously approved in over 100 other countries, limits the development of scar tissue by releasing the drug everolimus. By reabsorbing into the body after helping to open clogged arteries, Absorb may reduce the need for medications to prevent clotting and adverse reactions to foreign substances.

In a randomized trial of 2,008 patients, the Absorb user group had a slightly higher rate of adverse cardiac events than the control group receiving metallic stents, 7.8 percent to 6.1 percent, and blood clots, 1.54 percent to 0.74 percent. Absorb is made from poly (L-lactide), similar to what is used in stitches or absorbable bone screws.

The FDA advises against the new stent for patients with known allergies to the device materials or drugs contained in it, or for those who should not undergo angioplasty or take aspirin or other blood thinners long term.

An estimated 850,000 patients a year receive coronary stents in the United States, and data from the National Heart, Lung, and Blood Institute estimate that 370,000 Americans die from coronary disease each year. If it works as expected, Absorb would allow the cleared arteries to return to their natural shape and function after dissolving, with only four platinum markers remaining for identification.

FDA Approves Hepatitis C Treatment

Epclusa, in combination with other drugs, proves effective in treating major forms of hepatitis C virus.

The Food and Drug Administration (FDA) approved Epclusa for adult patients with chronic hepatitis C virus (HCV), with and without cirrhosis.

“FDA Approves Epclusa for Treatment of Chronic Hepatitis C Virus Infection,” on the FDA website, notes that the fixed-dose combination tablet contains sofosbuvir and velpatasvir. It’s the first drug approved to treat all six major forms of HCV.

The three-phase clinical trial, with 1,558 subjects, was reviewed under the FDA’s priority review program “which provides for an expedited review of drugs that treat serious conditions and, if approved, would provide significant improvement in safety or effectiveness.”

After 12 weeks of treatment, 95 to 99 percent of patients had no detectable HCV in their blood. A group of 267 patients with decompensated cirrhosis (moderate to severe cases) was also tested. Eighty-seven subjects in this subgroup received Epclusa in combination with ribavirin. Ninety-four percent also had no detectable HCV in their blood after 12 weeks of treatment.

“This approval offers a management and treatment option for a wider scope of patients with chronic hepatitis C,” adds Edward Cox, director of the FDA’s Office of Antimicrobial Products.

Although effective, the drug carries a warning that symptomatic bradycardia and “cases requiring pacemaker intervention have been reported when amiodarone is used with sofosbuvir in combination with another HCV direct-acting antiviral. Co-administration of amiodarone with Epclusa is not recommended,” the announcement adds. The drug also should not be used with certain other drugs that may reduce the amount of Epclusa, possibly reducing its efficacy.
Isoprene Could Signal Hypoglycemia Attack

Elevated isoprene is the reason dogs can detect low blood sugar levels in their owners with diabetes.

For patients with diabetes, volatile organic compounds (VOCs) such as isoprene in their breath can signal blood glucose changes, perhaps offering a noninvasive alternative to detect hypoglycemia.

“Exhaled Breath Isoprene Rises During Hypoglycemia in Type 1 Diabetes,” in *Diabetes Care,* notes that given “anecdotal reports of domestic pets alerting owners to blood glucose changes, especially hypoglycemia,” the study set out to determine whether VOCs in breath change at low glucose.

The small study involved eight women (ages 46 ± 5 years) with type 1 diabetes for 23 ± 7 years who did not smoke. Their blood sugar levels were lowered under controlled conditions, and VOCs were measured with soft-ionization mass spectrometry.

“Strikingly, exhaled breath isoprene rose significantly at hypoglycemia compared with nonhypoglycemia,” according to the study, conducted at Wellcome Trust-MRC Institute of Metabolic Science and University of Cambridge in the United Kingdom. It’s unclear how hypoglycemia increases isoprene, and the source of endogenous isoprene remains undetermined. It may, in part, be a byproduct of cholesterol biosynthesis.

A related article in *Gizmodo* notes that isoprene is the reason dogs can detect low blood sugar levels in their owners with diabetes. Since they are sensitive to isoprene’s odor, dogs can easily tell when a person’s breath contains too much.

“Using this knowledge, the researchers would like to develop a medical sensor that does the same thing as diabetes sniffing dogs,” the related article explains, adding that a breath device could replace the “finger prick test, which is inconvenient, painful, and relatively expensive.”

