Breathe

Instead of an afternoon coffee, try a walking meditation: Just walk slightly slower than your normal pace but not so slow that anyone would notice. What makes it a meditation is that you’re paying attention to the experience. As you move along, really see what’s in front of you and notice the sensation of your feet against the ground.

Whenever you realize that your mind has strayed, in a friendly but firm way, return it to the experience. Integrating mind and body with a conscious walk lets you cultivate concentration, engage your muscles, bring fresh air into your lungs, and take your brain off your worries.

Remember — you don’t have to walk super slow, like a zombie.

But take your time. You’re not trying to go anywhere but inward.

—Cyndi Lee


A New Vital Sign

How do you prepare yourself to enter the room of a patient and family for the first time? Do you perhaps pause or take a deep breath — especially if the off-going nurse reported that the patient or family member was unhappy or dissatisfied? What is your routine for completing the patient’s physical assessment, greeting the family, or taking and recording vital signs?

Read more in my note on page 22.

Clareen Wiencek
AACN President

When you are a nurse, know that every day you will touch a life or a life will touch yours.

—Anonymous
Save the Date for NTI 2017 in Houston: Housing Is Open

You won’t want to miss NTI 2017 when we travel to Houston, the fourth largest metropolis in the US and one of the great American cities.

The American Association of Critical-Care Nurses’ annual National Teaching Institute & Critical Care Exposition (NTI) is May 22-25, 2017, in Houston (preconferences May 21). NTI, the premier conference for high acuity and critical care nurses, offers 37.5 hours of continuing education via live sessions — and additional hours of self-study during and for a limited time after the conference.

You won’t want to miss NTI 2017 when we travel to Houston, the fourth largest metropolis in the U.S. and one of the great American cities. With its unmistakable skyline, big-city dining scene, seemingly endless upscale shopping, music clubs, and vibrant arts and cultural venues, Houston has something to please everyone. Find out more about the city at www.visithoustontexas.com.

As we prepare for the last months of 2016, get a head start planning for NTI 2017:

- Submit your request early for reimbursement or time off.
- Book your hotel now for the best selection and discounted rates, since reservations are assigned on a first-come, first-served basis. Visit https://chmcloud.com/site.html#/rooming/202ADE7 for a list of hotels and rates, and to book your hotel reservation, or call 800-340-1840 if you have questions.
- Outline your professional development needs and align with your hospital or unit goals using our online Return on Investment toolkit. Take advantage of unspent money in your employer’s budget as the fiscal year closes by working with your manager now to secure funding.

AACN Launches Updated CSC Certification Review Course Online

AACN has launched an updated CSC Certification Review course online in preparation for the new CSC (cardiac surgery) subspecialty certification exam that goes into effect Dec. 1.

The revised online course reflects revisions made to the CSC test plan and exam based on the 2015 study of practice of cardiac surgery nurses conducted by AACN Certification Corporation. It explores valuable knowledge covered in the new test plan and how to apply this knowledge in clinical practice settings.

The comprehensive review program — presented by Myra Ellis, clinical nurse IV, Duke University Hospital in Chapel Hill, North Carolina — provides an in-depth overview of cardiovascular surgical procedures, complications and therapeutic interventions, and includes a PDF handout of the slides, suitable for notetaking. Interactive practice questions are provided throughout to support learners’ translation of content to the testing environment, with full discussion of rationale provided for the answers.

After taking the course, participants should be able to:

- Validate their knowledge of cardiac surgical nursing prior to sitting for the CSC certification exam.
- Identify the areas of study to focus on prior to sitting for the CSC certification exam.

Learners must complete 100 percent of the activity and the associated evaluation to be awarded the contact hours. No partial credit will be awarded.

Find out more about the updated CSC Certification Review course online at www.aacn.org/certification under Certification News.
Taking Flight With CCRN Certification

Nurses caring for acutely/critically ill patients during air transfers find CCRN provides a strong foundation for their practice.

“I have the best job in the world,” says Brian Wilson, a CCRN-certified flight nurse at LIFE STAR Hartford Hospital in Hartford, Connecticut. “Professional opportunities at the local, regional, national and international levels abound for flight nurses. Our extended scope of practice and degree of autonomy are second to none for a registered nurse.”

Wilson is one of over 4,000 flight nurses in the U.S., more than 1,100 of whom are CCRN certified.

Just what do flight nurses do, and how does CCRN certification benefit their practice and patients?

Who flight nurses care for

According to Jan Eichel, who oversees air transport as director, Clinical/Comm Operations at West Michigan AirCare, flight nurses at her organization typically care for patients who are being transferred between facilities, mostly from the ICU or emergency department.

“Complex interventions, monitoring and medication titration are within the scope of practice for our flight nurses,” Eichel says. “During a transport, we maintain or initiate the therapies necessary for the safety, comfort and stabilization of the patient.”

In his position, Wilson “provides critical care transport from scenes outside the hospital and outlying hospitals to larger tertiary and specialty care centers. Our scope of care includes adult, pediatric and neonatal critical care and high-risk OB populations.”

Daniel Storzer, a hospital-based CCRN-certified acute care nurse practitioner and part-time flight nurse for Air Medical Transport Express in Green Bay, Wisconsin, says that his transport patients “span the life spectrum” and include “many critically ill patients on ventilators and end-of-life patients going home to family.”

Why critical care certification makes a difference

After embarking on his nursing career, Wilson “quickly realized CCRN would play a part in achieving my goals. I was lucky to be raised on a unit that valued certification.”

