My optometrist wouldn’t know a bedside manner if he had just put his book and reading glasses on it. He looks at one of my test results, does a double take, and says, “Oh. Okay! You have myasthenia gravis, an autoimmune disease. This is serious. People die.” He goes on to explain how nerve cells release the molecule acetylcholine which opens a protein called an acetylcholine receptor (another sodium channel) in a nearby muscle cell which then starts a biochemical process that signals the muscle to contract. In myasthenia gravis, the body’s immune system has mistakenly produced antibodies that interfere with this process — specifically with the acetylcholine receptor. Typically, the disease affects muscles that control the eye and eyelid, face, and throat. My symptom is double vision. But I might also start having trouble swallowing or eating or breathing.

Later I learn that myasthenia gravis, “once a uniformly disabling and even fatal disorder,” can now be managed effectively with drugs. Likely I have ocular myasthenia gravis, confined to the muscles in my eyes, and maybe — in any case — the symptoms will continue to be mild or even disappear. I push this to the bottom of things I worry about in the middle of the night, and since that kind of night worry is tediously repetitive, I never get beyond the top two items.

I do occasionally find myself in conversation with protein receptors in my left eyelid. In response to acetylcholine, these bulbous shapes allow positively charged sodium ions to enter cells, triggering the internal release of calcium ions which in turn creates an electric current which results in movement. I have become the acetylcholine whisperer. Go, go, go, I say to the sodium ions. Sweetheart, I encourage that receptor. You’re doing great. Pay no attention to those antibodies.

—Sharman Apt Russell


What Does — and Doesn’t — Matter?

Nurses have a long history of saving lives and doing what matters for our patients and families. But, as I reflect, I realize that our history also includes doing what doesn’t matter. It is just in that moment we thought a particular intervention, drug or workflow process did matter that a team member asked: Does this work? Does this make a difference?

Read more in my note on page 22.

Clareen Wiencek
AACN President

Question everything!

—Albert Einstein
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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Beth Henneman Named 2017 Distinguished Research Lecturer

Her research has enhanced patient safety and facilitated patient- and family-centered care for the acutely and critically ill.

Elizabeth “Beth” Henneman, whose research centers on testing interventions that enhance patient safety and facilitate patient- and family-centered care for the acutely and critically ill, is named the 2017 Distinguished Research Lecturer.

The award recognizes nurses whose research significantly influences high acuity and critical care, and is one of critical care nursing’s most prestigious honors. Established in 1982, it is funded by a grant from Philips Healthcare, Andover, Massachusetts.

Henneman, an associate professor at the University of Massachusetts College of Nursing in Amherst, has been an educator and researcher since 1999. With a nursing career spanning more than 35 years, she is widely known for her research on how nurses and physicians recover (identify, interrupt and correct) medical errors at the point of care.

“Dr. Henneman is an inspiration and mentor for countless advanced practice nurses, staff nurses and students within critical care,” says Anna Gawlinski, adjunct professor at UCLA School of Nursing and former director of research and evidence-based practice at Ronald Reagan UCLA Medical Center. “Her leadership constantly challenges critical care nursing to move forward and grow as a profession and as a science.”

Henneman is currently using eye-tracking technology as a tool to provide objective evidence on how nurses and physicians carry out routine but sometimes error-prone processes such as administering and ordering medications. She also has used eye tracking as a debriefing strategy with student nurses practicing in a simulated setting.

In addition to other funded research studies, she has been co-principal investigator on three projects funded by the National Science Foundation to improve patient safety and medical processes.

She serves as a team leader on the Society of Critical Care Medicine’s safe medication task force; a reviewer for several journals, including Critical Care Nurse (CCN) and Quality and Safety in Healthcare; and was on the editorial board of The Joint Commission’s Journal on Quality and Patient Safety for five years. Her research has been published in numerous peer-reviewed clinical and research journals, including CCN, the American Journal of Critical Care (AJCC) and the Journal of Patient Safety.