The abilities of medical assistance dogs, including claims of detecting lung cancer, colorectal cancer and Parkinson’s disease, are being investigated. “Still, it’s an exciting line of medical research that, like this recent study, could lead to new scientific insights and powerful new medical technologies.”

You can say a lot of things to Cindy Bohmont. She’s very engaging and will likely join you in conversation. But please don’t tell her to get a life. Bohmont, a 1971 graduate of the University of Nebraska School of Nursing, has worked at Mercy Springfield (Missouri) Hospital for 45 years, and she has been a CCRN for all 40 years of the credential’s existence. But that’s just her day job. She’s also a boxing coach and official, Harley-Davidson rider, ATV junkie and trapshooting expert. Oh, and she helps her husband tend to their cattle ranch. She also works at St. Rose San Martin Hospital in Las Vegas, just to, you know, pass the time.

How did you decide to become a nurse?
I decided to become a nurse the summer I was 14, and our 4-H bus wrecked on the way home from summer camp, killing a man and injuring many of the kids. I decided at that point that I never wanted to be in the position that I couldn’t help someone because I didn’t know how. Hence, I went to the University of Nebraska School of Nursing, and here I am in critical care. I have been at Mercy Springfield for 45 years, and a CCRN for 40 years. Our ICU family is so special. We truly take care of each other as well as the patients.

What do you like about working at the bedside?
I love being a bedside nurse. It makes me feel good to be able to connect with the sickest of the sick and be able to make them feel better, and most generally get better. I keep my skills sharp and my education current to be able to better serve them. My goal is to like that person I see in the mirror at the end of my day — because I did the very best I could for those in my care.

In my eyes, being the bedside nurse is a great privilege with great personal rewards. I hear many of the newer nurses saying things like they don’t want to “wipe butts for very long; they are going to be a practitioner,” or whatever their aspirations are. Well, when we get all these directors, and no one to play the violins, where will that poor patient be? I fear that the day of the “laying on of the hands” is quickly fading away.

You seem very passionate about nursing.
I have cared for a great many patients over the years, and I try to do absolutely everything I can to make their ICU experience as positive as possible, and we all know how difficult that can be. One day I was in a department store, and a lady came up to me and said, “Cindy. It’s you! You took care of me in ICU when I had my surgery! You were so kind. And I want you to know how wonderful you were to wash my hair that day! I felt so nasty, and you made me feel so good. Thank you!” I had no idea how important that little thing was to her. I doubt that we realize how the little things affect people. We all need to continue to do those little things as well as the big things we all do.

How do you feel about certification?
Certification arrived about when I had my little feet pretty well on the ground and was looking around for another way to grow. I didn’t want to leave the bedside, and I had always read the AACN journals, and here came CCRN when it was first launched in 1976. There was a master’s program at the university, but it was not in anything even close to nursing. I learned a lot studying the manual for CCRN. I got my CCRN for my personal growth, and it caught on with my co-workers pretty quickly. I think it is a wonderful tool for credentialing nurses that don’t choose to leave the bedside and become advanced practice folks. It validates that the nurse is educated and has made the step to obtain the credentialing from a national organization.

When I first wrote the exam for my CCRN, I had to travel 300 miles to Kansas City to sit for the exam. Remember, most of us were struggling when we first started in the nursing profession with finances, so it was indeed an effort for me. But the challenge of obtaining the credential was too much to pass up. When I passed that exam, it was a huge validation that I was on the right track in my career.

What struggles did you face back then in maintaining it?
It was difficult to maintain my CCRN, but I was really proud of my certification so I did whatever I needed to do. Our
institution did not pay for any continuing education at that time (they do now), and I could not afford to travel to seminars, etc. All my studies were independent, and it was much cheaper to go to Kansas City every several years and recertify by taking the exam again and again. I found the AACN journals essential to continue to learn. Eventually, I was able to recertify with CEUs and stopped taking the test.

**What is it about boxing that attracted you?**

Most people think of boxing as a vicious sport, because most people don’t understand the sport. There are fewer injuries in boxing than most other sports, especially amateur boxing. Everyone knows someone with a “football knee” or “tennis elbow,” but do you know anyone that has been injured in amateur boxing? In my gym, it isn’t even about boxing, although they learn how to make points and defend and block. It’s about discipline, feeling good about yourself, fitness, good nutrition, fair play, self-esteem and being part of a team. The kids are all members of our gang. My gym was at the Boys and Girls Club for years, and those kids were so much at risk for all the bad things in the world. I was the only “normal” woman many of them knew, and, goodness, I’m not normal. It has been good for my soul to be able to step from caring for the sickest of the sick to working with these healthy kids and young adults.