“I consider CCRN the cornerstone certification in my practice,” he says. “The process of achieving CCRN certification was instrumental in my development as a critical care nurse and later provided the foundation for me to move into flight nursing — the best decision of my professional life.”

Pursuing CCRN certification “significantly increased...
“The process of achieving CCRN certification was instrumental … and provided the foundation for me to move into flight nursing.”

Storzer also became certified early in his career.

“I took the exam at the first opportunity, as soon as I was eligible,” he says. “You’re pursuing excellence. You want to do the best job you can, and certification is part of that. It’s still a source of pride for me.

“When you introduce yourself to patients and family members,” Storzer adds, “and they learn you’re certified, they feel more comfortable with you. They may not know exactly what certification means, but they understand you’ve gone the extra step to be an excellent practitioner.”

To learn more or apply for CCRN certification, visit www.aacn.org/ccrn.
Viruses Seem More Dangerous in the Morning

The findings could lead to new ways of stopping pandemics.

Viruses are more dangerous when they infect their victims in the morning and 10 times more successful if the infection starts in the morning, suggests a study of mice.

“Cell Autonomous Regulation of Herpes and Influenza Virus Infection by the Circadian Clock,” in PNAS: Proceedings of the National Academy of Sciences, explains that “time of day of host infection regulates virus progression.”

A related article in BBC News adds that the study mice were “infected with influenza, which causes flu, or herpes virus, which can cause a range of diseases including cold sores.” The mice infected in the morning had 10 times the viral levels of those infected at night. Although there were only two viruses in the study, each was very distinct (a DNA virus and an RNA virus), which led the research team to suspect that the morning risk may apply to many other viruses. The findings could lead to new ways of stopping pandemics. Unlike bacteria or parasites, viruses “depend on hijacking the machinery inside cells in order to replicate,” adds the related article. However, those cells change dramatically during the 24-hour pattern of the body clock.

The study “demonstrates that viruses exploit the (body) clockwork for their own gain and that the clock represents a novel target for modulating viral replication that extends beyond any single family of these ubiquitous pathogens.”

Further results show that disrupting the mice’s body clock allowed the viruses to thrive. “This indicates that shift workers, who work some nights and rest some nights and so have a disrupted body clock, will be more susceptible to viral diseases,” lead author Rachel Edgar, University of Cambridge, England, explains in the related article. “If so, they could be prime candidates for receiving the annual flu vaccines.”


Metastatic Prostate Cancer Increases Dramatically

The increase could be because the disease is becoming more aggressive, or because there is less screening.

Although overall cases of low-risk prostate cancer have declined, the incidence of metastatic prostate cancer has grown dramatically in recent years.

“Increasing Incidence of Metastatic Prostate Cancer in the United States (2004-2013),” in Prostate Cancer and Prostatic Diseases, notes that new cases of advanced prostate cancer rose 72 percent in the past decade. The largest increase, 92 percent, was among men ages 55 to 69.

The study “identified all men diagnosed with prostate cancer in the National Cancer Data Base (2004-2013) at 1089 healthcare facilities in the United States. Joinpoint regressions were used to model annual percentage changes” in the incidence of prostate cancer based on the stage compared to 2004.

“The increase could be because the disease is becoming more aggressive, or it could be because there is less screening being done, but we don’t know why,” lead researcher Edward Schaeffer, chair of urology at Feinberg School of Medicine, Chicago, says in a related article in HealthDay News.

The data highlight the need for further refinements in prostate cancer screening and treatment, the study suggests.

A higher level of anxiety one week after discharge raises the 30-day readmission risk 110 percent.

A small study of kidney transplant patients indicates that post-discharge anxiety, which frequently leads to readmission, can be mitigated through consistent, simplified information delivered with empathy.

“Role of In-Hospital Care Quality in Reducing Anxiety and Readmissions of Kidney Transplant Recipients,” in Journal of Surgical Research, reveals that interviews with 20 patients and a retroactive survey of 77 previous recipients show that a higher level of anxiety one week after discharge raises the 30-day readmission risk 110 percent.

More than 30 percent of the approximately 17,000 patients who receive kidney transplants annually in the U.S. are readmitted to the hospital within 30 days, some for medical reasons but others because of complex discharge instructions, the study explains. Inconsistent advice on how much water to drink and information conveyed in a “some-rushed manner” were among the challenges patients identified.

The Ohio State University Medical Center, where the research and surveys were conducted, used the results to make improvements in its discharge process, relying in particular on discharge nurses, who reduced the number of instructions from 80 to 25, adds a related news release. “When you go home you’re going to be more confident, you’re going to be safer and you’re going to be less likely to come back to the hospital,” study co-author Susan Moffatt-Bruce, Ohio State’s Wexner Medical Center, adds in the release.

The study authors “did not find a direct link between consistency and empathy measured in the surveys and readmissions. But they did find that those elements appeared to play a clear role in raising anxiety, which was linked to readmissions,” the release adds. “With some simple interventions, including being kind and being present, we can make a difference,” Moffatt-Bruce notes.


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New Therapy for Chemotherapy-Induced Nausea

The Food and Drug Administration has approved Heron Therapeutics Inc.’s new therapy, Sustol.

The drug, which had been rejected twice, can prevent the nausea and vomiting associated with chemotherapy, explains “FDA Approves Heron’s Therapy for Chemotherapy-Induced Nausea,” in Reuters.

The drug is expected to offer longer-acting relief for about 80 percent of patients who have debilitating bouts of nausea and vomiting due to chemotherapy. These adverse effects are the main reason patients discontinue treatment.

