The first flush of enthusiasm we’ve felt in designing and planting a new garden may give way to boredom as we settle into the routines of tending established plants. It’s easy to tire of caregiving after the dedicated watchfulness required in helping young seeds and plants get started. We may mistakenly hope that things in the garden can, with some water and fertilizer, mature on their own.

Although weeding, cutting back, and transplanting are activities that may seem repetitive and never-ending, when seen as a necessary and integral part of the overall unfolding of the garden scheme, they become purposeful rather than boring. In fact, what may appear on the surface to be tedious physical work may, in the actual doing, be spiritually liberating. In taking time to contemplate the small — in observing the details of our garden — we can experience life on a manageable scale.

—Marilyn Barrett


The Greatest Innovation

Look around your unit. What innovations do you see? You may have said ECMO machines, CRRT, ventricular assist devices, ventilators, intra-aortic balloon pumps and high-tech monitors of various sorts. Such technology defines our work environments — but look again. In his book “The Innovators: How a Group of Hackers, Geniuses, and Geeks Created the Digital Revolution,” Walter Isaacson says the greatest innovation that propelled us into the digital age is — the team.

Read more in my note on page 22.

Clareen Wiencek
AACN President

If you want to walk quick, walk alone. If you want to walk far, walk together.

—African proverb
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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FDA Approves Black Box Warnings for IR Opioids

The plan is to focus on policies that will help reverse the overdose epidemic, while ensuring patients have access to effective pain relief.

The Food and Drug Administration (FDA) announced class-wide safety labeling changes for immediate-release (IR) opioid medications and is considering new warnings related to interactions with benzodiazepines.

“FDA Announces Enhanced Warnings for Immediate-Release Opioid Pain Medications Related to Risks of Misuse, Abuse, Addiction, Overdose and Death,” an agency news release, notes that safety warnings also will be required for “all prescription opioid medications to inform prescribers and patients of additional risks related to opioid use.” The plan is to focus on policies that will help reverse the overdose epidemic, while ensuring patients have access to effective pain relief. In 2013, the FDA required labeling changes for extended release/long-acting opioid products.

“Opioid addiction and overdose have reached epidemic levels over the past decade, and the FDA remains steadfast in our commitment to do our part to help reverse the devastating impact of the misuse and abuse of prescription opioids,” FDA Commissioner Robert Califf adds in the release.

In addition, the FDA is requiring updated labeling for all opioid products to include information about possible adverse drug interactions with other medicines that can lead to serotonin syndrome. And the agency is reviewing information about potential adverse outcomes due to interactions between opioids and benzodiazepines.

The FDA says it is committed to combating this health crisis and its “profound impact on individuals, families and communities” across the country.

Recall: Error in 2016 Cardiac Medications Pocket Card

If you recently purchased or received the AACN Cardiac Medications Pocket Reference Card (#400801), REV 1/16, there is an error, as follows:

Instructions listed in the Critical Care Considerations column for DOBUTamine incorrectly state: ‘Initially give 6 mg IV over 1-2 sec. If no response within 1-2 min give 12 mg rapid IV push: may repeat 12 mg dose in 1-2 min if still no response.’

The ‘Critical Care Considerations’ for DOBUTamine should read: ‘Dosage is determined by patient response to the drug. Titrate dose to individual response. Correct hypovolemia before DOBUTamine infusion.’

We took immediate steps to remedy the error and stopped the sale, promotion and distribution of this card. Please do not reference the information, and immediately destroy this card, labeled REV 1/16 (date on bottom right, see image above). AACN will replace your pocket reference card, at no charge. Please contact us at info@aacn.org or 800-899-AACN (2226) and give us your mailing information.

We know that you count on AACN for reliable and accurate resources to assist you in the care you provide to patients. We are grateful for that trust and apologize for this error and the inconvenience of waiting for the new card to arrive.
CERTIFICATION CORNER

CCRN Certification Supports Advanced Practice Nursing Excellence

An acute care nurse practitioner discusses how her APRN practice aligns with CCRN certification.

“CCRN certification is a way to distinguish yourself as someone with expertise in critical care. Whether embarking on an advanced practice (APRN) role, participating in a new committee or project or continuing in your current role, CCRN demonstrates your commitment to excellence in critical care.”

So says Kiersten Henry, a CCRN-certified acute care nurse practitioner (ACNP) specializing in cardiology and critical care, who also serves as chief advanced practice provider at MedStar Montgomery Medical Center in Olney, Maryland.

Often, ACNPs desiring specialty certification in critical care are uncertain whether CCRN or CCRN-K is the right credential for them. Henry’s practice illustrates how many ACNPs qualify for CCRN certification.

Since CCRN eligibility is based on direct care hours, ACNPs may not realize the direct care aspect of their practice allows them to maintain eligibility for CCRN certification.

“Clinically, I provide direct care in critical care, progressive care and cardiology,” Henry says. “This covers the spectrum of acutely and critically ill patients from the decision to admit via the emergency department to discharge.

“Administratively, I am chief of the hospital-employed advanced practice providers in critical care, cardiology, glycemic care and surgery,” she continues. “I serve on the critical care committee, potentially preventable complications committee, stroke committee and system-wide patient and family education committee.”

Celebrating 40 years of CCRN at NTI

Three nurses discuss how certification has supported their professional journey.

During the Certification Celebration at the National Teaching Institute & Critical Care Exposition (NTI) 2016, AACN honored several CCRNs who this year celebrate the 40th anniversary of their certification. We chatted with three of them, who shared examples of how certification has supported their personal nursing journey.

Ellen Prewitt, acute care nurse practitioner, critical care transport: “It gave me the confidence to go on and become an ACNP. I don’t know if I would’ve done that had I not felt confident, through taking that initial CCRN test, to go back to school, continue pursuing education and know I can develop that level of expertise — and the first step was CCRN.”

Olinda Spitzer, clinical nurse specialist: “In 2004, we had the tsunami in Indonesia and they needed critical care nurses. So now 3,000 nurses apply, and how are they going to decide who gets to go? Well, being a CCRN helped. Fifty nurses were able to go, and I happened to be one of them. Certification opened that door, and it was an incredible experience.”

Carolyn Langstraat, CVICU staff nurse, educator and preceptor: “Sometimes you have families where, in the modern age of the internet, they can Google any type of treatment, and at times they’ll question your care. But when they see your name on the wall of honor, they’ll say, ‘Hmmm, you’re certified.’ It’s knocked down a lot of barriers where families are skeptical of the care their loved one is getting.”

Henry spends well over 12 hours per month engaged in direct care activities (e.g., physical assessment, interventions) distinct from her administrative responsibilities, supporting her eligibility for CCRN certification.

“The knowledge required to obtain and maintain CCRN certification enhances the direct care I provide to acutely/critically ill patients,” she says. “Maintaining competency through critical care-specific continuing education and clinical resources — such as AACN Practice Alerts — helps ensure my practice is evidence-based. This in turn helps ensure patients receive optimal care, especially when new protocols or practices are developed.”

