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American Association of Critical-Care Nurses
Just a cup of tea.

Just another opportunity for healing. Just the hand reaching out to receive the handle of the cup. Just noticing hot. Noticing texture and fragrance.

Just a cup of tea.

Just this moment in newness. Just the hand touching the cup. Just the arm retracting. The fragrance increasing as the cup nears the lips. So present.

Noticing the bottom lip receiving heat from the cup, the top lip arched to receive the fluid within. Noticing the first taste of tea before the tea even touches the lips. The fragrance and heat rising into the mouth. The first noticing of flavour. The touch of warm tea on willing tongue. The tongue moving the tea about in the mouth. The intention to swallow. The warmth that extends down into the stomach.

What a wonderful cup of tea. The tea of peace, of satisfaction.

Drinking a cup of tea, I stop the war.

—Stephen Levine


It Matters

Walk with me for a minute. We’re walking down a long, dark hall. A new graduate nurse is working the night shift, a few months out of orientation, on a large cardiac monitoring unit.

Read more in my note on page 22.

Clareen Wiencek
AACN President

Our lives begin to end the day we become silent about things that matter.

—Martin Luther King Jr.
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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We Welcome New Board Members, Thank Those Who Completed Their Service

We begin the next fiscal year with new, returning and offgoing board members — and a new theme: It Matters.

The AACN community celebrates July 1, the start of the fiscal year, and our exciting new theme, “It Matters.” We are so proud to welcome our new members to the AACN and AACN Certification Corporation boards of directors.

The AACN board unites our community of exceptional nurses to shape the future of nursing practice and further our vision of a patient- and family-driven healthcare system where acute and critical care nurses make their optimal contribution.

Clareen Wiencek begins a one-year term as president of the AACN board, joined by Christine S. Schulman as president-elect. Elizabeth Bridges, Mary Beth Flynn Makic and Rosemary Timmerman each begin three-year terms as directors. Kimberly Curtin, Wendi Froedge, Michelle Kidd and Louise Saladino begin a second year. Megan E. Brunson, Nancy Freeland, Deborah Klein and Paula S. McCauley start a third year. Curtin and Brunson also serve one-year terms as secretary and treasurer, respectively.

The AACN Certification Corporation board supports patient health and safety by establishing and maintaining high standards of excellence through comprehensive credentialing of acute and critical care nurses.

Karen S. Kesten starts her two-year service as chair, with Denise Buonocore as chair-elect, Lisa A. Falcón begins a second year as secretary/treasurer, and Sonia Astle begins her fifth year as director. Teresa Jahn and Elizabeth Scruth start a three-year term as directors, and Patty Cox begins three years as consumer representative. AACN board director Nancy Freeland begins a concurrent second year, and AACN board director Deborah Klein serves a concurrent one-year term on the AACN Certification Corporation board.

We’re particularly grateful for the dedication of our offgoing members. Karen Johnson and Lisa Riggs complete their third year of service on the AACN board, and Karen McQuillan becomes immediate past president and new chair of the Nominating Committee. Milisa Manojlovich completes her term on the AACN Certification Corporation board, and Mary Frances Pate becomes immediate past chair.

We thank the AACN Nominating Committee and AACN Certification Corporation Governance Committee for their oversight on the selection of qualified leaders — and, most of all, we thank the AACN members who voted in Election 2016!
Progressive Care? Stepdown? Intermediate Care? It’s All About the Patient

An experienced progressive care nurse can intervene and prevent a patient from needing intensive care-level services.

The increasing acuity of hospitalized patients coupled with a move toward shorter hospital stays continues to propel the growth of progressive care nursing in the U.S. Despite its prevalence, understanding this nursing specialty remains hazy for some.

The concept of progressive care emerged in the 1970s to describe care provided to patients with post-myocardi infarction. Since then, it has expanded beyond basic cardiac telemetry to encompass many of the same technologies and therapies once limited to critical care units. It now refers to a specific level of patient care and is considered part of the critical care spectrum — with intensive care on one end and progressive care on the other.

“Critical care is a continuum of care, and we need skilled nurses at all levels of the continuum to provide patients with the best care,” says Lynn Orser, clinical nurse educator at St. Vincent’s Medical Center in Bridgeport, Connecticut, who is certified in both progressive and critical care.

“Many patients require complex assessment and monitoring without the advanced therapies of intensive care. Progressive care nurses need to have highly developed assessment skills and the knowledge to monitor and anticipate their patients’ course.”

It’s the who, not the where

The progressive care patient population consists of high-acuity patients who are moderately stable with an elevated risk of becoming unstable, and who require a high intensity of care and vigilance.

“Progressive care is determined by the type of patient cared for and the nursing care delivered, not by the unit name,” says Jo Ellen Craghead, a 36-year nursing veteran at St. Mary’s Hospital-Audrain in Mexico, Missouri. “Progressive care patients are not quite as physiologically unstable as critical care patients. This doesn’t mean they need any less nursing care; they just need different care.”