**And you’re very good at it.**

Well, I recently got back from the National Junior Golden Gloves (NJGG) Boxing Tournament in Mesquite, Nevada, where I was chosen as Outstanding Official of the NJGG tournament. I am certified by USA Boxing, the governing body of amateur boxing, as a Level 3 official (as high as you can go without becoming an international official, which I chose not to do). I have been certified as a Level 4 coach for several years. But I can coach at national events, and I was chosen several years ago to take the USA team to Toronto for the USA/Canada duel. I was also chosen as Greater Kansas City Golden Gloves Coach of the Year several years ago. I have had several national champions over the years and love this sport.

**Is there any one experience that stands out where nursing has mixed with boxing?**

No one will ever forget the night we were at a regional boxing competition and one of the superheavyweight boxers dropped to the canvas, unresponsive following the fight he had just won. I hopped into the ring and started CPR with the ring doctor. It took the paramedics 20-30 minutes to get to the ring from the local hospital and take over his care. We had him going, but he died at the hospital. We later found out his brother had just died the week before of a sudden massive MI (myocardial infarction), just like his father did years ago. And this 34-year-old boxer had the same genetics and the same massive MI. Every boxer has a physical before every bout, and a quick check after each bout. It was a terrible shame, but not a boxing death. This was a pretty traumatic event for the large crowd and youngsters competing in the tournament. Not a sound was heard during the CPR, and unfortunately no one stepped forward to assist. My hands, palms and forearms were bruised from the compressions—the boxer was 230 pounds of solid muscle. Luckily, I’m a strong farm girl.

**Anything else you do for fun?**

Lots of stuff. Just for kicks and grins, I also ride a Harley-Davidson motorcycle. And I shoot trap and skeet and sporting clays. I’ve won 32 shotguns, rifles and handguns shooting in charity shoots. Also, we recently converted part of our 1,100-acre ranch into an ATV/UTV motorpark, so of course I have to go riding once in a while. I have always helped on the ranch with the cattle, hay, seed, etc. So, needless to say, my days are filled to the brim. And that is the key to not burning out in nursing. You have to have other things enriching your life, whatever it is. You have to have things that are healthy and matter to you.

My goal is to like that person I see in the mirror at the end of my day, because I did the very best I could for those in my care.

Interview by Paul Taylor, paul.taylor@aacn.org
Stroke Can Be Prevented With Population-Level Interventions

More than 90 percent of risk factors for stroke, led by hypertension, are controllable and universal across countries, age groups and genders.

“Global and Regional Effects of Potentially Modifiable Risk Factors Associated With Acute Stroke in 32 Countries (INTERSTROKE): A Case-Control Study,” in The Lancet, discusses 10 potentially modifiable risk factors associated with about 90 percent of the population attributable risk (PAR) of stroke in each major region of the world, among ethnic groups, men and women, and all ages.

Preventable PARs the study cites include physical inactivity, lipids (apolipoproteins), poor diet, obesity, smoking and cardiac causes.

The study also finds regional variations in most risk factors for stroke, which could contribute to variations in frequency and case-mix. “Our findings will inform the development of global population-level interventions to reduce stroke, and how such programs may be tailored to individual regions,” study co-leader Salim Yusuf, a professor at McMaster University in Ontario, Canada, notes in a news release.

The study included 26,919 participants in 32 countries from 2007 to 2015, with 10,388 patients with ischemic stroke, 3,059 with cerebral hemorrhage and 13,472 control group members. The collective PAR was higher for ischemic stroke (91.5 percent) than cerebral hemorrhage (87.1 percent) and ranged from a low of 82.7 percent in Africa to 97.4 percent in Southeast Asia.

A related commentary, also in The Lancet, identifies three key takeaways from the study: Stroke is highly preventable globally across all populations, prevention programs should focus on the identified regional risk factors, and further study should include countries and populations not covered by this analysis. “Now is the time for governments, health organisations, and individuals to proactively reduce the global burden of stroke.”

REFERENCES:

Guidelines Provide Framework for ICU Admission, Discharge, Triage

The evidence-based update is the first since SCCM initially released the guidelines in 1999.

Updates to the Society of Critical Care Medicine’s (SCCM’s) guidelines for ICU admission, discharge and triage provide strategies for practitioners to make informed care decisions.