APRNs whose practice involves primarily non-direct care responsibilities that positively influence the care delivered to acutely/critically ill patients could be eligible for CCRN-K. If your APRN role includes both direct care and administrative components, you should hold the specialty credential that best aligns with your practice.

To learn more about CCRN and CCRN-K certifications, visit www.aacn.org/certification > Select Your Program.
Medication Errors Still Occur With Computerized Systems

This survey underscores the need for hospitals and patients to be vigilant when it comes to overseeing medications.

Software programs developed to prevent in-hospital medication errors are not catching as many mistakes as expected.

“Hospital Software Often Doesn’t Flag Unsafe Drug Prescriptions, Report Finds,” in KHN: Kaiser Health News, states that a voluntary survey of about 1,800 hospitals’ software systems by The Leapfrog Group did not catch “potentially harmful drug errors” almost 40 percent of the time. In 13 percent of the cases, the errors could have resulted in death.

Prescription drug errors included the wrong dosages, possible drug interactions or the wrong drug for the illness or condition. To perform the survey, prescriptions for “dummy patients” were entered into the system, with errors the software should flag.

Electronic health records, including computer-based medication ordering systems, are seen as a way to improve patient safety and quality of care. It is believed that these systems improve safety by incorporating patient information, such as diagnosis, test results and current medications, with the new prescriptions, flagging users if something appears incorrect or inconsistent. However, not all users are pleased with the computerized approach; some find it difficult to use and time-intensive.

No software fits the needs of all facilities, so software that works well in one facility may have to be adapted for another. This survey, although not peer-reviewed, “underscores the need for hospitals and patients to be vigilant when it comes to overseeing their medications. For hospitals, that means instituting ‘checks and balances’ — system-wide initiatives like requiring manual reviews of a patient’s drugs, on top of the computer checks.”

The article concludes that while the survey may be flawed (some Leapfrog surveys have been criticized for their methodology and metrics), there is room for improvement in prescription software safety.

Is the Data on Deaths From Medical Errors Correct?

An opinion piece in STAT finds fault with the methodology for a study that estimates annual U.S. deaths from medical errors, proclaiming them the third-leading cause of death.

In “Don’t Believe What You Read on New Report of Medical Error Deaths,” Vinay Prasad, assistant professor of medicine at Oregon Health & Science University, Portland, criticizes a report in BMJ for making headlines with uncertain data. “If the researchers had really wanted to update the estimate for the modern age,” Prasad writes, “they should have dug into patient records and made tough decisions about which deaths were truly due to errors — in other words, they should have done their own analysis.”

“Medical Error — The Third Leading Cause of Death in the US,” the report in BMJ, attempts to determine what the Centers for Disease Control and Prevention’s statistics neither account for nor standardize — which deaths are attributable to medical errors and what defines them. The report estimates 251,454 deaths in 2013 due to medical error, after reviewing four previous studies.

Observing that the report in BMJ defines medical error vaguely, and therefore “the sensational figure is imprecise and may be wrong by a large magnitude,” Prasad cautions that it could lead to harm if patients become afraid and avoid treatment.

The authors of the report argue that heart disease and cancer — the leading causes of death — receive their due attention, but medical errors elude policymakers and receive less funding, because they are not properly tracked. “We focus on preventable lethal events,” they write, “to highlight the scale of potential for improvement.”

REFERENCE: Makary MA, Daniel M. Medical error—the third leading cause of death in the US. BMJ. 2016;353:i2139. doi:10.1136/bmj.i2139.
Persistent Critical Illness Extends ICU Stay

The findings could lead to better care and ways to prevent patients from slipping into this situation.

A small percentage of critically ill patients goes from one health crisis to another and may never be well enough to leave the ICU, according to a study in *The Lancet Respiratory Medicine*.

Part of the reason is that advanced intensive care treatment prolongs the lives of those with conditions that previously would have been fatal, but it can also produce a devastating condition known as persistent critical illness (PCI).

“Timing of Onset and Burden of Persistent Critical Illness in Australia and New Zealand: A Retrospective, Population-Based, Observational Study,” which analyzed data from more than 1 million ICU patients in 182 ICUs across Australia and New Zealand, finds that 5 percent of these patients accounted for 33 percent of all days that ICU beds were used.

About 51,500 patients of the total studied had PCI. This group collectively spent more than 1 million days in the ICU and more than 2.2 million days in the hospital overall.

In addition, almost one-quarter of the patients with PCI died in the ICU. Just under half of ICU patients with PCI went directly home from the hospital, compared to three-quarters of ICU patients who did not have PCI.

The findings could lead to better care and ways to prevent patients from slipping into this situation.

“We have found that this truly is a separate ‘thing’—a state patients transition into where you’re there because you’re there, stuck in this cascade that we can’t get you out of,” study leader Theodore Iwashyna says in a news release from University of Michigan (U-M), Ann Arbor.

Iwashyna, a U-M Medical School ICU physician, led the study while on sabbatical in Australia.


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Helmet Ventilation Effective for Patients With ARDS

The patients with helmets had more than three times lower intubation rates than those with face masks.

Using a helmet to deliver noninvasive ventilation (NIV) may be more effective than a face mask for patients with acute respiratory distress syndrome (ARDS), finds a study in *JAMA: The Journal of the American Medical Association*.

Although face-mask NIV has reduced the need for endotracheal intubation in patients with chronic obstructive pulmonary disease and pulmonary edema, it’s not as effective for patients with hypoxemic respiratory failure. According to “Effect of Noninvasive Ventilation Delivered by Helmet vs Face Mask on the Rate of Endotracheal Intubation in Patients With Acute Respiratory Distress Syndrome,” higher levels of positive end-expiratory pressure are often needed to improve oxygenation for patients with ARDS, which can push the limitations of face masks and lead to air leaks.

However, helmets are transparent hoods that cover the entire head. The soft collar neck provides a better air seal and is overall more tolerable for patients than a mask. As a result, patients with helmets had more than three times lower intubation rates than those with face-mask NIV. The group with helmets also experienced a statistically significant reduction in 90-day mortality rates.

The randomized clinical trial followed 83 single-center ICU patients with ARDS who required NIV for at least eight hours in the medical ICU between 2012 and 2015. The median age was 59 years, 45 percent were women, and all were randomly assigned to receive NIV through a face mask (39 patients) or a helmet (44 patients).

The results were so robust that the study ended early. Approximately 61.5 percent of patients with face masks required intubation compared to 18.2 percent for those with helmets. The study adds that “multicenter studies are needed to replicate these findings.”


©StarMed/Intersurgical
Microchip Helps Paralyzed Man Regain Control of Hand

This new technology is not a cure — the man can use his hand only when connected to the lab computers.