Sustol is an injectable form of the generic granisetron and was approved in combination with other antiemetics. The therapy targets the serotonin-3 (5-HT3) receptor, which has a role in nausea and vomiting.

Other approved therapies, including Eisai’s ALOXI (palonosetron), which is also a 5-HT3 receptor antagonist, are generally effective for 48 hours or less. However, Heron claims the extended-release profile of Sustol can protect patients for five days.

Sustol cannot be used with platinum-based therapy regimens, which excludes about 7 percent of patients.
Less Aerobic Capacity Linked to Higher Mortality

Cardiovascular fitness might be an advantage in most illnesses that can lead to death.

A study that followed men in Sweden for 45 years finds that lower levels of aerobic capacity in middle age correspond with higher mortality rates regardless of traditional risk factors.

“Low Aerobic Capacity In Middle-Aged Men Associated With Increased Mortality Rates During 45 Years of Follow-Up,” in European Journal of Preventive Cardiology, notes that 792 men born in 1913 in the same town underwent tests of aerobic capacity at age 54 and were tracked until 2012. Only smoking ranked as a better predictor of increased mortality than cardiovascular fitness.

Of the men tested, 656 (83 percent) could perform the maximum cardiovascular workload, and they were divided into tertiles based on fitness level. Death for any reason occurred at the highest rates for the lowest-performing third, with the lowest rates achieved by the highest-performing third.

“We were somewhat surprised that the effect of aerobic capacity was even more pronounced than that of high cholesterol and high blood pressure,” study co-author Per Ladenvall, University of Gothenburg, Sweden, says in a related article in HealthDay News. An additional surprise is that cardiovascular-related deaths were not significantly associated with the established fitness levels.

The population-based, prospective cohort study speculates that increased cardiovascular capacity aids the body in reducing other risk factors and helps reduce mortality for certain diseases, including cancer. This research “suggests that cardiovascular fitness might be an advantage in most illnesses that can lead to death, and thus a benefit for general health and not only for cardiovascular health.”

The study’s main strengths are the long follow-up with a standardized population, a study group of all Caucasian males the same age, systematic sampling and the prospective design. The limitation is “the sample size, and therefore analyses on cause-specific mortality must be interpreted with caution.”


Higher Activity Levels Reduce Risk of Five Major Diseases

People should exceed minimum recommended levels of all types of physical activity to lower their risk of breast and colon cancer, diabetes, ischemic heart disease and ischemic stroke.

“Physical Activity and Risk of Breast Cancer, Colorectal Cancer, Diabetes, Ischemic Heart Disease, and Ischemic Stroke Events: Systematic Review and Dose-Response Meta-Analysis for the Global Burden of Disease Study 2013,” in BMJ, describes a meta-analysis of 174 studies on physical activity and the five diseases. Working from a baseline of the World Health Organization’s minimum recommended 600 metabolic equivalent (MET) minutes of activity per week, the analysis reveals that increasingly higher multiple MET minutes continues to reduce risk, with diminishing returns at the highest levels.

The breast cancer risk for women in low active (600-3,999 MET minutes), moderately active (4,000-7,999) and highly active (8,000 plus) groups was reduced 3, 6 and 14 percent, respectively, compared to women below 600. The respective risk reductions for both men and women were higher for all other diseases studied: colon cancer (10, 17 and 21 percent), diabetes (14, 25 and 28 percent), ischemic heart disease (16, 23 and 25 percent) and ischemic stroke (16, 19 and 26 percent).

Meeting the Needs of Older Patients

Despite a prevalence of older patients in hospitals, most clinicians are not adequately prepared to treat them and hospitalist programs often don’t emphasize geriatric skills.

“Hospital Management of Older Patients,” a review in *UpToDate*, states that older patients tend to arrive at the hospital with comorbid chronic illnesses and disabilities, making them particularly vulnerable to adverse events that require longer stays or further care. “While most younger patients are discharged to home, 40 percent of patients 85 years and older are discharged to a skilled nursing facility,” the review notes.

A related article in *KHN: Kaiser Health News* states that hospitals often focus so much on illnesses that they overlook other aspects of care, leaving older patients unable to care for themselves after discharge. This poor or inadequate treatment can lead to needless spending on extended hospital stays, readmissions, in-home caregivers and nursing home care.

“The older you are, the worse the hospital is for you,” Ken Covinsky, a geriatrics physician at the University of California, San Francisco, states in the article, adding that the “unique needs of older patients are not a priority for most hospitals.”

Some hospitals, including San Francisco General Hospital and Trauma Center, have established separate medical units to treat older patients. “They focus less on the original diagnosis and more on how to get patients back home, living as independently as possible,” the article notes; however, with about 200 in the country, such units are rare.

**AACN Resources for Older Adult Care**

“Optimizing Care for Acutely Ill Older Adults”
— Interactive learning course

“Older Adults: Myths, Truths and Caring” — Webcast
Tour of Duty
An Interview With Marge Wheeler

During the month of November, as we honor military veterans, who have sacrificed so much for us, we spoke with one of the veterans of critical care nursing and a past AACN board member, Marge Wheeler, about her vast experience, acumen and memories of her service in Vietnam.

How did you decide to become a nurse?
I started deciding about what my occupation would be when I was in high school. An opportunity came up to be a volunteer at a local hospital, so I tried this and liked the work very much. Our family dentist was on staff at this hospital and encouraged me to apply for the student nurse three-year program at this hospital. I applied successfully with the support of my parents, family and this wonderful family dentist. This career choice proved to be the right one for me for my entire working career. I loved nursing and being a nurse.