Despite a limited amount of high-quality evidence, the task force believes the recommendations provide a “comprehensive framework to guide practitioners in making informed decisions during the admission, discharge, and triage process as well as in resolving issues of nonbeneficial treatment and rationing,” the article notes.

Decisions to admit patients to the ICU are easy when resources are abundant, but scarce resources can threaten allocation of critical care services to patients who need them. Significant changes in healthcare legislation and ICU technologies and treatments since 1999 prompted the reevaluation and update, the article adds.

The ICU should be reserved for critically ill patients who require life-supportive therapies, but healthcare providers also have a responsibility outside the ICU. “We need to further develop preventative strategies to reduce the burden of critical care illness, educate our noncritical care colleagues about these interventions, and improve our outreach, developing early identification and intervention systems.”


Revised Guidelines for Hospital-Acquired, Ventilator-Associated Pneumonia

Revised clinical practice guidelines were released for the care of adult patients at risk for hospital-acquired pneumonia (HAP) and ventilator-associated pneumonia (VAP).

“Management of Adults With Hospital-Acquired and Ventilator-Associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society,” in Clinical Infectious Diseases, explains that the recommendations for the diagnosis and treatment of HAP and VAP are based on systematic literature reviews.

The main differences between the 2016 guidelines and the original version published in 2005 include the following:

- Use of the Grading of Recommendations Assessment, Development and Evaluation methodology to evaluate available evidence
- Removing the concept of healthcare-associated pneumonia (HCAP)
- Hospital generation of antibiograms to guide healthcare professionals in the optimal choice of antibiotics

“In an effort to minimize patient harm and exposure to unnecessary antibiotics and reduce the development of antibiotic resistance, we recommend that the antibiogram data be utilized to decrease the unnecessary use of dual gram-negative and empiric methicillin-resistant Staphylococcus aureus (MRSA) antibiotic treatment,” the article adds. Short-course antibiotic therapy for most patients with HAP or VAP independent of microbial etiology, as well as antibiotic de-escalation, is also recommended. The guidelines are considered voluntary, with the “ultimate determination regarding their application” based on individual patient circumstances.

Opioids Linked to Deaths in Patients With Chronic Pain

N oncancer patients prescribed long-acting opioids have a greater likelihood to die from cardiovascular or other non-overdose causes within six months. “Prescription of Long-Acting Opioids and Mortality in Patients With Chronic Noncancer Pain,” in JAMA: The Journal of the American Medical Association, presents a retrospective analysis of patients from 1999 to 2012. “Patients prescribed therapy for a long-acting opioid had a risk of all-cause mortality that was 1.64 times greater than that for matched patients starting an analgesic anticonvulsant or a low-dose cyclic antidepressant, corresponding to 69 excess deaths per 10,000 person-years of therapy.”

For deaths from all causes, including overdose and non-overdose, most occurred outside the hospital (154 of 185). Almost two-thirds of the non-overdose deaths (79 of 120) were from cardiovascular causes.

The analysis matched 22,912 Tennessee Medicaid patients with chronic noncancer pain who were prescribed opioids with the same number in a control group who were prescribed anticonvulsants or antidepressants, mostly for back or other musculoskeletal pain; mean ages were 46 to 48. There were 185 deaths within six months among the opioid users compared to 87 in the control group.

Among the possible explanations for the difference are the effects opioids have on the respiratory system, including apnea and other difficulties breathing while sleeping. “Patients with sleep-disordered breathing have increased incidence of nocturnal arrhythmias, myocardial ischemia or infarction, and sudden death.”

Patients 75 and older, those with cancer and other life-threatening illnesses, patients having palliative or hospice care, those in nursing homes and those with drug abuse noted in their case history were excluded from the analysis.

“Prescription of long-acting opioids for chronic noncancer pain, compared with anticonvulsants and cyclic antidepressants, was associated with a significantly increased risk of all-cause mortality, including deaths from causes other than overdose, with a modest absolute risk difference. The finding should be considered when evaluating harms and benefits of treatment.”


New Treatment for Patients With Obstructive Sleep Apnea

A new implantable device designed to prevent obstructive sleep apnea (OSA) shows promise for patients who cannot use existing treatments. “Pacemaker for the Tongue Helps Apnea Patients Breathe Normally,” in gizmag, notes that although continuous positive airway pressure (CPAP) is the most widely used treatment, not all patients with OSA can tolerate CPAP or a mouthpiece.