“This is a specialized population with specialized needs,” adds Craghead, who helped develop the first progressive care certification. “An experienced progressive care nurse can intervene and prevent a patient from needing intensive care-level services.”

There’s a certification for that

In 2004, AACN Certification Corporation launched PCCN specialty certification to enable progressive care nurses to validate their knowledge against national standards of nursing excellence. The PCCN Test Plan, based on a study of practice, defines the progressive care patient population and related nursing competencies. Today, more than 15,000 nurses are PCCN-certified.

“I was so happy when AACN recognized progressive care as a bona fide specialty and introduced PCCN certification in the mid-2000s,” Orser says. “Our hospital has a mixed medical ICU with progressive care beds and patients requiring progressive care in various units throughout the hospital.”

For Craghead, “Certification helps increase my confidence in my nursing skills. The knowledge I obtain to remain certified helps keep my practice current and allows me to contribute valuable input on patient care decisions. I believe I can better advocate for the patient.”

Learn more about PCCN certification at www.aacn.org/pccncert.

PCCN Eligibility

Pursuit of PCCN specialty certification reflects your dedication to excellence in caring for acutely ill adults and their families.

Who is it for?
RNIs or APRNs who provide direct care to acutely ill adult patients. These patients are often found in areas such as intermediate care, direct observation, step-down, telemetry and transitional care units.

What are the practice eligibility requirements?
• 1,750 hours of direct care in the previous two years, with 875 of those hours accrued in the most recent year preceding application
• OR, At least five years of direct care with a minimum of 2,000 hours, with 144 of those hours accrued in the most recent year preceding application
Drug-loaded ‘Backpacks’ Take Aim at Disease Sites

This new approach uses the body’s own defense system to carry medications to targeted areas.

Backpacks on white blood cells can attack disease by delivering drugs to specific parts of the body, reports an article in *FierceDrugDelivery*.

“Backpacks’ on White Blood Cells Could Deliver Cancer Drugs in a Targeted Fashion” explains that thin-layered polymers mounted on monocytes carry medications to inflammation sites. Teams at the Massachusetts Institute of Technology (MIT) and the University of North Carolina at Chapel Hill collaborated on the research, which was presented at the 251st National Meeting & Exposition of the American Chemical Society (ACS).

Unlike drug therapies that treat the whole body and may cause adverse effects, this new approach uses the body’s own defense system to carry medications to targeted areas, ACS explains in a news release. “How do we do that? Our lab developed cellular backpacks that can be loaded with therapeutic compounds and unloaded.”

Initial tests with the cancer drug doxorubicin hit a snag when the drug leaked from the polymers too early. However, when packed into tiny liposomes that were sensitive to ultrasound, the drug stayed in the polymers until reaching the desired destination, where the liposomes were burst open using external sound waves, the release adds.

In tests with mice, the drug-loaded cells with polymer backpacks accumulated successfully in inflammation sites, the article notes. “In the future, the team is looking to use the delivery mechanism across the blood-brain barrier to also treat Parkinson’s and Alzheimer’s disease.”
Elimination of Pain Should Not Be the Goal

Clinicians need to balance the needs of their patients, the concerns of society and the demands of their job.

While one of the main goals of healthcare is to reduce suffering, clinicians should not attempt to achieve the elimination of physical pain.

“Zero Pain Is Not the Goal,” an editorial in JAMA: The Journal of the American Medical Association, notes that elimination of physical pain is not feasible, but reduction of suffering is possible, writes Thomas H. Lee, chief medical officer at Press Ganey, Wakefield, Massachusetts. He believes the problem lies in “the difficulty of knowing what to do with the information that patients are in pain. The CDC guidelines offer important recommendations for addressing that issue.”

Although patients want relief from their symptoms, they “place greater emphasis on the how (whether they are receiving care that is compassionate, coordinated, and focused on optimizing their outcomes) than the what (whether their pain is completely controlled).”

By definition, suffering encompasses more than pain, so being respectful and honest at the bedside, for example, can ease suffering by helping patients understand and cope with their illness or injury. Lee writes that clinicians need to find a balance between compassionately meeting the needs of patients, addressing the concerns of society and satisfying the demands of their job.

Lee recommends the newly issued “CDC Guideline for Prescribing Opioids for Chronic Pain” as a reference. (The CDC also published an errata.) The 12-step document urges clinicians to be more cognizant of risks versus benefits when prescribing opioids for patients with chronic pain. When opioids are prescribed, the recommendation is to use the lowest possible effective doses.

Opioid Overdose Data From the CDC

“Prescription Opioid Overdose Data,” from the Centers for Disease Control and Prevention (CDC), Atlanta, states that prescriptions for opioid painkillers have nearly quadrupled over the last 15 years, contributing to an epidemic of abuse. It is estimated that 1.9 million patients abused or were dependent on prescription opioid pain medication in 2013; and more than 165,000 people have died from opioid overdoses since 1999.