What were the challenges to becoming a nurse then compared to today?
Back in 1960 to 1963, nursing had fewer challenges in technology, computers, fewer specialty units and complexities of healthcare specialties. This three-year program had us working on the wards and going to school at the same time from the second week in training. We were bedside nurses, “hands-on” care, trained in the classroom by MDs and trained on the wards by the RNs.

I think that helped us stay focused on the patient. We listened to the MDs, and they listened to us about what we saw in their patients’ progress. We stood up when the MD came to the nurses’ station, and it did not seem a challenge at the time. Our hospital did not have an intensive care unit and had just completed a recovery room as I was graduating in 1963, which did also serve as an intensive care area.

Today, I notice huge challenges to using and maintaining computer systems, electronic records, computerized devices throughout the hospital, staying on top of pharmaceuticals and their interactions, complex multiple disciplinary teams with complex role definitions, delegation of some hands-on care to aides and technicians, increased awareness and integration of cultural and lifestyle differences into patient care, impact of insurance and payment systems on care delivery, high expectations for complex end-of-life care at any age this occurs, and violence in the workplace.

How did your service in the military come to be?
Military service came to my attention during my second of the three-year nursing program. I had scholarships and worked on the wards in my second year to pay for my nursing education. Then, I learned about the U.S. Army Student Nurse Program in which I could enlist, continue my studies and work at my nursing school the last year. [This program was no longer available a while later.] Upon completion, I would
Please talk about your military experience.

My U.S. Army experiences started at Ft. Sam Houston, Texas, where medical personnel received their basic Army training. I worked on a ward at the hospital during the time after I passed my boards, received my commission as a 2nd lieutenant, and the next basic training began. It was a time I will always remember how grateful that I had hands-on nursing from the beginning at my three-year nursing diploma program. My first assignment was at Walter Reed Medical Center in Washington, D.C., assigned to a women’s ward. I applied to the three-month psychiatric nursing program and then went to work on the psychiatric wards. During this two-year tour of duty, I met and married another U.S. Army officer, Dave Wheeler, and we stationed together both in Germany and later in Vietnam. We were married for 39 years.

My next assignment was the 2nd Field Hospital in Landstuhl, Germany, for two years of a three-year tour of duty. I worked on neurology and psychiatric wards. Once again, I worked with competent, kind, caring MDs and corpsmen, who made the nursing work very rewarding.

The final assignment for me was the 3rd Field Hospital in Saigon, Vietnam. My husband received orders, and the Chief Nurses’ Office in Europe called to tell me I had a choice to stay here and be discharged in a few months when my time was up or go to Vietnam, and the two branches would coordinate our assignment so we could be stationed in the same area. I chose to go, because I was very grateful for the last year of nursing school paid for by the Army — very successful and satisfying nursing assignments — and my wish to help soldiers who were combat wounded in Vietnam. My experience at the 3rd Field Hospital in Saigon was professionally rewarding and life-changing, seeing young soldiers risking their lives and dying for their country. I was proud to serve then and would make the same choices again.

Are there any particular Vietnam experiences that stand out for you during that time?

One experience in Vietnam stood out for me so vividly, and I never talked about it until [AACN] President Teri Lynn Kiss mentioned it in an article in Bold Voices. One day, I was assigned to the “expected” area in the outdoor triage area. These soldiers were not expected to live. As I assessed this soldier, it was obvious that he could not survive. The first comment from him to me was, “Am I going to die soon?” I

Since we honor veterans this month, is there anything you would especially like to say about them?

For those who are serving and who have served, I would say to continue to honor their choice to serve our country. The current and past wars and service duties have put veterans at risk for health problems, some immediate and some long-term. To veterans: Thank you for your service then and now. Please always stay tuned in to how you personally can take care of your own health, given your service experience and exposure to the environmental, physical and mental stress of service. Reach out for help when you need it and, as so many do, offer help when you can to your comrades. Take pride in the uplifting positive things you were able to do. Thank you!

As you look back, any highlights that really stand out for you in your career, Marge?

As I look back on my career, which started as a hospital teenage volunteer through today, two main events stand out for me. First, the opportunity and honor to serve our country as a U.S. Army nurse during wartime and to serve a tour of duty in Vietnam, a first exposure to critical care. Second, membership in AACN as the most highly professional nursing organization, always driven by patient-centered care, recognizing and speaking out for local and world events affecting patient care and the critical staff who provide care for them at their most vulnerable time. Leadership and growth as a human and as a nurse to be positive, uplifting, life-affirming in everything I try to do. These events helped mold me even today in areas where I chose to devote time and energy continuing to serve others.

What is so great about being a nurse?

The most profound aspect of being a nurse for me is the ability to help people when they are sick and can’t take care of themselves. Then, to teach the patient and/or family and/ or community how to help the patient take care of themselves, whenever that self-care is realistic.

Interview by Paul Taylor, paul.taylor@aacn.org
Childhood Cancer Linked to Pulmonary Complications Later in Life

The study increases understanding of specific, long-term risks to pulmonary health for survivors of childhood cancer.

Adult survivors of childhood cancer have a substantial risk of developing asthma, chronic cough, emphysema and other pulmonary complications.

“Risk and Impact of Pulmonary Complications in Survivors of Childhood Cancer: A Report From the Childhood Cancer Survivor Study,” in Cancer, surveyed 14,316 survivors of childhood cancer and compared the results with a control group of 4,027 of their siblings.

The study indicates that by age 45, 29.6 percent of survivors reported having a pulmonary condition compared to 26.5 percent in the sibling group. Even though fewer survivors reported ever smoking, they were more likely than siblings to report chronic cough, oxygen need, lung fibrosis and recurrent pneumonia.