Approved by the FDA in 2014, the hypoglossal nerve stimulation device has three subcutaneous components, including a tiny generator with a sensing lead implanted under the chin. When the leads pick up interruptions in breathing, two wires stimulate the hypoglossal nerve, which controls tongue movement, and enlarges the upper airway. Patients use a remote control to turn the device on before going to sleep and off after waking up.

The study followed 20 successful implant cases. Recipients were typically overweight, middle aged and had severe OSA. The device decreased the number of events an average of 35 per hour after implantation, which is an average reduction of 84 percent. In addition, the lowest blood oxygen level during sleep rose from 79 percent to 90 percent.

A news release from the University of Pennsylvania notes that data about the study was presented at SLEEP 2016, the 30th annual meeting of the Associated Professional Sleep Societies.
Smart Stitches Could Send Patient Data in the Future

The stitches would create a microfluidic network to monitor patients.

A team of researchers has developed a thread-based diagnostic device that could become stitches that can close wounds and send real-time health data to clinicians.

“A Toolkit of Thread-Based Microfluidics, Sensors, and Electronics for 3D Tissue Embedding for Medical Diagnostics,” in Microsystems & Nanoengineering, explains that cotton threads were given a hydrophilic coating to improve capillary action. The treated threads became electrodes after dipping them in conductive ink.

Once sutured, the stitches would create a microfluidic network to monitor the patient. Tiny sensors could measure pH, the chemical composition of the tissue, glucose concentration, temperature, tissue strain and even blood pressure. All of this data would be collected by an external module that would wirelessly transmit the information to a computer.

Further study is needed to determine whether an immune response is triggered when the threads are used long term, the study adds. However, the technology lends itself to many applications, including surgical implants, smart bandages to monitor wound healing or added to a personalized health monitor. Other electronic components also could be integrated in the future to create a self-contained monitoring platform.


Common Surgeries Linked to Chronic Opioid Use

Surgeries can increase the risk of chronic opioid use among opioid-naive patients, with men and older patients possibly being more vulnerable.

“Incidence of and Risk Factors for Chronic Opioid Use Among Opioid-Naive Patients in the Postoperative Period,” in JAMA Internal Medicine, examines the risk for patients undergoing 11 of the most common surgeries. The article defines chronic opioid use as “having filled 10 or more prescriptions or more than 120 days’ supply of an opioid in the first year after surgery, excluding the first 90 postoperative days.”

The Stanford University School of Medicine retrospective analysis examined the health claims of 641,941 opioid-naive patients (ages 18 to 64) from 2001-2013 who had surgeries such as cesarean section, total knee or total hip arthroplasty, or laparoscopic or open cholecystectomy. They were compared to a control group of more than 18 million nonsurgical patients. “For nonsurgical patients, chronic opioid use was defined as having filled 10 or more prescriptions or more than 120 days’ supply following a randomly assigned ‘surgery date’.”

All of the surgeries were associated with an increased risk of postoperative chronic opioid use except cataract surgery, laparoscopic appendectomy, functional endoscopic sinus surgery and transurethral prostate resection. Compared to the control group, the risk was highest for patients with total knee arthroplasty, followed by gallbladder surgery.

“The message isn’t that you shouldn’t have surgery,” lead study author Eric Sun explains in a related article in the Stanford Medicine News Center. Instead, it’s a reminder that surgeons and physicians should closely monitor patients’ use of opioids after surgery — even patients with no history of using these drugs.

To reduce post-surgery opioid needs, Sun and colleagues try to use regional anesthetics. In addition, patients should be encouraged to try pain-control alternatives such as acetaminophen after surgery. Alternative methods of pain management based on evidence-based techniques that can help calm the nervous system include “diaphragmatic breathing, progressive muscle relaxation and mindful meditation,” the article adds.

Vaccine Protects Against Ebola, Influenza, Parasite — in Mice

Engineers from Massachusetts Institute of Technology (MIT) have created an easily customizable vaccine. “Engineers Design Programmable RNA Vaccines,” in MIT News, notes that in tests with mice, the vaccine has proven 100 percent effective against Ebola, H1N1 influenza and Toxoplasma gondii.

The vaccine was made from strands of a genetic material called messenger RNA, which can be coded against any viral, bacterial or parasitic protein; the molecules were then put in a nanoparticle that delivers RNA directly into the cells. The vaccine was then translated into proteins that stimulate the immune system and fully generated T-cell and antibody responses.