What are your unit’s guidelines on discussing pain with your patients? 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.

New Blood Analysis May Detect Sepsis

Elevated monocyte distribution width was a good sepsis biomarker in this trial, but validation from larger, multisite studies is required.

Automated immune cell volume parameters can be used as biomarkers of early sepsis in the emergency department (ED).

“A Feasibility Trial to Detect Sepsis in the ED Based Upon Blood Monocyte Volume Variability,” presented at the Society of Critical Care Medicine’s Critical Care Congress, is a blinded observational trial comprising 1,320 patients from two separate EDs; 879 of the patients were controls. After blood analysis, 98 patients had sepsis, severe sepsis or septic shock, 140 had infection without systemic inflammatory response syndrome (SIRS), and 203 had infection with SIRS.

“People are 2.4 times more likely to present with SIRS than with sepsis,” notes an article about the findings in Medscape Medical News, “so it is important to find a biomarker that works well for this purpose or you will miss a lot of cases of sepsis.”

The analysis differentiates sepsis from other conditions better than other volumetric cell parameters, including mean neutrophil volume, neutrophil distribution width and routine complete blood count, the abstract notes.

“Monocyte distribution width was also better than any of the other volumetric cell parameters assessed at distinguishing sepsis from SIRS,” the article adds. It was also superior in distinguishing severe sepsis or septic shock from patients who did not have infections. “For sepsis, the negative predictive value of normal monocyte distribution width was 98 percent.”

Elevated monocyte distribution width was a good sepsis biomarker in this trial, but validation from larger, multisite studies is required, the abstract concludes.

Funded by Beckman Coulter, the trial was conducted using a Beckman Coulter DxH 800, version 2.0 system.
Hospital Guidelines Can Decrease Opioid Overdoses

At the forefront in fighting the rising number of overdose deaths from opioid addiction, emergency departments can make a difference by following prescription practices that help decrease misuse.

In “Hospitals on the Front Lines in the Fight Against Opioid Addiction,” published in Hospital Impact, Maryland Hospital Association president Carmela Coyle explains how all acute care hospitals in her state agreed to adopt new guidelines last fall. The hospitals responded to a rapid spike in overdoses, the leading cause of accidental death in the U.S.

According to “Opioid Addiction: 2016 Facts and Figures,” from the American Society of Addiction Medicine, deaths from heroin overdose nearly quadrupled from 2000 to 2013. Eighty percent of new heroin users misused prescription opioids as a starting point, and 94 percent cite the expense of those pills as a reason they switched to heroin.

Access to potentially addictive medication is high, and it’s growing.

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Overdose deaths reached 47,055 in 2014, with 18,893 tied to prescription opioids and 10,574 to heroin. “Access to potentially addictive medication is high, and it’s growing,” Coyle says.

With total opioid prescriptions in the U.S. topping 250 million in 2012, and death rates rising as prescription sales increase, the Maryland acute care hospitals agreed to guidelines that encourage prescription practices that reduce addiction. Coyle says these best practices include screening tools “to help detect and treat conditions that can lead to misuse,” electronic systems that share health information with more effective tracking of opioid misuse, and standards that reduce unnecessary prescriptions.

Coyle explains the guidelines “were crafted to allow doctors the flexibility to prescribe opioids when medically necessary while encouraging practices that can reduce the risk of opioid addiction.” Maryland hospitals are also working on a Prescription Drug Monitoring Program that can show a patient’s full medication history more accurately.

Hospitals’ Solutions Ease Opioid Overdose Crisis

Hospital best practices for opioid prescriptions have helped decrease the opioid overdose epidemic.

According to “How Hospitals Are Fighting on the Frontlines of the Opioid Crisis,” in Hospitals & Health Networks, emergency departments (EDs) in Massachusetts reduced opioid prescriptions 25 percent in five months by implementing nine best practices that include not replacing controlled substances that are reported lost or stolen and counseling patients on how to store and discard pain-killers. The practices were carried over to all other hospital departments.

A Wisconsin health system focused on alternatives for chronic pain management and crafted an agreement that patients must sign before receiving prescriptions. A study from a Boston hospital found that 91 percent of patients who overdosed still received prescription refills (70 percent from the same physician), and lack of communication between primary care physicians, ED physicians and those at outpatient facilities created unnecessary risks.

In addition, a 12-hospital system in Michigan committed resources to screen patients for addiction at the primary care level and develop treatment options to prevent the conditions that lead to overdosed patients going to the ED.
Aspirin Linked to Lower Risk for Most Cancers

Long-term aspirin use was associated with a 3 percent lower risk for cancer, except breast, advanced prostate and lung. Long-term aspirin use is associated with a reduced risk for most cancers, especially gastrointestinal tract tumors and colorectal cancers.

“Population-wide Impact of Long-term Use of Aspirin and the Risk for Cancer,” in *JAMA Oncology*, examined the benefits of aspirin for overall and subtype-specific cancer prevention at a range of doses and durations of use, and to estimate the benefit of aspirin in the context of screening.