Chronic cough had a greater impact on daily activities for cancer survivors, and their standardized mortality ratio for death due to pulmonary causes was 5.9, a factor associated with platinum exposure and lung radiation, according to the study.

Lung tissue is especially sensitive to cancer treatment, and pulmonary symptoms such as lung fibrosis, chronic cough and difficult or labored breathing with exercise increase over time, according to a Children’s Hospital Los Angeles (CHLA) news release about the study. “While often asymptomatic, damage to the lungs may limit activities of daily living with potential impact on the overall quality of life,” says study author Andrew Dietz of CHLA.

The study findings hopefully will lead to targeted interventions to decrease adverse pulmonary events among survivors of childhood cancer, study author Daniel Mulrooney of St. Jude Children’s Research Hospital, Memphis, Tennessee, adds in the release. “This study adds to our understanding of specific, long-term risks to pulmonary health for survivors of childhood cancer, and will help refine guidelines for appropriate screening, health surveillance and counseling.”


Review of Cancer Policies

Major gains have been made in policies to improve patients’ quality of life.

An annual state-by-state report on legislative policies and efforts to combat cancer finds that progress is being made, but there’s still much work to do.

“How Do You Measure Up? A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality,” by the American Cancer Society Cancer Action Network, ranks the states on policies and funding for measures such as tobacco control, cancer prevention, access to care and patients’ quality of life.

The 14th edition of the report indicates that progress has slowed in several cancer prevention areas, according to a related news release. For example, few states have passed strong tobacco-control measures, only eight states fund breast and cervical cancer screening programs, and most states fall short in protecting minors from the dangers of indoor tanning.

However, the release notes that major gains have been made in policies to improve patients’ quality of life and ensure access to the appropriate chemotherapy drugs.
Heart Risks for Women Increase Before and During Menopause

A study of 1,470 women finds that the severity of metabolic syndrome (MetS) and related cardiovascular and diabetes risks increase rapidly before and during menopause but decrease afterward.

“Progression of Metabolic Syndrome Severity During the Menopausal Transition,” in *JAHA: Journal of the American Heart Association*, assessed women in the Atherosclerosis Risk in Communities study for changes in MetS severity over a 10-year period during menopausal transition. Overall, the study finds that MetS severity increased more rapidly in the years before and during menopause. The results differed from previous research, which finds that MetS risk is greater in postmenopause.

“This latest study indicates that the increased risk observed earlier may be related more to the changes happening as women go through menopause and less to the changes that take place after menopause,” study author Mark DeBoer, associate professor at the University of Virginia, Charlottesville, says in an American Heart Association news release.

Particularly striking, the study notes, is the difference in severity of MetS progression between black and white women. Black women experienced a much more rapid increase in MetS severity before menopause but a slower rate afterward.

“The reason for these racial differences is unclear but did not appear to be because of socioeconomic status, education or hormone replacement therapy, which were included in the models,” the study notes. These findings confirm previous studies showing that risks for cardiovascular disease and diabetes are greater overall for black women, according to the release.

In a related article in *HealthDay News*, DeBoer says all women should make changes in their lifestyle, if necessary. “The study results should provide doctors and other health care professionals with convincing information to motivate women before they go through menopause to decrease the risk of getting health problems.”

The constant ringing of the phone. The never-ending beep of the IV pumps. The dinging of the call lights. As my new patient rolled onto the unit from the ER and into his new ICU bed, I looked at the clock: 0525. I am almost to shift change, I thought to myself. As I started to get him settled, I heard my IV pump beep from across the hall for what felt like the 100th time that night. Infusion complete. AGAIN. Every hour and 48 minutes, this IV pump had beeped infusion complete, because the patient was maxed out on their Nimbex drip. The 23-year-old patient who laid in the bed had ended up there because of an unfortunate fall from a bridge; he had extensive injuries to his lungs and chest, which had ultimately led to his medical team making the decision to chemicallyparalyze him.

As I ran across the hall to change the empty medication bag, my new patient yelled out, and I heard someone say, “Hold on, I’ll grab the nurse.” In a hurry, I got a new bag of medication. I spiked it and added volume, and then I made the quick decision that I would scan the medication in a minute. But that minute never came. I got busy. I forgot. As I gave report to the oncoming nurse, I remembered that I had hung a new bag of medication, so I just marked it done in the MAR. I finished report, helped the new nurse reposition the patient and looked at the important things on the patient. And I left for the day thinking the night had gone well.

How wrong I was.

Later that morning, I received a phone call. It was my nurse manager, who informed me that there had been a significant medication error on the patient I had taken care of last night. I couldn’t breathe. I felt sick to my stomach. My immediate thoughts were what damage had I done to this patient, and was he going to be OK? Without further ado, she informed me that somehow a bag of Levophed had been hung instead of a bag of Nimbex. Two medication errors had been made in that moment: The Levophed was an old order, which had been discontinued, and the Nimbex had been abruptly stopped on a critical patient.

She was calling to ask me about the care I had given because the last time I hung a bag of medication, I hadn’t scanned the bag. They had no way of knowing at that moment if I had made this mistake, or if the mistake had been made by someone else. Overcome with conflicting emotions, I couldn’t think straight. I couldn’t remember if I had checked the bag before I hung it to see what medication it was. I had no validation as to if I had done this or not. The pit in my stomach continued to grow as time passed.

Every nurse knows the five rights of medication administration:

1. Right Patient
2. Right Drug
3. Right Dose
4. Right Route
5. Right Time

So how did this happen? How could I have possibly failed at something so fundamental as hanging a bag of medication?