“This nanoformulation approach allows us to make vaccines against new diseases in only seven days, allowing the potential to deal with sudden outbreaks or make rapid modifications and improvements,” adds Daniel Anderson, associate professor at MIT and senior author of a paper about the new vaccines.

The innovative method would be ideal for fighting influenza, because existing flu vaccines can take a long time to manufacture.


Care Challenges at Rural Hospitals

Hospitals achieve strong satisfaction scores through innovative approaches.

Rural hospitals often care for some of the country’s unhealthiest populations with a smaller staff of specialists and lack of time to adopt new technology, yet they produce positive results.

“Rural Hospitals Face Unique Challenges,” in The Sauk Prairie Eagle, describes several rural Wisconsin hospitals’ efforts to expand telehealth systems to meet the needs of patients who may be hours away from a full-service hospital. One ICU links with the hospital’s parent company in St. Louis to access a team of critical care specialists via video within seconds.

All five of the rural hospitals profiled achieve patient satisfaction scores at or above the national average, largely by capitalizing on the value patients place on familiarity and proximity, while supplementing services they cannot provide locally with creative efforts. About the high-tech telehealth cameras, one hospital administrator adds, “It’s as though they’re in the same room with us.”

One of the profiled counties ranks among the highest in Wisconsin in mortality rates due to heart disease and cancer; poverty, substance abuse and obesity are also higher than average. To meet patient needs more effectively, a cooperative assists in coordinating services across multiple rural facilities, and hospitals contact area physicians to learn which specialties have the highest priority.

Among the specialties that rural hospitals struggle to fill are mental health, because emergency department physicians must consult with psychiatrists in larger cities to obtain medication recommendations, the article adds. One facility has adapted by using telespsychology in a substance abuse treatment setting, with on-site psychologists supported remotely.

AACN Resources for Care in Tele-ICUs

CCRN-E specialty certification for acutely/critically ill adult patients; www.aacn.org/ccrn-e

“AACN Tele-ICU Nursing Practice Guidelines” — booklet or free download

“AACN Issues First Tele-ICU Nursing Guidelines” — news release

“Assessing the Impact of Telemedicine on Nursing Care in Intensive Care Units” — American Journal of Critical Care, January 2016

“Development of a Tele-ICU Postorientation Support Program for Bedside Nurses” — Critical Care Nurse, August 2015
Graduate-level Education Helps Transform Quality of Care

Six programs in the U.S. and Canada offer a master’s degree in healthcare quality and safety.

Can graduate-level education in patient quality and safety alleviate the medical error crisis? Advocates for new master’s and PhD programs that teach mid-career healthcare professionals leadership skills say yes.

“(Traditional) medical education is stuck in a paradigm that is 35 years old, with a very modest emphasis on patient safety and quality,” David Nash, founding dean of Jefferson College of Population Health, Philadelphia, says in “The Education of a Safety Specialist,” published in Modern Healthcare. “The way to reduce death and injury due to medical error is to have more people trained in these tools and techniques in order to advance the field.”

The school’s online program, which culminates in a Master of Science in Healthcare Quality and Safety, began in 2009. Three years earlier, Feinberg School of Medicine, Chicago, began a two-year, classroom-based master’s program. “There are currently six programs in the U.S. and Canada that offer a master’s degree in healthcare quality and safety.”

Students in Jefferson’s program average 52 years old — most are physicians who seek a leadership role to help fix what they see as a flawed system. Currently, 60 people from 30 states and one foreign country are enrolled.

Curriculums differ at each school, with no agreement yet on the core competencies that master’s graduates should have, according to the article. However, programs usually cover “evidence-based knowledge on how healthcare quality is defined, measured and improved; common medical errors, methods of reporting errors and specific tools for prevention; the development of safety culture; and how public policy drives change.”

‘I Am a Critical Care Nurse’

Leesa Souza has a photo from kindergarten that shows her in a white cap and dress caring for a patient. The caption reads, “When I grow up I want to be a nurse.” Souza did become a nurse and works in the cardiovascular ICU at Castle Medical Center, Kailua, Hawaii. •

“The acuity is high and patient loads are heavy,” she says. “The need to create a happy work environment where we care for not just our patients but for each other and ourselves has become paramount to our job satisfaction and longevity. Laughter, genuine teamwork and an attitude of going the extra mile for each other is how you get through a rough shift and leave feeling a true sense of accomplishment and satisfaction. We need each other.” •

Read more about her journey, which includes living on a small Hawaiian island with no electricity, when you open October’s Critical Care Nurse from the back.
Rudeness vs. Team Performance

If rudeness damages your cognitive system, you can’t function appropriately in a complex situation.