A chip implanted in the brain of a 24-year-old man with quadriplegia — who sustained a cervical spine injury five years ago in a diving accident — helped him regain control of his right hand and fingers.

According to “Restoring Cortical Control of Functional Movement in a Human With Quadriplegia,” in *Nature*, neuroscientists from The Ohio State University and Battelle Memorial Institute isolated the part of the man’s brain that controls hand movement and implanted an intracortical chip in the motor cortex. The device helps the team decode brain signals and match them to specific movements.

Electrical stimulation is then sent to 130 electrodes embedded in a flexible sleeve wrapped around the paralyzed arm. After months of repetition and training, the man completed six different wrist and hand motions that included pouring liquid from a bottle, picking up objects and even playing video games.

A related article in *The New York Times* adds that he improved enough to have the injury reclassified from a “severe C5 function to a less severe C7 designation.” It is the “first account of limb reanimation, as it is known, in a person with quadriplegia.”

The new technology is not a cure, however; the man can use his hand only when connected to lab computers. But study authors hope to one day develop a wireless system that could restore some mobility to thousands of people who have paralysis.


Headset and Smartphone App Turn Thoughts Into Speech

The ‘think to speak’ technology works by reading the brainwaves of the user and expressing them as phrases spoken through the app.

Using a wireless headset from Emotiv paired with its :prose smartphone app, California-based Smartstones can restore speech to those who have difficulty communicating verbally.

“Thought-Reading Headset Lets Users Speak Their Mind,” in *gizmag*, explains that “the ‘think to speak’ technology works by reading the brainwaves of the user and expressing them as phrases spoken through the app.” The system can help people with ALS, autism, cerebral palsy or brain or spinal cord injuries who are unable to speak and/or can’t type on a smartphone.

Users “simply think about the motions tied to each command, and the headset reads their brainwaves, transmits the signal to the app via Bluetooth, and speaks the related phrase aloud.” They also will be able to wirelessly send messages to other devices.

Smartstones collaborated with Pathpoint, a California-based nonprofit company, to test the technology, which is reportedly easy to use and relatively inexpensive.

Gil Trevino, Pathpoint’s lead direct support professional, tells *gizmag*: “One of our participants now can communicate by using mental commands. Within minutes she was speaking several phrases aloud, compared to years of training with other technologies. This advancement has allowed someone who once was a non-verbal communicator, the ability to communicate thoughts, feelings and answers in a way she never has before.”

The Smartstones :prose app is available for Apple iOS, and the system itself is in beta testing.
Older Population Increasing at Unprecedented Rate

The increase in our aging population presents many opportunities and several public health challenges to prepare for.

The world’s older population is growing at an unprecedented rate, according to a U.S. Census Bureau analysis funded by the National Institutes of Health (NIH). And even though they are living longer, people aren’t necessarily healthier.

“World’s Older Population Growing Rapidly, Report Finds,” on Fox News Health, notes that 8.5 percent of people worldwide are age 65 or older and projects that number will be 17 percent by 2050, which could present costly healthcare challenges.

The report, “An Aging World: 2015,” which was commissioned by the NIH’s National Institute on Aging (NIA), examines the demographic, health and socioeconomic trends accompanying the growth of the aging population.

Among the key findings:

• The U.S.’s 65-and-over population is expected to increase from 48 million to 88 million by 2050.
• Global life expectancy at birth is estimated to grow from 68.6 years in 2015 to 76.2 years in 2050.
• The global number of people age 80 and older is projected to surge from 126.5 million in 2015 to 446.6 million in 2050.

“The increase in our aging population presents many opportunities and several public health challenges that we need to prepare for,” NIA Director Richard Hodes says in the article. “NIA has partnered with the U.S. Census Bureau to provide the best possible data so that we can better understand the course and implications of population aging.”

AACN Resources to Care for Older Adults

• “Optimizing Care for Acutely Ill Older Adults” – online course
• “Older Adults: Myths, Truths and Caring” – webinar
• “Medications, Delirium and Older Adults” – article in American Journal of Critical Care

Common Medications Associated With Cognitive Decline

A small study of older patients suggests a link between taking anticholinergic (AC) medications and increased risk of cognitive impairment and brain atrophy.

“Association Between Anticholinergic Medication Use and Cognition, Brain Metabolism, and Brain Atrophy in Cognitively Normal Older Adults,” in JAMA Neurology, describes testing participants with a mean age of 73.3 in a range of assessments of brain structure and function. Users of AC drugs, 52 of the 402 study participants, scored significantly lower in all five rated areas covering memory, executive function and glucose metabolism in the brain as well as less brain volume and larger ventricles.

“These findings highlight the importance of considering the cognitive adverse effects of AC medications before using them to treat older adults at risk for cognitive decline in a clinical setting, as well as in therapeutic trials,” the study adds. “Use of AC medication among older adults should likely be discouraged if alternative therapies are available.”

Because of some self-reporting, the small sample size and uncertainty that the AC drugs produce the outcomes, compared to unexplored factors, future studies might include a larger controlled population with a focus on the duration of medication usage.

Many AC medications are in common use as sleep aids and for chronic diseases, and the study sought to prove what has been long suspected about the risks. “These findings might give us clues to the biological basis for the cognitive problems associated with anticholinergic drugs,” lead author Shannon Risacher, assistant professor, Indiana University School of Medicine, Indianapolis, says in a related article on www.cnn.com, “but additional studies are needed if we are to truly understand the mechanisms involved.”

Strategies to Address Workplace Violence

U.S. workplace assaults averaged about 24,000 a year between 2011 and 2013, and nearly 75 percent occurred in healthcare settings.

Workplace violence in healthcare (verbal and physical) is an “underreported, ubiquitous and persistent problem that has been tolerated and largely ignored.”

“Workplace Violence Against Health Care Workers in the United States,” a review in The New England Journal of Medicine, notes that U.S. workplace assaults averaged about 24,000 a year between 2011 and 2013, and nearly 75 percent occurred in healthcare settings. In most cases, the perpetrator was a patient or visitor who became violent while being served.

“Our industry is, statistically, the most violent non-law-enforcement industry in the United States,” the review’s author, James Phillips of Harvard Medical School, Boston, explains in a related article in Reuters Health. “And that’s using government statistics that have been shown to under-report the actual violence that takes place by up to 70 percent.”

Since assault rates correlate with patient-contact time, nurses and nurses’ aides are affected the most, Phillips writes. In one large study, 46 percent of nurses reported some type of workplace violence during their five most recent shifts, and one-third were physically assaulted.

“Emergency department nurses reported the highest rates, with 100 percent reporting verbal assault, and 82.1 percent reporting physical assault during the previous year.”

Still, most studies attempt to quantify rather than prevent the problem. “There is a lack of high-quality research, and existing training does not appear to reduce rates of workplace violence,” Phillips adds.

Strategies to reduce workplace violence include training workers in aggression de-escalation and self-defense. In addition, healthcare organizations can strengthen infrastructure by hiring guards and installing fences, security cameras and metal detectors.