As I started to contemplate the events that could have prevented this error, I realized there were multiple opportunities for myself and others to have prevented this. Here are three things as a nurse that I can take responsibility for:

1. The dosage, the route, the need for medications — these are things that all change on a daily basis. An opportunity to have prevented this error was to simply remove medications that were no longer needed/ordered from the patient’s medication drawer. The Levophed order for this patient had been discontinued for over a week. How many nurses had picked through that medication drawer and not removed the unneeded medications?

2. I had opted for speed and convenience over the safety of my patient. I was in a hurry, like most nurses on a daily basis, so I took a shortcut, and I failed to scan my medication. I had changed those bags so many times in that 12-hour shift. What was one more? Safety protocols are implemented to help us accomplish tasks by following step-by-step instructions to prevent errors. I had completely sidestepped those protocols and ended up learning an invaluable lesson that day. Shortcuts make you vulnerable.
3. Proper bedside shift report. After giving report to the oncoming nurse, we went into the room to examine the patient and what was going on with him, but we never looked at the IV pumps or the drips hanging on those pumps. This was a simple way to ensure the correct medications were hanging at that moment, but it wasn’t done.

As I sat at home that day, isolated and alone, my thoughts started to get the best of me. What was going to happen to the patient? Was the patient’s family, who had entrusted me to take the very best care of their family member, going to be mad at me? How was I ever going to practice nursing again?

Later that day, I was informed that the patient had not suffered any ill effects from the medication error. It was also brought to my attention that I was not the nurse who had made this unfortunate mistake, but it very easily could have been my mistake. I didn’t feel lucky; I felt conflicted. I could have hurt someone. Nurses are not supposed to hurt people. Eventually, the good days started to outweigh that one awful day.

Growth as a human being can occur in numerous way. I have learned that everyone makes mistakes, and those mistakes do not define who that person is. What defines who you are as a person is how you pick yourself up off the ground. What can you learn from it?

So I challenge you: Take the time to think about what you are doing and why you are doing it. What harm can come to your patients when you make the choice to take shortcuts? Make a conscious decision to put your patient’s safety first.

Sarah Roth works in the Surgical Trauma ICU at St. Mary’s Medical Center in Evansville, Indiana.

Do you have a first-person account of your bedside nursing practice you’d like us to consider for AACN Bold Voices? Send it to us at aacnboldvoices@aacn.org.
The Philosophy of Servant Leadership

A servant leader recognizes the importance of building a sense of community among staff.

Nurses in leadership positions should embrace the philosophy of servant leadership to connect with their staff on a deeper level. The goal of this philosophy is to achieve organizational goals by attending to the needs of those you serve, writes Rose O. Sherman, professor of nursing and director of the Nursing Leadership Institute, Boca Raton, Florida, in "Remembering to Be a Servant Leader," an article in her blog, Emerging RN Leader.

“A nurse servant leader looks to the needs of his/her staff and continually asks how they can help them solve problems and promote their personal development. The servant leader manager works with his/her staff to help them meet the needs of patients, while coaching them in their professional practice. The ability to provide service is their primary motivator for seeking a leadership role,” Sherman writes.

Characteristics that are important to the development of a servant leader include listening, empathy, healing, awareness, foresight and stewardship.

Commitment to the growth of people is another characteristic. “The servant leader is inclusive of all staff and sees value in everyone. They attempt to maximize the strengths of all who work with them.” In addition, a servant leader “recognizes the importance of building a sense of community among staff.”

The servant leadership philosophy is especially important, because many nurse leaders are perceived by their staff as not being caring. “Young nurses today often complain about a lack of advocacy from their leaders who seem more focused on costs and performance measures than on care.”

Listening to Frontline Healthcare Staff

Open communication channels can improve morale and quality of care.

“Hospital Impact: To Make a Difference, Listen to Frontline Healthcare Workers,” an editorial by Thomas Dahlborg in FierceHealthcare, notes that frontline healthcare workers are in the best position to offer productive feedback to their organization.

Dahlborg, president of Dahlborg Healthcare Leadership Group, says that everyone wants to provide the best care to patients. However, when organizations don’t listen to employees, or they penalize them unjustly for going outside established policies, workplace morale can plummet.

Dahlborg cites several examples. One nurse says, “I can’t tell you the number of scales that I have purchased over my career for people [who could not afford one on their own] just to help them maintain and monitor their weight — because that is the No. 1 step in managing congestive heart failure.”

She adds, “When we have someone in a wheelchair, why are we not giving them a $100 ROHO cushion to prevent the bedsores? Give it to them before we have two stage 2 bedsores, which require that I go out there three times per week.” The nurse also shared additional insights to improve patient care, lower costs and prevent readmissions.

Dahlborg closes his column by emphasizing the importance of an open forum between employees and management. “Who will you listen to tomorrow to make a difference?”

“How are you making a difference in improving care?” Tell us at aacnboldvoices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.

AACN Resources for a Healthy Work Environment

AACN standards and assessment tool — www.aacn.org/hwe

AACN resource page — articles, statements, slides and other presentations
Strategies to Reduce RN Turnover

While most organizations view retention as a key strategic imperative, only half of them have a formal retention strategy.

For the first time, turnover among RNs has exceeded the overall rate of hospital staff nationwide. “2016 National Healthcare Retention & RN Staffing Report,” published by Nursing Solutions Inc., finds that turnover among bedside RNs rose to 17.2 percent in 2015, up from 16.4 percent in 2014. The overall hospital rate is 17.1 percent, which is slightly below the 2014 mark of 17.2 percent.