For the study, researchers at Massachusetts General Hospital, Boston, reviewed the records of 135,965 healthcare professionals (88,084 women ages 30 to 55 years and 47,881 men ages 40 to 75 years) who participated in the Nurses’ Health Study from 1980 to 2010 and the Health Professionals Follow-up Study from 1986 to 2012, as noted in a related article on www.upi.com.

Among the participants, 20,414 cancers were diagnosed in the women, and 7,571 in the men. Long-term use of aspirin (twice or more per week) was associated with a 3 percent lower risk for overall cancer. For gastrointestinal cancer, the risk decreased 15 percent when taking 0.5 to 1.5 aspirin tablets per week for six years, and the risk for colorectal cancers (both colon and rectal) decreased 19 percent. However, “regular aspirin use was not associated with the risk for breast, advanced prostate, or lung cancer,” the study adds.

In addition, “aspirin may be a potential low-cost alternative to endoscopic CRC (colorectal cancer) screening in resource-limited settings or a complement in settings in which such programs are already implemented, including the general U.S. population, in whom screening adherence remains suboptimal.”


Wearable Defibrillators Provide Another Option

Patients at risk of sudden cardiac death (SCD) who can’t tolerate an implanted defibrillator may benefit from one they can wear like a vest, according to an advisory in *Circulation*.

“Wearable Cardioverter-Defibrillator Therapy for the Prevention of Sudden Cardiac Death: A Science Advisory From the American Heart Association” states that unlike an implantable cardioverter-defibrillator (ICD), the wearable cardioverter-defibrillator (WCD) is temporary, easily removed and doesn’t require surgery. The device is “designed for patients at risk of SCD who are not immediate candidates for ICD therapy.”

Worn under clothes and resembling “a glorified fishing vest” a WCD connects to the body via electrodes, lead author Jonathan Piccini Sr., associate professor of medicine at Duke University Medical Center, Durham, North Carolina, says in a related article on www.upi.com. When it detects an abnormal heart rhythm, the device sounds alarms that get louder and ultimately delivers a shock if the patient doesn’t respond.

WCD therapy may benefit patients with heart or bloodstream infections, those whose defibrillator was removed because of infection, and women who develop cardiomyopathy during pregnancy or after giving birth, Piccini notes. The device also may be a short-term solution while physicians decide whether an ICD is the best option.

However, Evan Levine, a cardiologist at Montefiore Medical Center in New York, is critical of long-term use of the device, adds the related article. While it may benefit patients who had an ICD removed because of infection, Levine questions its benefit for patients ineligible for an ICD, adding that inexpensive medications are just as effective.

The advisory acknowledges that providers must weigh the individual risks and benefits of ICD placement and WCD use.

Positive Emotional Stress Can Trigger Broken Heart Syndrome

While the role of negative emotions in provoking TTS is acknowledged, the role of positive emotions is not commonly recognized.

Pleasant experiences also can be linked to broken heart syndrome, a rare condition that causes a sudden but temporary weakness in the heart muscle.

“Happy Heart Syndrome: Role of Positive Emotional Stress in Takotsubo Syndrome,” in European Heart Journal, analyzed data collected from 485 people with a “definite emotional trigger” among 1,750 patients with stress cardiomyopathy or broken heart syndrome. The condition was originally named takotsubo syndrome (TTS) after the researcher who first described it in 1990, adds an article on www.cbsnews.com.

The aim of the study was to “analyze the prevalence and characteristics of patients with TTS following pleasant events, which are distinct from the stressful or undesirable episodes commonly triggering TTS.” The findings reveal that while 95.9 percent of the 485 participants experienced broken heart syndrome after negative emotional stress, 4.1 percent experienced symptoms of “happy” heart syndrome after a positive emotional event.

The observation of pleasant emotional stress triggering TTS may lead to a shift in clinical practice, the study adds. While the role of negative emotions such as anger, grief or fear in provoking TTS is acknowledged, the association between positive emotions and TTS is not commonly recognized. The “findings further expose the multifaceted nature of this disease and broaden the spectrum of triggers associated with it.”

TTS is an example of a complex, intertwined feedback loop (encompassing psychological and/or physical stimuli in the brain) that impacts the cardiovascular system. “Perhaps, both happy and sad life events, while inherently distinct in nature, share a final common pathway in the central nervous system processing and output, which can ultimately trigger TTS.

“Future research is warranted to investigate this possibility and delineate the exact mechanisms underlying both ‘broken’ and ‘happy’ heart variants of TTS,” the study concludes.


AACN Scholarships:
Expand Your Knowledge and Skills

Continuing professional development scholarships enhance the value of membership in AACN, the largest specialty nursing organization. Whether you seek learning in a national or local program, AACN scholarships support you in expanding your knowledge and skills. www.aacn.org/scholarships
The Power of Compassion
An Interview With Windra Stringham
Windra Stringham, a critical care clinical educator at Lovelace Medical Center in Albuquerque, New Mexico, has been feted with a cornucopia of plaudits, awards, citations and other really cool things for the care and compassion she shows those she interacts with. But sometimes we need to wait for a good thing. Or maybe the nurse gods knew they had something good, so they took an extra-long time forging her with the fires of passion and empathy. And now, she’s New Mexico’s treasure.