“Perhaps most important are recommendations that healthcare organizations revise their policies in order to improve staffing levels during busy periods to reduce crowding and wait times, decrease worker turnover, and provide adequate security and mental health personnel on site,” Phillips writes. “The answer probably involves a combination of these ideas.”


Overcoming Incivility in the Workplace

Incivility in the workplace — characterized by bullying, rudeness and other negative behaviors — worsens performance and takes a personal toll.

Given the fact that incivility is prevalent, how does one overcome negativity and achieve his or her personal best? Christine Porath, associate professor of management at Georgetown University, Washington, offers some suggestions in “An Antidote to Incivility” in Harvard Business Review.

The most effective way is to build a culture that rejects incivility, she says, adding that it is “almost impossible to be untouched by incivility during one’s career.” During the last 20 years, she says, 98 percent of employees have experienced uncivil behavior, and 99 percent have witnessed it.

Taking a holistic approach is key to overcoming incivility, Porath adds. “Just as medicine is shifting from a focus on fighting illness to one on promoting wellness, research in my field — organizational behavior — has begun to discover that working to improve your well-being in the office, rather than trying to change the offender or the corrosive working relationship, is the most effective remedy for incivility.”

It is important to thrive cognitively, she notes. One way to promote cognitive growth is to work closely with a mentor. “Mentors have a knack for helping their protégés thrive by challenging them and ensuring that they don’t stagnate or get caught in an unproductive churn.”

Porath also explains how to confront an offender. “Proceed with the goal of mutual gain. During the discussion, focus on the issue and how the specific behavior harms performance.”

How is poor behavior handled at your facility? Tell us at aacnbold-voices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.

AACN Resources to Confront Incivility

- “AACN Standards for Establishing and Sustaining Healthy Work Environments,” 2nd edition
- “Critical Impact: How Work Environments Affect Nurses, Patients” – webinar
- “Bullying in the Workplace: It Harms More Than the Bullied” – webinar
- Moral Distress – webpage
To Choose Love in the ICU

This month’s Nurse Voices — “To Choose Love in the ICU” — was written by Kayla Eddins. She writes: I am a registered nurse at the University of Kansas Hospital in Kansas City, Kansas, on the Medical/Transplant ICU. I graduated with my BSN in 2015 and have now been a nurse for a little over a year. My favorite thing about being a nurse is the deep, meaningful connections I make with my patients and their family members during some of the darkest, scariest moments of their lives. When I’m not working I’m spending time at my parents’ farm, having game nights with friends and watching my two small kittens grow up. You’ll find me snowboarding in beautiful Colorado all winter and spending time outdoors all year long.

I cared for Nick [not his real name] and his family a week into his stay on the transplant ICU. I approached this assignment with a certain amount of dread. The patient was young, his mother was highly involved in his care, and the pair had quickly earned a reputation among the nursing staff for being needy, anxious and exhausting. To deny that certain families earn this type of reputation is to lie about the real experience of the nursing profession.

Learning to interact and care for difficult families is often one of the most challenging and emotionally exhausting aspects of being a nurse. However, I have found in my first year of nursing that meeting patients and families wherever they are emotionally can also be very rewarding. To end a shift with the sense of having made an impact emotionally on my patient or to recognize that a bond developed between my patient’s family and me is one of the most powerful experiences I have ever had. It is the one facet of nursing that bolsters me and drives me forward as a new nurse, even on particularly tough days when I feel defeated and exhausted.

And so, armed with a year’s worth of experience learning to connect and engage with challenging patients and families, I began my day with Nick and his mother. I used the communication skills I had honed over the past year to connect with challenging patients and families, and — to my gratification — I quickly bonded with both the patient and his mother. I identified the aspects that made them difficult to work with and addressed them for what they were — deep-seated, emotional and intellectual needs that had to be met.

I quickly discovered that my young patient had spent his entire life coping with debilitating chronic illnesses, which left him with both a pervasive sense of anxiety and a strong need to feel safe and well-cared for in the presence of his caregivers, particularly the ever-rotating nursing staff. It was my job to validate this need and care for him with the genuine concern and attention that he needed in order to trust me.

The other side of this coin was his mother, who had spent the last 21 years of her life caring for a chronically ill son and coping with the very real, raw fear that inevitably accompanies the process of watching your son die. Every day, she had to entrust the care of her son to strangers. To feel secure, she needed to be armed with knowledge about every aspect of her son’s evolving condition and the care he was receiving.

I was the stranger of the day, the nurse in charge of caring for her critically ill son, and it was my job to show her that I was capable of caring for him by answering her questions, following up on requests for information and addressing each concern as it arose.

I spent two days caring for Nick and his mother, and by the afternoon of the second day I was spent. I have learned that the process of conscientiously addressing the deeply rooted emotional needs of your patients and their families for 12 hours at a time is exhausting and requires more patience and empathy than I could have comprehended before becoming a nurse.

On the afternoon of that second day, Nick returned from surgery in excruciating pain, despite a hydromorphone PCA with hefty settings and an epidural placed before surgery. Nick couldn’t understand why he hurt so much — the last time he had an epidural, his pain had been all but resolved.

I spent an hour helping him address his pain in every conceivable way, including administering an extra PCA bolus, speaking with the surgery nurse practitioner and anesthesia pain team about the intractable pain, and helping him position many times. The surgeon warned me that the patient would hurt more after this surgery than after previous ones. I explained this to Nick. His abdomen was full of scar tissue after a lifetime of surgeries, and closing the surgical site made his abdomen so tight that the surgical team ordered Nick to remain in a flexed position until further notice.

Nothing helped; nothing even touched the pain. Nick gave me an anguished look and whispered, “I’m scared. I hurt so badly, and I don’t know why. Is it normal to feel so scared?”

Never in my life have I wished so much for a magic wand that could wave away the pain. Then, between moans, he said, “You never sang to me.”

I froze, staring at him. Throughout the last two days I had occasionally asked him if he wanted me to turn on the TV
or Pandora. He would inevitably say no, and then I would jokingly offer to sing for him, thrusting my arm into the air and letting out an operatic “la la la la!” Without fail, it always made him and his mother giggle appreciatively. But now he was asking me to really sing for him and not just in jest. I had never sung for anyone in my life — other than the children I babysat for. I told him this, and he just smiled weakly through the pain and asked, “Please?”

And so, with a bright red flush creeping up my cheeks, I shut the door and curtain to his room to make sure no one would hear me and returned to his bedside. He looked into my eyes expectantly. I swallowed my pride, took a deep breath and with my cheeks still burning I sang “Edelweiss,” the lullaby from “The Sound of Music.” And in that moment, he was completely focused on my face and my voice. For that moment, the pain was forgotten.

Of course, after the song was over the pain came roaring back. Eventually, a member of the anesthesia pain team arrived and put into place a bupivacaine PCEA with higher settings, and my patient finally experienced significant pain relief.