The survey involved 138 facilities, 474,545 healthcare workers and 120,630 RNs. Turnover for critical care nurses increased to 17.7 percent, up from 16.8 percent in 2014. RNs working in pediatrics (11.7 percent) and women’s health (14.5 percent) recorded the lowest turnover, while those in emergency (21.1 percent) and behavioral health (26.5 percent) experienced the highest rates.

The average cost of turnover for a bedside RN ranges from $37,700 to $58,400, and the related hospital losses average $5.2 million to $8.1 million. “The cost of turnover can have a profound impact on the already diminishing hospital margin and needs to be managed,” states the report’s executive summary.

Still, while 84.8 percent of organizations view retention as a key strategic imperative, only 51.5 percent have a formal retention strategy.

A related article in Emerging RN Leader cites an article in H&HN: Hospitals & Health Networks listing the following strategies to reduce nurse turnover:

- **Decrease overtime** — Mandatory overtime and on-call requirements are major sources of dissatisfaction.
- **Practice shared governance** — Lack of empowerment and involvement in decision making leads to disengagement.
- **Implement data-driven staffing** — With skill mixes trending toward less-experienced nurses, it is especially important to provide the necessary level of support.
- **Develop quality-of-life initiatives** — These initiatives could include support for learning about meditation and mindfulness, quiet rooms, gym membership, on-site childcare, yoga and additional time off.

Earn a BSN or Higher With an AACN Scholarship, a Benefit of Your Membership

AACN scholarships are awarded to members in support of lifelong learning, career enrichment and knowledge acquisition through a variety of programs and conferences.

A portion of the scholarship fund is also designated for members pursuing their academic education, because we understand the demands of nursing and want to support you on your journey to care for patients and their families.

AACN has designated additional scholarships for members who qualify and are pursuing a Bachelor of Science in Nursing, or higher degrees such as a Master of Science in Nursing or a doctorate.

When you fill out an application, you will assess gaps in your knowledge and skills, evaluate learning opportunities and develop a plan to show how an AACN scholarship will help you reach your goals.

AACN members may apply for continuing professional development scholarships anytime throughout the year, but please allow several months for application processing.

First read “Important Information for Scholarship Applicants,” and learn more at www.aacn.org/scholarships. Please email scholarships@aacn.org with your questions. If you aren’t a member yet, learn about the many benefits at www.aacn.org/membership.
Is Butter All That Bad?

Butter seems to have a neutral effect overall, so it should neither be demonized nor promoted as a route to good health.

Although butter was once associated with cardiovascular disease and diabetes, there is little or no association between butter consumption and chronic disease. “Is Butter Back? A Systematic Review and Meta-Analysis of Butter Consumption and Risk of Cardiovascular Disease, Diabetes, and Total Mortality,” in PLOS ONE, involved 636,151 individuals and 6.5 million person-years of follow-up.

Keywords for the review related to butter consumption and cardiometabolic outcomes. It was determined that people consumed about one-third to 3.2 servings of butter per day; about 1 tablespoon (14 grams per day) was considered a single serving.

Based on 28,271 deaths, 9,783 cases of incident cardiovascular disease and 23,954 cases of diabetes, “butter consumption was weakly associated with all-cause mortality … not significantly associated with any cardiovascular disease,” coronary heart disease or stroke, and “inversely associated with diabetes.”

The review indicates that butter seems to have a neutral effect overall, so it should neither be demonized nor promoted as a route to good health. The article adds that more research is required to better understand the observed lower risk of diabetes, which has been suggested in other studies on dairy fat.


Omega-3 Therapy May Help Patients After Acute Myocardial Infarction

Study patients who received omega-3 had a 13 percent reduction in left ventricular systolic volume.

Patients who took daily high doses of omega-3 fatty acids after an acute myocardial infarction (AMI) had improved heart function and less scarring after six months. “Effect of Omega-3 Acid Ethyl Esters on Left Ventricular Remodeling After Acute Myocardial Infarction,” in Circulation, finds that study patients who received high-dose omega-3 experienced a 13 percent reduction in left ventricular systolic volume. Patients taking omega-3 also had significant reductions in vascular inflammation and myocardial fibrosis. No negative effects were observed in this therapy.

The benefits of omega-3 for patients with heart disease have been studied for decades, although past studies have conflicting results, study co-author Raymond Kwong, Brigham and Women’s Hospital in Boston, adds in a related article in U.S. News. He says that patients in the new six-month study received a higher dose.

The multicenter, double-blind study involved 358 survivors of AMI, of whom 180 were randomly assigned to receive high-dose omega-3 fatty acids, and 178 control patients took a placebo. Heart benefits were monitored throughout the therapy using cardiac magnetic resonance imaging.

Study limitations include a substantial number of patients not returning for post-treatment follow-up; it is "uncertain whether this caused any bias to the main study findings." Also, over-the-counter fish oil supplementation could not be eliminated reliably and may have biased the results.

In Our Journals

Hot topics from this month’s AACN journal

Patient safety regulations and clinical research do not support the use of restraints, but they are often applied when ICU nurses feel there is no other choice. Researchers tested a decision support tool to help nurses who are undecided or who need reassurance on their decision to restrain or not restrain a patient. After implementation of the decision support tool, nurses decreased the use of restraints, yet maintained patients’ safety. Increased use of mitts as an alternative contributed to this reduction. No unplanned extubations or life-threatening disruption of therapeutic devices by unrestrained patients occurred.