How did you get started in nursing?
I’d wanted to be a nurse ever since high school. Probably even before that. My father and grandmother were nurses, and my grandfather was a physician. But things happen, and sometimes you get distracted. But with [a fatal accident involving her brother] Chris, it really shook things up for me, made me understand that it was time to take care of things. I just felt like I needed to make a difference.

We’ll get into what you do later, but what do you get out of it?
Doing what I do gives me incredible purpose in life. You feel like you really are making a difference. I am very proud of what I do.

Seems like you’re not the only one. You were recognized for Excellence in Critical Care Nursing at the 2015 New Mexico Nursing Excellence Awards, nominated for the award by your boss.
It is such an honor for other people to see what you do and think so well of it. It is very gratifying and incredible — but it doesn’t make me feel any different about what I do, nor is getting the award the reason I am a nurse.

You were also named a recipient of a 2015 DAISY Award for Extraordinary Nurses.
Yeah, I can’t even describe what it feels like. On some level, it’s like a kind of validation for what you do, but it is very humbling.

You recently were given a new role, as a critical care clinical educator. What do you miss the most about working at the bedside?
I really do miss the bedside. The contact you have as a critical care nurse with the patients is incredible. The personal stories that are shared … just them allowing you into their lives and those of their families. There’s something so intimate and powerful and really awesome about that. There’s nothing like it.

What is it about this new opportunity that is so attractive?
I am so passionate about nursing, and sharing best practices and helping us provide the best care possible to our patients. I have learned so much — I think I would be a much better nurse if I went back to the bedside tomorrow — and there is so much I want to do, including stressing the importance of getting our CCRN.

What do you see as the ultimate goal of a nurse?
I just want to see people get better. That’s it. We just want them to get better. And many times they won’t, particularly in the area in which we work. When they are in critical care, they can get very ill very fast. But when they do get better, 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.

And the not-so-good days?
Just being there for the families is so important, because they have let you in and many times you feel like you are part of the family. To hold the hand of the family member when they lose somebody — or even when they don’t have anybody and can feel alone or vulnerable — to be able to be sitting with them and holding their hand as the patient passes is an honor to me.

What do you do outside of work to try to keep a balance?
I really enjoy gardening. It really helps me to relax and calm down. And then, my husband and I like to go rock climbing — facing fear, and all that. It wakes me up a little bit.

What is it that inspires you about nursing?
I have found that my patients make me a better person. And each has impacted my life in some way. As a nurse, you see the world through so many eyes when you’re caring for your patients and their families. Their stories have enriched my life so much. The pride and passion I have as a nurse is fueled by my patients.

“Doing what I do gives me incredible purpose in life. You feel like you really are making a difference. I am very proud of what I do.”

Interview by Paul Taylor, paul.taylor@aacn.org
Safe Practice Recommendations for Copy and Paste

ECRI hopes the toolkit will help healthcare providers ensure that copied and reused information remains accurate and reliable.

The ECRI Institute, Plymouth Meeting, Pennsylvania, released a toolkit for healthcare providers on copying and pasting health information.

“Recommendations on Safe Use of Copy and Paste Issued at HIMSS16,” an ECRI news release, reviews how the Partnership for Health IT Patient Safety, a multi-stakeholder collaborative convened by ECRI, developed “Health IT Practices: Toolkit for the Safe Use of Copy and Paste.” Forty leaders from participating organizations were part of the work group.

“We defined copy and paste, looked at uses, looked at the literature, reviewed events that had come into ECRI Institute’s Patient Safety Organization, talked about vendor functionalities and explored best practices from a couple of organizations and how they’re working on copy and paste, and then, at the end, got to some recommendations,” National Patient Safety Foundation President and CEO Tejal Gandhi, who chaired the work group, explains in the release.

Copy and paste is widespread, as users duplicate text, images and other data between documents, adds an ECRI resource page. “Despite the importance of this topic, no published articles to date have systematically reviewed the evidence regarding prevalence of and patient safety risks associated with copy/paste or copy-forward.”

The four recommendations:

• Provide a mechanism to make copy and paste material easily identifiable
• Ensure the provenance of copy and paste material is readily available
• Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste
• Ensure that copy and paste practices are regularly monitored, measured and assessed

ECRI hopes the toolkit will help healthcare providers ensure copied and reused information remains accurate and reliable, and that it will lead to discussions on safe practices.

Are Stethoscopes Ready for Retirement?

Most physicians don’t use stethoscopes very well, and auscultation skills decrease over time.

Afeter 200 years, the usefulness of stethoscopes is being questioned by practitioners who now have access to more accurate tools, including cellphone apps.