Henneman earned an undergraduate nursing degree from Boston College and a master’s degree from the University of Colorado in Denver, in addition to her PhD from UCLA. She spent more than 12 years as a clinical nurse specialist in the medical ICU at UCLA Medical Center.

AACN previously honored Henneman with its Circle of Excellence award in 2012. Among her numerous other awards, she is a fellow of the American Academy of Nursing and a member of Sigma Theta Tau International.

As the Distinguished Research Lecturer, Henneman will discuss her career and research journey during AACN’s 2017 National Teaching Institute & Critical Care Exposition (May 22-25) in Houston.

Call for DRL Nominations

Participate in selecting the 2018 Distinguished Research Lecturer by nominating a nationally recognized nurse researcher. Honorees, who are also AACN members, represent a legacy of contributions to acute and critical care nursing research.

Established in 1982, the Distinguished Research Lectureship is one of critical care nursing’s most prestigious honors. It recognizes nurses whose program of research has significantly influenced high acuity and critical care. Find more information at www.aacn.org/drl, and submit a nomination by Dec. 1.
A Critical Care Societies Collaborative report shows that more than half of critical care health professionals may be affected by burnout, which could negatively impact quality of care.

Posttraumatic stress disorder. Social isolation. Suicidal thoughts. Many Americans probably associate this list of symptoms with war veterans. However, these symptoms are also documented consequences of burnout syndrome, a real and present danger for critical care health professionals.

A new report in *American Journal of Critical Care* shows that burnout — defined as compounded stress triggered by a discrepancy between employee expectations and the job requirements — affects more than half of critical care health professionals, including nurses.

The Critical Care Societies Collaborative (CCSC) — AACN, American College of Chest Physicians, American Thoracic Society and Society of Critical Care Medicine — published “An Official Critical Care Societies Collaborative Statement: Burnout Syndrome in Critical Care Health Care Professionals: A Call for Action,” showing that critical care nurses have one of the highest burnout rates.

According to the report, caring for critically ill patients, while very rewarding, often comes with the risk of witnessing death on a regular basis, at times accompanied by moral distress.

Despite its prevalence, burnout and its consequences are not widely recognized in healthcare. As a result, there is often a lack of resources from hospital administrative staff, minimal education in terms of self-care and a paucity of research.

According to a CCSC op-ed that accompanies the report, “If there is little support from hospital administrative staff, lack of education in terms of self-care and coping skills, and regular encounters with traumatic and ethical issues, then patient care may be compromised. Research shows that burnout in nurses is associated with not only reduced quality care, but lower patient satisfaction, increased number of medical errors, higher rates of health care-associated infections and higher 30-day mortality rates.”

In 2012, Marc Moss, co-author of the report and president-elect of American Thoracic Society, and colleagues launched a pilot program to teach resiliency to ICU nurses who experience burnout. Other research finds that mindfulness training is beneficial.

According to the report, other ways to prevent and treat burnout include:

- Team-based interventions, such as team debriefings
- Structured communication tools
- Interpersonal and team-building training

The report points out that although pilot programs throughout the country are beginning to address burnout issues, there is more work to be done. Because burnout is systemic, no one person, organization, administrator, ICU leader or policymaker can stop it.

The CCSC urges nurses to read the report and join the conversation about burnout on social media, using the hashtag #StopICUBurnout.

AACN’s Facebook Community Weighs in About Burnout Syndrome

Here’s how AACN Facebook followers answered a question posed to them about burnout. Post your own comments on AACN’s wall, or send them to aacnboldvoices@aacn.org.

AACN American Association of Critical-Care Nurses Burnout syndrome (BOS) is a huge problem for critical care nurses: Up to one-third manifest symptoms of severe BOS, and nearly 90 percent exhibit at least one of the three classic symptoms. What are you doing to reenergize and help prevent BOS?