Rude comments in high-pressure medical settings could have deadly effects on patients.

“The Impact of Rudeness on Medical Team Performance: A Randomized Trial,” published in Pediatrics, indicates that a rude comment from a physician decreased performance among other physicians and nurses more than 50 percent in a hypothetical life-or-death situation.

“We found that rudeness damages one’s ability to think, manage information and make decisions,” study author Amir Erez, professor of management at the University of Florida, Gainesville, says in a related article in New York. “You can be highly motivated to work, but if rudeness damages your cognitive system, you can’t function appropriately in a complex situation. And that hurts patients.”

During the study, 24 neonatal ICU teams participated in a simulation with a preterm infant whose condition had deteriorated acutely due to necrotizing enterocolitis. Participants were advised that an expert on team reflexivity in medicine would be observing them.

Teams were randomly assigned to exposure to rudeness (expert made mildly rude statements unrelated to team performance) or control (neutral comments). Three independent judges, blinded to team exposure, viewed the videotaped simulations using structured questionnaires to evaluate team performance, information-sharing and help-seeking.

“The composite diagnostic and procedural performance scores were lower for members of teams exposed to rudeness than to members of the control teams,” the study adds. Rudeness alone accounted for nearly 12 percent of the variance in diagnostic and procedural performance.

Rudeness had adverse effects on both the diagnostic and procedural performance of the neonatal ICU teams. However, information-sharing lessened the effect of rudeness on diagnostic performance, and help-seeking decreased the influence of rudeness on procedural performance.


Nurses Contribute to Dress Code Change

Nurses at a Pennsylvania hospital now wear standard pewter-gray and white scrubs displaying the hospital logo and embroidery to distinguish them as RNs.

By surveying patients about their perceptions of a professional image for nurses, a Pennsylvania hospital made an evidence-based change in the dress code.

“Contributing to a Quality Patient Experience: Applying Evidence Based Practice to Support Changes in Nursing Dress Code Policies,” in OJIN: The Online Journal of Issues in Nursing, notes that Geisinger Medical Center in Danville, Pennsylvania, identified a need to reevaluate the dress code policy based on input from nurses and feedback from patients and families about nurses’ attire.

A survey distributed to 400 adult patients addressed verbal interactions with nurses, nurse appearance and the ability to identify caregivers. The result was that nurses now wear standard pewter-gray and white scrubs displaying the Geisinger logo and embroidery to distinguish them as RNs. Licensed practical nurses and nursing assistants will transition at a future date.

The team approach included the nurses’ and nursing council’s participation in identifying the issue, conducting the patient survey and analyzing results, developing the new policy, getting the change approved and communicating it. Their efforts also caused the entire health system to evaluate their dress code and focus on standardizing it across the system in order to promote a professional appearance and contribute to a positive experience for patients.

What evidence-based changes have nurses made at your hospital? Tell us at aacnbvvoices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.

How does the concept of medical futility pertain to the use of extracorporeal membrane oxygenation (ECMO) in critically ill patients? The authors explain the rationale for using ECMO and describe ethical issues including patient autonomy and distributive justice, and moral distress when the treatment does not result in the desired outcome. Suggestions for advanced practice and staff nurses to address these issues include communication strategies with families, consultation with ethics or palliative care services, and developing criteria for evaluating the futility of ECMO.

(Williams, CCN, October 2016) www.ccnonline.org

By using esophageal balloons to measure pleural pressures, critical care providers can optimize ventilator settings to ensure pressures effectively achieve alveolar recruitment without creating an excessive risk of ventilator-induced lung injury. This article describes the rationale for esophageal pressure measurement and the procedure for placing the balloons. It includes graphics and a case study to illustrate the impact of esophageal pressure measurements on ventilator management.

(Hofmann, CCN, October 2016) www.ccnonline.org

Vigilant adherence to isolation procedures such as those required for Ebola virus is essential in limiting the devastation of infectious disease outbreaks. When outbreaks end, competency in the proper use of personal protective equipment can be lost. Videos, slide presentations, return demonstrations and simulation exercises ensure that members of an interprofessional team are ready to respond to future outbreaks of Ebola, multidrug-resistant bacteria or other pathogens that pose a public health threat.