(Hevener et al, AJCC, November 2016) www.aacn.org

The stress of an ICU stay can result in posttraumatic stress disorder (PTSD), which impairs psychological and physical recovery. Prompt recognition of PTSD allows for early intervention that can mitigate its harmful effects. A study of patients recently discharged from the ICU demonstrated the feasibility of measuring posttraumatic stress syndrome (PTSS), which often occurs in the weeks before the onset of PTSD. Levels of PTSS, found in 17 percent of study participants, were associated with depression, episodes of delirium and sedation use during the ICU stay.

(Warlan et al, AJCC, November 2016) www.aacn.org

Sleep quality has an obvious impact on quality of life, but little is known about the relationship between sleep quality and heart failure survival rates. Patients with heart failure were asked to rate their sleep quality and then followed for about one year to track subsequent cardiac events. Researchers found that the 63.2 percent of the study participants who reported poor sleep quality were 2.5 times more likely to experience a cardiac event than those with high-quality sleep. Clinicians should assess and manage sleep quality in patients with heart failure to improve outcomes.

(Lee et al, AJCC, November 2016) www.aacn.org

To see the entire table of contents for the November issue, please visit www.aacn.org.

Transitions

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

Linda Burnes Bolton, chief nursing officer at Cedars-Sinai in Los Angeles, and past president of the American Organization of Nurse Executives and American Academy of Nursing, was interviewed for an article on nursing and quality improvement in H&HN: Hospitals & Health Networks.

Mary Jane Lindquist, most recently clinical lead, becomes nurse manager of the progressive care unit at Florida Hospital DeLand.

Barbara McLean, critical care clinical specialist, Grady Health System, Atlanta, and an AACN Circle of Excellence award recipient, was the featured speaker at the 6th Annual UAB Hospital Critical Care Symposium.

Bernadette Melnyk, dean of The Ohio State University College of Nursing, is named a 2016 Champion of Health Care by Columbus Business First.

Barb Nickel, advanced practice nurse at St. Francis Medical Center, Grand Island, Nebraska, is chosen as Infusion Nurses Society’s Member of the Year.

Fran Watson. ICU nurse manager at Conemaugh Memorial, Johnstown, Pennsylvania, is honored in a health system news release for 40 years of certification as a CCRN. She says, “Certification is the difference maker in a nurse’s career.”

The following nurses become fellows of the Academy of Emergency Nursing in recognition of their contributions to advancing the profession and providing visionary leadership:

Andrew J. Bowman — Lebanon Indiana (AACN member since 1989)
Cheryl Randolph — Petaluma, California
Diane F. Switzer — Bellevue, Washington
Cindy Tryniszewski — Chester Springs, Pennsylvania
Kathleen E. Zavotsky — East Brunswick, New Jersey

The CGFNS Intl. board of trustees includes the following recently elected officers and members:

President: Michael Bleich, Goldfarb School of Nursing
Trustee: Christine Kovner, New York University College of Nursing
Continuing trustee: Sean P. Clarke, William F. Connell School 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.
How do you prepare yourself to enter the room of a patient and family for the first time? Do you perhaps pause or take a deep breath — especially if the off-going nurse reported that the patient or family member was unhappy or dissatisfied? What is your routine for completing the patient’s physical assessment, greeting the family, or taking and recording vital signs?

As humans, we are wired to follow routines, to repeat the same behaviors over and over. I think about how we routinely ask our patients, “What is the matter with you?”

This question predictably leads to routine answers: I am having pain, my breathing was hard, my husband became confused, my wife could not walk, my child is very sick, my heart failure/diabetes/blood pressure (fill in the blank) is out of control.

Now consider the power of changing just one thing: the order of those words to “What matters to you?”

This is neither novel nor my idea. Nurses have been asking some variation of this question throughout our entire history, because we value holistic care.

But I gained a new perspective after watching a TED Talk by Jason Leitch, clinical director of Scotland’s National Health Service, titled “What Matters to Me – a new vital sign.” It was transformative to think about the impact of reordering the words in that question and about considering it as vital as those vital signs we take on a regular basis.

He tells the story of Rose, an older patient with dementia known for her agitation and frequent falls. What mattered to Rose was her rosary, and, when nurses placed it in her hand, she was transformed from an older, demented fall risk to a human being who was calmer and at whose bedside visitors and staff could sit with her to pray.

I’m sure you have treated a patient like Rose during your career. And if you haven’t yet, most likely you will. That patient who, despite how their illness and the technology used to help them may have altered them physically or mentally, you were able to reach in, locate their personhood and discover what mattered to them.

We can even use this approach on a unit level with peers and colleagues. What if you asked, “What matters to you?” on your unit? If you are already asking some version of this question, think about committing to making it a multidisciplinary effort and the first question for the team before anything else — diagnosis, lab values, hemodynamic values, CT scan results —is asked.

We can also turn this question on ourselves and ask, “What matters to me as a nurse?” As a community, AACN has been asking that question as a way to learn how to best serve nurses’ needs. Last month, based upon your input we launched a new website containing new features, such as nurse stories, in addition to the clinical resources that drive excellence, because nothing less is acceptable. I hope you are discovering the new website to be a top-notch experience that enhances the value of your membership.

Because it’s the time of year when we pause as a country to give thanks and to share what matters most to us, I ask you to advocate for what matters not only to patients and families but also to you and your team members.

And I want to hear about it. Have you cared for a patient like Rose? How did the experience touch you? How would you answer, “What matters to me?” What do you think of AACN’s new website? Your thoughts matter to me, so please send them to itmatters@aacn.org.

Happy Thanksgiving to you ... and everyone who matters to you.