Vanessa Nuñez I honestly feel that the shift to 24/7 visitation has INCREASED burnout! Now, not only do I have to care for two critically ill patients but I have to play waitress and maid to the family all while stating plan of care on repeat for every new person walking in the door. Nursing CANNOT be both a healthcare industry AND a service industry without sacrifice.

Carol Hannibal Nurses have GOT to get their breaks at work!! Not being able to do self-care (eat, pee, go for a short walk, unplug, put your head down on the table, pray, meditate, contemplate, etc.) is a fast track to burn out for caregivers at ANY acuity level!

Patty Doehr Forst This study is a good start. Identifying the problem(s) in a logical, and not emotional, manner. I hope that further detailed studies follow, as this will help reduce burnout, turnover & preserve our profession.

Christy Battazzo Asboe Leaving ICU. Maybe we’re coming to a time where ICU nursing cannot be a sustained lifelong career? I see more and more skilled and experienced nurses leaving the ICU now than ever before. They want us to be better educated but still want to treat us like workhorses instead of educated professionals. Until hospitals start providing respite and self care opportunity to their nurses, BOS and PTSD will remain.

Simone Aller I spent 40 years at the bedside, without burning out. I attribute this to nearly always taking my breaks. The last straw for me was, they took away our monitor techs. 24 bed ICU/CVU! I now teach and do case management. The only downside is, I don’t get my 12 hour work out! Packing on the pounds.

Lindsay Lawless Thank you for highlighting a very important topic. Feeling burned out led me to really pay attention to where happy nurses are — advice given by a mentor. I am now starting a new job in the pediatric intensive care unit soon after being in the ED/ICU for 5 years. Changing it up and hoping her advice will pay off!

Kristin Bender Kowalske This will never change until nursing changes. One patient per nurse and educational opportunities /continuing Ed and opportunities to contribute to the hospital policies, procedures, and processes NOT during patient care hours. Treat them like professionals, not interchangeable workhorses.

Sandy Hebda Ferland Personally I feel there have been many times that I have given inadequate care due to turnaround rates and the ever increasing patient ratios, and acuity. It truly is important to breathe. Day by day it varies. We are strong men and women but sometimes the caregiver needs some care too.

Pamela Sullivan Moss Unfortunately I feel that most ICU nurses are aware of this but are not given the opportunity to care for themselves appropriately. Between lack of uninterrupted breaks, mandatory flexing up and the constant turnover of experienced staff being replaced by inexperienced staff, ICU nurses are constantly trying to tread water to keep up.

Marcia Rufener After 30 years I left the bedside & took desk just to focus on MY health. No one will do that but you. You have to be in tune with your own health & know how to cope — otherwise how can you give your all for patients?

Lynda Bruce It is not just what is going on in the hospital, on top of that I am required when I transferred within my hospital to get a BSN. Add school to the stress and that takes away whatever breathing room you have in your personal life. So for the next 2 yrs it will be hectic.
PCCN-K Certification for Progressive Care Knowledge Professionals

This new credential enables certification for many nurses whose practice influences care delivered to acutely ill adults.

Many progressive care nurses and current PCCN certificants involved in caring for acutely ill adults but not necessarily providing direct care have a new specialty certification option: PCCN-K for progressive care knowledge professionals.

This month, AACN Certification Corporation launches the PCCN-K credential for progressive care nurses who do not exclusively or primarily provide direct care but in their practice apply knowledge in a way that influences patients, nurses and/or organizations to have a positive impact on acutely ill adult patients.

The term “progressive care” — introduced more than a decade ago — describes the increased level of care and vigilance required by acutely ill patients who are not in an ICU but have complex healthcare needs with an elevated risk of instability. A growing number of nurses specializing in progressive care have advanced in their careers, evolving away from daily direct care but exerting a significant influence on care delivered to acutely ill patients.

“Adding PCCN-K to the AACN family of nursing certifications reflects evolving roles and changing times in nursing and healthcare,” says Connie Barden, AACN chief clinical officer. “Offering this credential not only enables a wider range of progressive care nurses to pursue or maintain certification, it tells the world that our professional community recognizes the instrumental role of knowledge professionals in optimizing the quality, safety and outcomes of care for acutely ill adult patients.”