“Heart Doctors Are Listening for Clues to the Future of Their Stethoscopes,” in The Washington Post, explains that although stethoscopes “retain their value for listening to lungs and bowels for clues of disease,” they’re far less accurate in other areas, such as cardiology.

One underlying problem is that most physicians don’t use stethoscopes very well, and auscultation skills decrease over time, the article adds. As a result, there are fewer qualified mentors to impart their skills to new physicians. At least one medical school doesn’t use stethoscopes and issues handheld ultrasound equipment to students for real-time views of the heart at the bedside.

However, proponents cite how alienating technology can be to some patients. Stethoscopes and exams can help narrow the growing physical distance between patients and their increasingly busy physicians. W. Reid Thompson, pediatric cardiologist at Johns Hopkins School of Medicine, Baltimore, has collected thousands of heart sounds at www.murmurlab.org for anyone who would like listening practice (new users must apply to access the database).

What is your hospital’s view on stethoscopes — for nurses and physicians? 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.
New Orleans provided a colorful and musical backdrop for more than 8,000 nurses in May, as the National Teaching Institute & Critical Care Exposition assembled once again in the Crescent City.

Although it often seemed more like a Mardi Gras celebration than a gathering of nurses, NTI 2016 offered attendees everything they’ve come to love: dynamic educational sessions, inspiring SuperSessions, more than 400 exhibitors demonstrating cutting-edge technology, countless networking opportunities and the unveiling of our new theme: It Matters. Old friends reconnected, new friends found one another and just about everyone joined the second line parade to party at Mardi Gras World for a truly joyous Nurses’ Night Off.

Make plans now to attend NTI 2017, when we travel to Houston, the fourth largest metropolis in the U.S. and one of the great American cities.

You’ll find more NTI stories and photos at www.ntivoices.com and at facebook.com/aacnface.
A highlight of every NTI is honoring the healthcare community’s visionary leaders. This year, AACN honored Suzanne “Suzi” Burns (right) and Cathie Guzzetta (left) with its Pioneering Spirit Award and Barbara Safriet with the Marguerite Rodgers Kinney Award for a Distinguished Career.

The week kicked off in grand style with a Mardi Gras party during Monday’s SuperSession.

The traditional overflow crowd floods the Critical Care Exposition’s Tuesday morning opening.

President Karen McQuillan started the week with an inspirational reminder “to be our boldest, most courageous selves.”
AACN CEO Dana Woods expressed her gratitude to critical care nurses, speaking about the true impact they make on patients and families.

Forty-year CCRNs were honored at the Certification Celebration Tuesday night — and then everybody danced!

Comedian Josh Blue shared his experience as someone with cerebral palsy and elicited laughs at the Chapter Presidents’ Luncheon.

ABC news anchor Dan Harris entertained the crowd at Monday’s SuperSession with his wry telling of his personal story of how after an on-air panic attack he found help through meditation and increased his focus and mindfulness.
President Karen McQuillan entrusts the care of AACN’s vision to incoming president Clareen Wiencek.

Tuesday SuperSession keynote speaker Mel Robbins motivated and inspired nurses with her “5-second” rule for change: “If you have an impulse to act on a goal, you must physically move within five seconds or your brain will kill the idea.”

Revelers joined the party at Mardi Gras World during Nurses’ Night Off.

On Wednesday, incoming president Clareen Wiencek — shown here during a quiet moment with her granddaughter — announced AACN’s 2016-2017 theme, It Matters.
AACN’s Facebook Community Weighs in About NTI

As always, this year’s National Teaching Institute & Critical Care Exposition in New Orleans had something for everyone. Here’s how AACN Facebook followers answered a Monday poll question. Post your own comments on AACN’s wall, or send them to aacnboldvoices@aacn.org.

 AACN American Association of Critical-Care Nurses
Monday Poll: Do you know what it means to miss New Orleans?

† Candy May Dorman The entire experience was surreal. Being in the presence of 8000 other nurses that share the same passion and dedication to patient care that you do is beyond any expectations I had for attending NTI. Can’t wait for Houston 2017.

† Mike Ackerman Post NTI Syndrome: the experience of coming back really excited to a group of co-workers that don’t share that same enthusiasm! Share if it’s happened to you, like if not.

† Maria Wright Hagg AMAZING experience!!!!! I couldn’t get enough crammed into my little pea brain—but I tried!!!! Went back to work today and all I could do was talk about all the neat things I learned!!! Can’t wait for next year!! I am so excited for my staff that I will be making sure that everyone who can go does go next year!!!!

† Bonnette Villalba New Orleans withdrawal! It was amazing to see nurses getting together to learn and having fun together. Wishing every nurse would get the amazing experience with NTI ...

† Sharon Bourassa I am so thankful to the AACN for providing me the opportunity to attend via scholarship!! Loved NTI NOLA!! Many great ideas to share with my peers. I miss the Southern hospitality already.