Nick never mentioned to anyone that I had sung for him, at least not while I was within earshot, and for that I was immensely grateful. It was an intimate moment between a nurse and her patient, and it was powerful. It forced me as far out of my comfort zone as I had ever been in my nursing career. It would have been easy to ignore his request, telling him I was too busy or promising to do it later, and both of us would have known that later would never come. I had to choose to love my patient with all the compassion, empathy and patience I possess, and I had to choose that over pride.

Choosing love in the ICU is often hard, particularly in the context of caring for medically complex patients and a laundry list of tasks that often distract from the emotional component of nursing.
Key Concepts of the Go-Live Process

It’s important for change leaders to be responsive to staff needs when overcoming obstacles.

Successful implementation of a major management change requires deep planning and constant nurturing, notes an article in Nursing Management. In “It’s All About That Base, Part 2: Going Live,” Katherine Geyer, a former clinical nurse at Duke Raleigh Hospital in Raleigh, North Carolina, who is pursuing a Master of Science in Nursing, and Marian Altman, AACN clinical practice specialist, outline how to roll out lasting changes. Part 1 shares the journey of an AACN Clinical Scene Investigator Academy team “through change management while developing an early progressive mobility initiative,” and part 2 discusses the initiative’s go-live process.

The article recommends reinforcing project objectives with visual cues and learning aids for reference, such as flip cards placed at workstations or hanging from employee badges. It stresses the importance of change leaders being responsive to staff needs when overcoming obstacles. This support can include feedback via end-of-project surveys, audits to monitor progress and resources — such as extended education — to ensure team members are prepared to handle their work, physically and mentally.

To keep up momentum and validate the efforts of team members, the article recommends establishing short-term goals. Duke Raleigh implemented a program that tracked “mobility mileage” to reward the most productive employees. The hospital also recognized staff efforts with appreciative emails and stories in the hospital blog. Patients were incentivized to take ownership of their own health and well-being with token rewards that encouraged them to “walk toward a healthier life.”

The article closes with a summary of the main points and the importance of having team member buy-in before starting a new protocol. “A leader with successful change management skills can motivate people to change in a meaningful way,” so that practice aligns with the evidence and strengthens the collaborative team.


Program Reduces Hospital-Acquired Pressure Ulcers

Based on the team’s efforts, the rate was 69 percent lower in 2013 than in 2011, despite a 22 percent increase in the number of patients. A comprehensive, proactive, collaborative prevention program based on staff education and adherence to patient care protocols can reduce hospital-acquired pressure ulcers (HAPUs) in the ICU.

“Use of a Comprehensive Program to Reduce the Incidence of Hospital-Acquired Pressure Ulcers in an Intensive Care Unit,” in American Journal of Critical Care (AJCC), reports that a team of nurses at Eskenazi Health Center, Indianapolis, more than halved the rate of HAPUs in an adult ICU and reduced related costs about $700,000 a year. The nurses were part of AACN’s Clinical Scene Investigator Academy, a nursing leadership and innovation training program.

The team introduced products and interventions for the ICU and advised other clinicians that HAPUs, which are largely preventable, are often a costly effect of care. Based on the team’s efforts, the rate was 69 percent lower in 2013 than in 2011, despite a 22 percent increase in the number of patients, for a potential savings of about $1 million. Medicare does not reimburse hospitals for stage III and IV HAPUs.

Initiatives include using revised skin care protocols, fluidized repositioners and face-to-face teaching. The team also initiated weekly skin audits to evaluate compliance and give feedback to the nurses, notes a related article in FierceHealthcare.

Key challenges include staff compliance and achieving consistency in using the Braden algorithm and silicone adhesive dressings. “In our particular situation, limitations to hiring additional nurses during the first 6 months of 2013 resulted in reliance upon a larger-than-normal number of per diem staff, which increased responsibilities for regular staff. Thus, it is possible that, without these limitations, even better results could have been achieved,” notes the article in AJCC.

The team’s convincing results led to approval of a hospital-wide rollout of the prevention program and a commitment to keep preventing device-related HAPUs.

High-Flow Oxygen After Extubation Reduces Reintubation Rates

Patients considered low risk for reintubation who receive high-flow oxygen therapy following extubation have a reduced risk of reintubation within 72 hours. “Effect of Postextubation High-Flow Nasal Cannula vs Conventional Oxygen Therapy on Reintubation in Low-Risk Patients: A Randomized Clinical Trial,” in JAMA: The Journal of the American Medical Association, states that 4.9 percent of patients at low risk for reintubation who received high-flow oxygen following extubation were reintubated within 72 hours, compared to 12.1 percent of the patients who received conventional oxygen therapy.

High-flow oxygen was “initially set at 10 L/min, titrated upward in 5-L/min steps until the patients experienced discomfort” and continued for 24 hours. Conventional oxygen therapy was provided via nasal cannula or nonbreather face mask. Both groups were assessed for FiO2 targeted to 92 percent or greater.

The trial included 527 patients who had been intubated for at least 12 hours. The secondary outcome of post-extubation respiratory failure noted that 22 patients (8.3 percent) in the high-volume oxygen group experienced post-extubation respiratory failure compared to 38 patients (14.4 percent) in the regular oxygen group.

The study also finds no significant difference between time to reintubation between the two groups. No differences in the secondary outcomes of shortened ICU and hospital stays were noted, probably due to the low percentage of reintubated patients in the entire group. “The high rate of non-respiratory-related reintubation and the high proportion of neurocritical patients also might account for this lack of difference in these outcomes.”

The trial was small, the patients were already at low risk for reintubation, physicians could not be blinded and FiO2 was not a reliable measurement for the control group. Despite these limitations, the study concludes that low-risk extubated patients given high-flow nasal cannula oxygen were less likely to be reintubated.


Ventricular Assist Device Helps Patients With AMI

Durable VAD implantation should be considered early for patients with MI and low output states who do not respond to medical therapy.

Patients with acute myocardial infarction (AMI) who also had acute heart failure or cardiogenic shock have a greater chance of survival after implantation of a durable ventricular assist device (VAD). “Ventricular Assist Device in Acute Myocardial Infarction,” in JACC: Journal of the American College of Cardiology, notes that patients with AMI and a VAD had similar outcomes to non-AMI patients with a VAD. One month following implantation of the device, nearly 92 percent of patients with AMI were alive and continued with VAD support. AMI patients also had lower rates of rehospitalization, right heart failure and cardiac arrhythmias. Death was reported for 7.2 percent. Historically, patients with complicated AMI who are treated with conventional therapy have high mortality.

The cohort study included 502 patients in the INTERMACS registry who had AMI upon admission (or who developed major MI during hospitalization) and had a VAD implanted. The median age was 58.3 years, and 77.1 percent were men. Patients with AMI and a VAD were compared to 9,727 non-AMI patients with a VAD.