(Eckes, CCN, October 2016) www.ccnonline.org

Transitions

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

**Tom Ahrens**, nurse educator, author and past recipient of an AACN Circle of Excellence award, and **Martin Doerrler**, associate chief medical officer at Northwell Health, were honored at the 5th Annual Sepsis Heroes Gala for their advocacy of sepsis awareness and education.

**Patricia Alingh**, an ICU nurse at Newman Regional Health, Emporia, Kansas, is recognized for excellence in nursing practice and service through the system’s Nursing Excellence Program.

**Merrilee Andelbradt**, an 80-year-old critical care nurse in the ICU at Edward Hospital, Naperville, Illinois, who has worked at the hospital for 43 years, was interviewed in the Chicago Tribune. She works full time on the night shift and is chair of the Intensive Care Unit Practice Council. Her daughter, also a nurse at Edward Hospital, works in cardiac telemetry.

**Dorrie Fontaine**, dean of the University of Virginia School of Nursing and AACN past president, presented “Compassion Is the Key to Quality Health Care” at The Chautauquan Institution, New York. “Practice mindfulness and compassion and you’ll engage in resilient behaviors. Practice being patient, being kind, being in the moment …” she notes in the article.

**Teri Lynn Kiss**, past AACN president, gave the keynote speech, “Focus the Flame: Attention on Excellence,” at the 11th Annual Nursing Research & Evidence Based Practice Workshop & Conference in Lynnwood, Washington.

**Todd McDonald**, family nurse practitioner, Sylvester Family Practice, Georgia, is honored in The Sylvester Local News for 20 years of continuous certification as a CCRN.

**Julie Stanik-Hutt** — a member of AACN since 1978, a CCNS and ACNPC for many years and past recipient of the AACN Flame of Excellence award — becomes professor and founding director of the AG-ACNP program at University of Iowa College of Nursing.

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.
Andy liked beer. When he knew he was dying, he asked if he could go outside to the garden one more time, drink a beer and share a private moment with his wife.

This was not going to be easy. He was bedridden and in excruciating pain from metastatic cancer. The nurses on this acute medical unit could hardly turn him or do basic nursing care. He had three smart pumps running different medications, oxygen per nasal cannula and an epidural for pain control. The garden was four floors, three elevators and one building away. When he made his request of his nurse, Lisa, “voices in her head” may have told her that this was not allowed, it was too complicated, too risky or just a lot of work.

But if that was the case, Lisa ignored those voices. Instead, she recruited Andy’s physician and a volunteer to assist with moving him — bed and all — to the garden.

Because of her, Andy and his wife enjoyed that beer outside together on a warm summer afternoon. He died a few days later.

I have talked in these columns about the importance of having clarity around your values and vision as a nurse and that it allows your unique perspective to make a difference for patients and their families. But if we do not use our voice to bring those values and vision to life, then our unique perspective will not be heard. It will not matter.

What little voices in your head sometimes tell you not to act? And which voices inspire you to act?

In “You Are the Leader You Have Been Waiting For,” author Eric Klein compels us to know our core values as the source of passion and purpose. He asks us to examine what he calls “inherited values” that may obscure our own true set of values. You know what inherited values are — those habitually repeated phrases that parents, teachers, preceptors, bosses and other authorities may have chanted at you at different points in your life: “Sit up straight”; “You can’t play until all your work is done”; “Be good or people won’t like you”; “Don’t you dare get that patient out of bed.”

It’s important to examine our inherited values to see the impact they have on our own true values and our voice. And when we examine them, it’s crucial that we listen and discover, keeping a neutral and curious attitude. Because those same values that make us unique and able to give and care for the most vulnerable patients in our healthcare system may also make us feel uncomfortable at times about using our voice.

So I was happy to read in the July 2016 issue of Bold Voices that critical care CNS Windra Stringham of Lovelace Medical Center in Albuquerque used her voice to talk about her ultimate goal: to see people get better.

“But when they do get better,” she says, “and they come back to visit and come up to you and say, thank you — boy, that’s a good day. That’s a really good day.”

We all have the power to help create the best possible experience for patients and their families along their healthcare journey — whether it’s the chance to get better or an opportunity to share a final private moment with a loved one. But often that power depends on speaking up about what matters — even when it’s uncomfortable, and those little voices tell us not to.

Let me know how you use your voice to speak up at itmatters@aacn.org.