† Lisa Lyn Always an interesting new location for me and rewarding for the knowledge earned! It’s not long enough!!! would love 5 full days! So much to learn in so little time. Great job AACN and thank you!!! I will continue to promote to my co-workers as more and more come each year!!

† Cynthia Lentz I missed it because I had 2 major family events before and after — both long trips. I’d like to see the transcripts and do the CEUs though.

† Betsy Boris Starting missing it before the last day ended. Trying to figure out how to make this happen next year! Making every day matter until then ...

† MC RB New learning and seeing 8000 nurses under one roof get down, have fun, and act crazy … PRICELESS.

† Noelle M. Hartley I’m missing the walking!! I did at least 10 miles a day while there!!

† Peggy Hurst Was just thinking “One week ago I was in New Orleans ...” Always goes by so fast!

† Phyllis McCauley Richards Awesome conference in an awesome city. Had a blast!!!!

† Karen Mack Great time of learning and a perfect tone from the leadership!

† Jo Ann Miles Carr Awesome conference, had a great time and learned a lot!!

† Denisa Smart El-Sabae Had my identity stolen the last time NTI was in NOLA. Yeah, not so much fun!

† Diane Ogren Stevens It was wonderful but I am still tired!!

† Myra Sanders I missed it. Maybe Houston!

† Mary Santapaula Awesome conference!!
Building Trust With Patients Through Genuine Connection

Sometimes patients just need their nurses to be emotionally present and acknowledge the situation.

The best emotional support a nurse can provide a patient or family member is sometimes giving them permission to experience their emotions in a nonjudgmental atmosphere.

“This builds trust. This builds confidence. This is care,” says Kati Kleber on her blog, www.NurseEyeRoll.com. She offers the following example:

“It was a typical neuro ICU kind of day. I had two patients in rooms next to each other. They both were pretty sick but in very different ways. I didn’t say anything profound all day. I didn’t put together the pieces of some intricate clinical picture, call the doctor and suggest the perfect thing to improve their outcome. I didn’t manage my time perfectly.”

Not trying to fix the emotional pain of the two patients and their family members, assessing their needs and just being there was the best she could do for them that day. And the results were positive.

“Sometimes they just need a little extra explanation and reassurance. Sometimes they need to see you prove to them that you know what you’re doing and that they or their loved one is important to you because they are important to them. Sometimes they just need you to be emotionally present and acknowledge the situation,” she reflects.

New Recommendations to Enhance Patient Safety

Better data, valid metrics and greater transparency represent the best formula to make the U.S. a world leader in patient safety.

Although there is an increased focus on patient safety and reducing medical errors, safety can be compromised due to the lack of standard measures in U.S. hospitals.

In “Toward a Safer Health Care System: The Critical Need to Improve Measurement,” a commentary in JAMA: The Journal of the American Medical Association, Ashish Jha (Harvard T.H. Chan School of Public Health, Boston) and Peter Pronovost (Johns Hopkins Medicine, Baltimore) criticize the administrative data used to determine the number of medical errors and recommend federal action to improve metrics.

“Without standards of accuracy or timeliness,” they write, “some rating programs will label some of the best clinicians and hospitals as unsafe and some of the neglectful ones as safe, which has the potential to do more harm than good.”

The authors recommend the Centers for Medicare & Medicaid Services develop “a standardized set of validated metrics” based on clinical data to encourage patient safety rather than coding. Reliable metrics with defined standards would ensure that the healthcare industry, journalists and government share accurate data.

The only adverse events that are tracked well, the authors contend, are hospital-acquired infections, which have been reduced. The Centers for Disease Control and Prevention should use clinical data from electronic health records in creating mathematical models to detect other adverse events, they add.

The authors also propose that Congress invest in system funding, because large cost savings can come from simple changes, such as the checklist intervention to reduce central line infections. “Without these measures, the key ingredient in these efforts is missing: systematic, real-time data on adverse events with timely feedback to clinicians and health care organizations. Without effective measurement and reporting, progress in patient safety will be arduous and slow.”

The Healthcare Association of New York State published a similar call to action, “Measures That Matter,” seeking to reduce costly reporting to various entities, often with disparate requirements. “This lack of alignment and coordination … has created an environment of measure madness — displacing and redirecting resources from meaningful improvement efforts,” the report notes.

“Better data, valid metrics, and greater transparency represent the best formula for making the United States a world leader in patient safety,” the commentary adds.