“Durable VAD implantation is an effective management strategy and should be considered early for patients with MI and low output states who do not respond to medical therapy,” adds a related article in Cardiology Advisor, which notes that additional studies will be needed to fully establish definitive evidence for their use in the setting of complicated AMI.

**3-D Heart Modeling Predicts Sudden Cardiac Death Risk**

Three-dimensional computer heart modeling is appreciably superior to current clinical metrics in predicting arrhythmia risk associated with myocardial infarction (MI).

“Arrhythmia Risk Stratification of Patients After Myocardial Infarction Using Personalized Heart Models,” in *Nature Communications*, states that the virtual-heart arrhythmia risk predictor (VARP) could radically change sudden cardiac death (SCD) risk assessment.

Clinical practice currently relies on the one-size-fits-all left ventricular ejection fraction metric to determine SCD risk, the study explains, adding that the method is often unreliable and can result in unnecessary use of implantable cardioverter defibrillators (ICDs).

The VARP method, however, uses magnetic resonance imaging data to create 3-D computer images of the heart, incorporating the patient’s ventricular geometry and MI structural remodeling as well as electrical functions. “Thus, the interplay between abnormal myocardial structure and electrical instability in the heart that predisposes to SCD can be directly assessed,” the study notes.

By significantly outperforming other clinical metrics in predicting arrhythmic events, VARP could eliminate many unnecessary ICD implantations and associated complications. “Should the predictive capability of the approach be demonstrated in larger studies, VARP has the potential to radically change the process of SCD risk assessment and patient selection for prophylactic ICD implantation,” the study adds.

“By accurately predicting which patients are at risk of sudden cardiac death, the VARP approach will provide the doctors with a tool to identify those patients who truly need the costly implantable device, and those for whom the device would not provide any life-saving benefits,” Natalia Trayanova, professor of biomedical engineering at Johns Hopkins University, Baltimore, explains in a news release.

The small study, involving 41 patients, is reportedly the first to use a significant number of patient-derived computational heart models to address a clinical need. “Computer modelling is poised to transform areas of medicine and serve as a vehicle to advance personalized approaches to human health.”


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**Silent Myocardial Infarctions May Go Unnoticed**

Nearly half of all MIs may be silent — without the typical symptoms of chest pain, shortness of breath and diaphoresis.

Silent myocardial infarction (SMI), which represents more than 45 percent of incident MI, has a poor prognosis.

“Race and Sex Differences in the Incidence and Prognostic Significance of Silent Myocardial Infarction in the Atherosclerosis Risk in Communities (ARIC) Study,” in *Circulation*, finds that nearly half of all MIs may be silent — without the typical symptoms of chest pain, shortness of breath and diaphoresis — which triples the odds of dying from heart coronary disease.

Among nearly 9,500 Americans included in the study, 45 percent of all MIs were silent.

“Silent heart attacks are almost as common as heart attacks with symptoms and just as bad,” senior author Elsayed Soliman, Wake Forest School of Medicine, Winston-Salem, North Carolina, says in a related article in *U.S. News & World Report*.

Because symptoms of SMI are mild, they often go unnoticed, Soliman adds. Most are discovered accidentally, with damage indicated on an electrocardiogram (ECG) given during a regular exam or before surgery.

Patients who experience chest pain and other risk factors — high blood pressure, obesity or diabetes — should have an ECG “not only to see if they have had a heart attack, but also for prevention of outcomes that can happen later,” he advises.

Although not involved in the study, Suzanne Steinbaum, with Lenox Hill Hospital in New York, adds, “When heart attacks are silent, people are less likely to get treatment. And that’s been a problem with women. Symptoms are sometimes more subtle than the crushing chest pain.” Although SMI is more common among men, it is deadlier for women, the study indicates.

Based on the findings, clinicians might consider SMI in assessments of coronary heart disease risk, notes the article in *Circulation*.

Combat Cancer With Healthy Lifestyle

The study defines a healthy lifestyle as not smoking, no or moderate alcohol use, a body mass index of 18.5 to 27.5 and weekly aerobic activity.

A healthy lifestyle may substantially reduce cancer cases and deaths, indicating that primary prevention should remain a priority for cancer control, finds a study in *JAMA Oncology*.

“Preventable Incidence and Mortality of Carcinoma Associated With Lifestyle Factors Among White Adults in the United States,” in *JAMA Oncology*, set out to determine the proportion of cancer cases and deaths (except skin, brain, lymphatic, hematologic and nonfatal prostate malignancies) that could be prevented with lifestyle modifications. The study defines a healthy lifestyle as not smoking, no or moderate alcohol use, a body mass index of at least 18.5 but lower than 27.5 and weekly aerobic activity.

The prospective cohort study, involving 89,571 white women and 46,339 white men from the Nurses’ Health Study, the Health Professionals Follow-Up Study and U.S. national cancer statistics, finds that 16,531 women and 11,731 men met the healthy lifestyle (low-risk) criteria. All others were in the high-risk group. Incidence and mortality of carcinomas between the low- and high-risk groups were compared to calculate the population-attributable risk (PAR).

“Within the two cohorts, the PARs for incidence and mortality of total carcinoma were 25 percent and 48 percent in women, and 33 percent and 44 percent in men, respectively,” the study explains. Results for individual cancers in both men and women also favored those in the low-risk group.

Other recent research has suggested that “random mutations during stem cell divisions” are the major contributors to cancer, the study adds. These findings, however, “provide strong support for the argument that a large proportion of cancers are due to environmental factors and can be prevented by lifestyle modification,” study authors Mingyang Song of Massachusetts General Hospital and Edward Giovannucci of Harvard Medical School contend in a related article in *Live Science*.


FDA Approves New Drug for Urothelial Carcinoma

Tecentriq (atezolizumab) is the first in its class of drugs, called PD-1/PD-L1 inhibitors, to be approved for this cancer.

The Food and Drug Administration (FDA) has approved a new drug to treat patients with urothelial carcinoma, the most common type of bladder cancer, notes “FDA Approves Bladder Cancer Drug,” in *U.S. News & World Report*.

Tecentriq (atezolizumab) is the first in its class of drugs, called PD-1/PD-L1 inhibitors, to be approved for this particular cancer. “Products that block PD-1/PD-L1 interactions are part of an evolving story about the relationship between the body’s immune system and its interaction with cancer cells,” adds Richard Pazdur, director of the office of hematology and oncology products at the FDA’s Center for Drug Evaluation and Research.

Treatment is for “patients with locally advanced or metastatic urothelial carcinoma whose disease has worsened during or following platinum-containing chemotherapy, or within 12 months of receiving platinum-containing chemotherapy, either before or after surgery,” the article adds.

Approval follows a 310-patient clinical trial, noting that nearly 15 percent of patients had at least partial shrinkage of tumors for about two to 14 months at the time the data was analyzed. Tumor response was better in patients who were positive for PD-L1 protein expression (26 percent) compared to those negative for PD-L1 expression (9.5 percent).
Depression in Caregivers Can Be Long-Term

Most caregivers of patients in the ICU for at least seven days have high rates of depression up to a year after ICU discharge.