Adequate nutritional therapy for critically ill patients is integral to optimal outcomes. To determine the influence of enteral nutrition on overall morbidity in surgical ICU patients, investigators compared patients with high calorie and protein deficits to those with lower deficits. They found significant differences. The high deficit groups were more likely to have prolonged ICU stays and longer hospital stays. In addition, the high deficit groups had more complications and fewer ventilator-free days than the lower deficit groups. This study highlights the value of enteral nutrition in recovering surgical ICU patients. (Yeh et al, AJCC, July 2016) www.ajcconline.org

Identifying patient populations that require more resources allows for intervention to reduce costs. Associations between body mass index and outcomes have been noted when assessed as independent variables. However, when resource use was assessed as a multifaceted outcome variable, injury factors (higher Injury Severity Score, lower scores on the Glasgow Coma Scale, more physiological complications) were associated with resource use (increased length of stay in the ICU and increased number of procedures). These findings offer clinicians a new perspective for evaluating the complex relationship between patient/injury characteristics and hospital resource use. (Lee et al, AJCC, July 2016) www.ajcconline.org

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

Cynthia Bautista, previously neuroscience clinical nurse specialist at Yale-New Haven Hospital, Connecticut, is now an associate professor at Egan School of Nursing and Health Studies at Fairfield University. A member of AACN since 1984, she has been a CCNS since 1999 and is past president of AACN’s South Central Connecticut Chapter.

Bernice Coleman, advanced care nurse practitioner and noted researcher on heart transplantation, Cedars-Sinai Heart Institute, Los Angeles, and a past recipient of AACN’s Pioneering Spirit Award, was this year’s commencement speaker at Yale School of Nursing, New Haven, Connecticut.

Margaret Crawford, director of trauma services at Delray Medical Center, Delray Beach, Florida, and a member of AACN since 1979, is honored in the South Florida Sun-Sentinel for 35 years of continuous certification as a CCRN.

Cindy Munro, associate dean for research and innovation, University of South Florida College of Nursing, Tampa, co-editor-in-chief of American Journal of Critical Care and past AACN distinguished research lecturer, is inducted into the Honor Society of Nursing’s 2016 Nurse Researcher Hall of Fame.

Richard Savo, previously director of surgical critical care, becomes director of adult critical care services at Maimonides Medical Center, Brooklyn, New York. He is also co-editor-in-chief of American Journal of Critical Care and serves on the editorial board of Critical Care Medicine.

Samantha Staub, a nurse at Carroll Hospital, Westminster, Maryland, receives a DAISY Award for delivering exceptional patient care.

Mary Fran Tracy, editor of AACN Advanced Critical Care, AACN past president and a member since 1989, assumes a new joint position. She becomes a tenured associate professor at University of Minnesota School of Nursing, Minneapolis, and a nurse scientist with University of Minnesota Health.
Walk with me for a minute. We're walking down a long, dark hall. A new graduate nurse is working the night shift, a few months out of orientation, on a large cardiac monitoring unit.

A high-level alarm sounds, and the nurse runs down the hallway to enter her patient's room to find him in full arrest. The bedside monitor shows VFib. Watch as this new graduate and the other night shift nurse — a veteran of 30 years — defibrillate the patient as the code team arrives. At first, you hear the noise and commotion of the code team in full action. Then, the room becomes quiet. The resuscitation attempt fails, and the team leader calls the code.

The next day the new graduate hears, through the rumor mill, that the other nurse believes that her inexperience as a new graduate contributed to the unsuccessful resuscitation.

She is devastated. But she did not use her voice to talk to her co-worker or anyone else to gain insight into what she did wrong — or right. She remained silent.

Then, within that same week, another nurse tapped her on the shoulder and invited her to join a group she had never heard of: the American Association of Critical-Care Nurses. That tap on the shoulder made a difference to the young nurse. It told her she had value. She was being invited to join a nursing community, and someone had a vision for her future.

She joined AACN that day — and she is still a member today.

That event started my journey as a critical care nurse. And sometimes in those early days, my vision was not always clear about that journey and my voice was not always strong. But when I heard AACN's vision, it became my own: AACN is dedicated to creating a healthcare system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution.

I love the elegant simplicity of that statement. It recognizes that our contributions as nurses matter and that our work environment matters if we are to meet the needs of those we have pledged to serve: our patients and their families.

Living that vision means that each of us must show up, speak up and not give up.

Author and surgeon Atul Gawande says that "medicine has forgotten how vital such matters as … memories, connecting with loved ones, and reflecting on life's work are to people."

Medicine may have forgotten, but nurses have not. We have not forgotten, because we know exactly how much these things matter.

In fact, we know it matters that we care courageously for the sickest patients.

It matters that we are members or leaders of interdisciplinary teams who are always at the bedside watching, preventing errors, averting disasters.

It matters that nurses are certified, as evidence that we value patient safety and quality.

It matters when we hold the hand of a dying patient and wipe the tears of the patient's wife … or father … or daughter — or sometimes our own.

It matters that we are the architect of the memory for the family of every patient who experiences the crisis of acute or critical illness.

And that's why It Matters is our theme for this year.

I am humbled to serve you as AACN's 47th president. I cannot wait to travel the country to meet you and your chapters and teams, and to witness how what you do matters at every level.

And I invite you to take another walk with me. I need you to use your voice and speak up about the things that matter most to you. I need you to tell me about them. Send me a note at itmatters@aacn.org to let me know how you and your teams are leading change — small or large. It Matters.