“One-Year Outcomes in Caregivers of Critically Ill Patients,” in The New England Journal of Medicine, notes that researchers at the University of Toronto assessed 280 caregivers for patients with minimum seven-day ICU stays on mechanical ventilation at intervals of seven days, three months, six months and 12 months after ICU discharge. The caregivers’ mean age was 53, and 70 percent were women.

High levels of depression symptoms were present for 67 percent of the caregivers initially. After one year, 43 percent still reported high levels, and 16 percent experienced no decline in symptoms.

The study notes that no patient characteristics consistently correlated with caregiver depression. The younger caregivers, whose other activities were the most adversely affected, and those earning less than $39,000 a year tended to have increased depression.

Without a definitive predictability about which caregivers are most likely to become depressed, the study suggests that caregiver health deserves long-term attention, because the end of the hospital stay does not mark a conclusion. “All phases of illness can be stressful as they can be very different,” lead study author Jill Cameron, University of Toronto, adds in a related article in HealthDay.

Eugene Grudnikoff, a psychiatrist at South Oaks Hospital in Amityville, New York, adds that grief also might be affecting caregivers. He says that being aware of their own physical and mental health needs for self-care and accepting emotional and physical help from others can be essential.


Neurologic Disorders Make ICU Care More Likely for Children With CAP

Children with neurologic disorders are more likely than children without these disorders to be admitted to the ICU when hospitalized with community-acquired pneumonia (CAP).

“Community-Acquired Pneumonia Hospitalization Among Children With Neurologic Disorders” in The Journal of Pediatrics, notes that children with neurologic disorders face an increased risk of complications and death from influenza and respiratory syncytial virus infection.

The study assessed 2,358 children younger than 18 years who were hospitalized with CAP from 2010 to 2012, including 280 (11.9 percent) with a neurologic disorder such as cerebral palsy, developmental delay, Down syndrome, epilepsy, non-Down-syndrome chromosomal abnormalities or spinal-cord abnormalities.

Results show that children with neurologic disorders were older (median age 4.2 years) and more likely to be admitted to the ICU (36.4 percent) than those with non-neurologic underlying conditions (median age 2.7 years; 19.8 percent) and those without underlying conditions (median age 1.8 years; 18.4 percent). In addition, children with neurologic disorders were more likely to stay in the hospital longer and have coexisting congenital heart disease (30.4 percent) and chronic lung disease (12.5 percent).

Considering the findings, lead study author Alexander J. Millman, with the Centers for Disease Control and Prevention’s Epidemic Intelligence Service, notes that it’s critical for these children to receive recommended immunizations. “If children with neurologic disorders are hospitalized with CAP, they may require extra attention, and it is important that they receive appropriate respiratory care,” he adds.

‘I Am a Critical Care Nurse’

Bryce Klassen felt called to become a nurse. • “The first time I stepped foot in a hospital was when, a month early, my son was miraculously delivered. My wife suffered a near-fatal amniotic fluid embolism, and I became a parent and nearly a widower in the same moment,” says the staff nurse in the ICU at Scripps Memorial Hospital Encinitas in San Diego. • Both his son and wife survived. But realizing that the hospital had become a second home to him and feeling truly in his element, Klassen went back to school to become a nurse. • “My journey to become a nurse is unique. Not too many contractors decide to switch careers at nearly 35 years old.” • Read more about his journey when you open August’s Critical Care Nurse from the back.

Oct. 13 Deadline to Apply for AACN Research Grants

Grants include three $50,000 Impact Research Grants and one $10,000 grant.

AACN research grants fund our community’s members who seek evidence that supports nurses at the bedside to ensure safe and excellent outcomes for high acuity and critical care patients and their families. The application period opens Sept. 1 and closes Oct. 13 at 5 p.m. PT.

Research projects are expected to be completed within two years. Initiatives may include technology to achieve optimal patient assessment, management and/or outcomes; healing and humane environments; processes and systems for the optimal contribution of high acuity and critical care nurses; symptom management; and managing outcomes and preventing complications.

Three $50,000 Impact Research Grants are available to fund priority projects that address gaps in clinical research at the organization or system level and translate the findings for bedside clinicians. One AACN-Sigma Theta Tau Critical Care Grant, up to $10,000, will be awarded.

Principal investigators must be current AACN members and have at least a master’s degree. For detailed information, including application criteria and supporting documents, visit www.aacn.org/grants.

Letters

HUDDLES

Re: Page 17 in June 2016 AACN Bold Voices

We have huddles at 0830 every day where we find out how many surgeries are coming in, who is getting transferred, who has a procedure, traveling to X-ray, which patient has a new device, etc. This also tells us who our buddy is.

Carol Banzon
Dallas

AACN Bold Voices invites your letters for possible print and/or online publication. Please be concise. Letters may be edited before publication. Include your name, credentials, city, state and email address (for verification). Write to aacnboldvoices@aacn.org.
Scans May Help Reduce Risky Operations

Benefits of imaging over surgery include saving patients from a week of recovery in the hospital and being more cost-effective.

Eighty percent of patients with cancer who were treated with chemoradiotherapy could have been spared follow-up surgery if they were scanned instead.

Physicians will typically operate on patients who have been treated for head and neck tumors to visually check if any active cancerous cells remain. But “PET-CT Surveillance Versus Neck Dissection in Advanced Head and Neck Cancer,” a small trial in The New England Journal of Medicine, finds that positron-emission tomography-computed tomography (PET-CT) scans offer similar two-year survival rates (84.9 percent vs. 81.5 percent) for patients who undergo the debilitating surgical procedure.

Other benefits of imaging over surgery include saving patients from a week of recovery time in the hospital, no risk of surgical complications and being more cost-effective overall.

The prospective, randomized controlled trial was conducted at the universities of Birmingham and Warwick in England and included 564 patients from throughout the U.K. (282 patients in the planned surgery group and 282 in the surveillance group). The follow-up was performed 12 weeks after the end of chemoradiotherapy; surgery was “performed only if PET-CT showed an incomplete or equivocal response.”

At the time of the trial, calibrating standard uptake values among various scanning systems was not possible. Since calibration is now possible, a retrospective evaluation is being conducted.


Prompt Care Reduces Risk of Serious Stroke

For patients with transient ischemic attack (TIA) or minor stroke, prompt evaluation and treatment can reduce the risk of acute stroke as much as one-half.

“One-Year Risk of Stroke After Transient Ischemic Attack or Minor Stroke,” in The New England Journal of Medicine, analyzed data of 4,789 patients from the TIAregistry.org project. When patients with TIA are treated promptly, their stroke risk is estimated to be 1.5 percent at two days, 2.1 percent at seven days, 3.7 percent at 90 days and 5.1 percent at one year.

The outcomes are at least 50 percent lower than those of previous studies, according to an accompanying editorial by Ralph Sacco and Tatjana Rundek of Miller School of Medicine, University of Miami.

While acknowledging that centers were not randomly selected — sites in 21 countries outside the U.S. participated — Sacco and Rundek write that urgent care in specialized TIA clinics or dedicated care units with stroke specialists “undoubtedly works.” The majority of patients, they note, were evaluated within 24 hours of symptom onset.

“Just as the rapid diagnosis and treatment of acute stroke has improved outcomes, the urgent evaluation of patients with a TIA or minor stroke and the use of preventive treatments can markedly reduce the risk of stroke,” they add. Sacco and Rundek believe the findings should prompt healthcare providers to make necessary changes — including implementation of specialized stroke units — to deliver the most effective care.

In a related article in Fox News Health, lead study author Pierre Amarenco of Bichat Hospital in Paris says the study, although not randomized, provides more evidence for seeking hospital treatment even if muscle weakness or slurred speech lasts a few seconds or minutes.

In Our Journals

Hot topics from this month’s AACN journal

Obese critically ill patients are more likely to experience complications and prolonged recovery. These patients may be well served in the progressive care setting, because they may require more intensive nursing care than can be delivered in a general care unit. Progressive care nurses have core competencies that enable them to safely and effectively care for obese patients. A plan of care with interdisciplinary collaboration illustrates the integrative care for obese progressive care patients. (Ecklund, CCN, August 2016) www.ccnonline.org

Methicillin-resistant Staphylococcus aureus (MRSA) is a common cause of central catheter-associated bloodstream infections. Vancomycin is often considered the definitive treatment for MRSA, but issues related to nephrotoxicity, inconsistent tissue penetration and treatment failure create concern. Alternative MRSA therapy is based on the reported minimum inhibitory concentration values, bactericidal activity, antibiotic penetration at the infection site, and comorbid conditions, including reduced renal function. A case study highlights the clinical signs of vancomycin failure and describes the indications for and appropriate use of alternative antimicrobials. (Thompson-Brazill, CCN, August 2016) www.ccnonline.org

Transitions

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

Darlene Burke, who teaches critical care theory to graduate nursing students at San Diego State University, receives the Professional Nursing Award during the Biennial Navy Nurse Corps Association Awards 2016.

Brianne Carruthers, an RN in the American Mobile Pediatric ICU, earns AMN Healthcare’s Commitment to Excellence Award for her passion, customer service and innovation.

Laura Cohen, a nurse practitioner at Rutland Heart Center, Vermont, is chosen as Rutland Regional Medical Center’s inaugural Advanced Practitioner of the Year for excellence in patient care.

Maria Cvach, director of policy management and integration for Johns Hopkins Health System, Baltimore, receives AAMI & Becton Dickinson’s Patient Safety Award.

Barbara “Bobbi” Leeper, an AACN Circle of Excellence recipient and a member since 1970, is named Texas Clinical Nurse Specialist of the Year by the Texas Clinical Nurse Specialists, Austin. She was honored during the organization’s recent conference.

Mary Roberts, a student in the doctoral program of Texas Woman’s University College of Nursing, an acute care nurse practitioner in trauma services at Parkland Hospital, Dallas, and an AACN member since 1985, receives a Virginia Chandler Dykes scholarship from the university.

Joan Vitello, AACN past president, is appointed a voting member of the board of trustees of Newton Wellesley Hospital, Newton, Massachusetts, and was previously named dean of the Graduate School of Nursing at University of Massachusetts Medical School.

John Whitcomb, associate professor, Clemson University School of Nursing and past AACN Certification Corporation board director, is recognized in Clemson’s newspaper for 20 years of continuous certification as a CCRN. “The purpose of renewal is to enhance continued competence, and I feel that knowledge can only benefit the students I teach every day,” he says in the article.

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.
Look around your unit. What innovations do you see? You may have said ECMO machines, CRRT, ventricular assist devices, ventilators, intra-aortic balloon pumps and high-tech monitors of various sorts. Such technology defines our work environments — but look again. In his book “The Innovators: How a Group of Hackers, Geniuses, and Geeks Created the Digital Revolution,” Walter Isaacson says the greatest innovation that propelled us into the digital age is — the team.

Now, teams may not seem like much of an innovation. There are no fancy buttons to push, no life-saving “wow” factor, no need for hours of learning how to use it to save the life of your patient. But because teams play such a vital role in our work lives, perhaps our orientation programs should include extensive training on team-based care just as they do for high-tech equipment.

Summer makes me think about teams, especially baseball teams. I think about the many hours they must practice in order to win. In the world of healthcare, it also makes me think about all the new faces — new graduates, new students, new medical residents, new staff members — that join our unit’s teams. It matters how we welcome and assimilate these new team members and how we show them what we value most.

I agree with author and surgeon Atul Gawande, who states that effective teamwork is a practical response to the recognition that each of us is imperfect. What if we led our teams in ways that show we embrace that imperfection and build on the skills each new team member brings to our workplace? This includes recognizing and blending the strengths of the different generations — baby boomers and millennials. By this, I mean pairing millennial nurses — with their hallmark aptitude for technology — with baby boomers, who have in-depth knowledge and skills after years of caring for the critically ill. Embrace their differences, and capitalize on the millennials’ preference to work in teams as the best way to solve problems. As for team skills with our interdisciplinary partners, challenge your imperfect side by developing or participating in a team skill-building simulation for medical students or new residents.

Maintaining high-functioning teams certainly takes work. Burnout syndrome is on the rise, and critical care interdisciplinary team members have one of the highest rates — more than 50 percent. The Critical Care Societies Collaborative recently issued a call to action to address this issue. They suggested using “AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence” and team-based interventions such as team debriefings, structured communication tools, and interpersonal and team building training to prevent and treat burnout syndrome in the ICU.

Evidence suggests that the health of nurses’ practice environments has deteriorated, that nurses do not feel included as decision makers, and that true collaboration on units has declined. Yet true collaboration is essential to achieve positive team outcomes.

Multiple studies show that healthy work environments are positively associated with higher retention, better patient satisfaction and fewer hospital-acquired conditions. Clearly, improvement in teamwork and the health of the work environment is needed. We must turn the tide of skilled team members — nurses, physicians, pharmacists, therapists — leaving our acute and critical care units. It matters if we are to achieve good patient and family outcomes, and if we are to thrive along the way.

Teams might be our greatest innovation, but it will take our continued ingenuity to preserve and enhance this vital resource in these turbulent times. While we all have moments of doubt, we also know we can do this … we have always done this. Teams created our specialty. And teams can sustain and advance it now.

Write to itmatters@aacn.org and let me know what you are doing to “team up.”

If you want to walk quick, walk alone.
If you want to walk far, walk together.
— African proverb

Clareen Wiencek