Beyond promoting continued excellence in progressive care nursing and helping nurses stay up-to-date on the latest research and evidence-based practices, certification as a PCCN-K acknowledges the valuable clinical specialty knowledge and skills of these accomplished nurses.

PCCN-K certification may be obtained through completion of an initial exam or as a renewal option for PCCN certificants. As with PCCN, the new credential focuses on care of the acutely ill adult patient population.

Nurses eligible for PCCN-K certification may work in roles such as those listed below. This is not an all-inclusive list, and not all nurses working in these roles are eligible for PCCN-K.

- Clinical or Patient Educator
- Academic Faculty
- Manager/Supervisor/Clinical Director
- Nursing Administrator
- Case Manager/Transitional Care Coordinator

Learn more about PCCN-K — including eligibility, test plans and preparation resources — at www.aacn.org/pccn-k.

Initial PCCN-K Eligibility

Pursuit of PCCN-K specialty certification reflects your dedication to excellence in influencing the care of acutely ill adults and their families.

Who is it for?

RNs or APRNs who do not primarily provide direct care but in their practice apply knowledge in a way that influences patients, nurses and/or organizations to have a positive impact on acutely ill adult patients and their families.

What are the practice eligibility requirements?

- 1,040 hours of practice within the previous two years, with 260 of those hours accrued in the most recent year preceding application
- Practice hours may be a combination of non-direct care and direct patient care
Innovative Research Projects Improve Practice at the Bedside

Since 2010, AACN has awarded more than $750,000 to nurse researchers driving evidence-based care and better outcomes for high acuity and critically ill patients and their families.

AACN will award $160,000 in research funding this year, including three Impact Research Grants up to $50,000 each, to support inquiry that drives change in high acuity and critical care nursing practice.

Since 2010, AACN has awarded more than $750,000 to nurse researchers driving evidence-based care and better outcomes for high acuity and critically ill patients and their families.

The 2016 funded Impact Research Grants and recipients:

- **Postoperative Respiratory Failure.** Postoperative respiratory failure is the most common and severe postoperative pulmonary complication, and this matched case-control analysis seeks to identify the impact of nursing care on potentially modifiable risk factors. Lead researcher Jacqueline Stocking is a critical care nurse pursuing a doctoral degree at the Betty Irene Moore School of Nursing at the University of California at Davis.

- **Arrhythmia Monitoring and Alarm Fatigue.** Arrhythmia alarms alert nurses to changes in a patient’s heart rhythm, but the sheer number of alarms contributes to alarm fatigue, a known patient safety issue. Michele Pelter, assistant professor and director of the ECG Monitoring Research Lab at the University of California at San Francisco, will lead a research team to analyze a large dataset of annotated arrhythmia alarms to learn whether these arrhythmias have clinical significance or are associated with serious outcomes. Results will provide guidance to manufacturers to better define their alarms requiring action and to hospitals as they create policies and procedures to address alarm management requirements mandated by The Joint Commission.

- **Moral Distress Consultations.** Most moral distress interventions focus on distinct groups of healthcare providers or specific ethically challenging situations, but the Moral Distress Consult Service of the University of Virginia (UVA) Health System is one of the few programs that are multidisciplinary and institution-wide in scope. A team from the UVA School of Nursing and Center for Biomedical Ethics and Humanities, led by Elizabeth Epstein and Mary Faith Marshall, will formally evaluate the consult service and its effects on moral distress and the elements of a healthy work environment.

Priority projects address gaps in clinical research at the organization or system level and translation of these findings to bedside clinicians. Projects include use of technology to assess patients and manage outcomes; ways to create a healing and humane environment; and processes and systems to optimize high acuity and critical care nursing.

AACN continues to offer annually the AACN-Sigma Theta Tau Critical Care Grant, up to $10,000.

Principal investigators must have a master’s degree and be current AACN members. Sigma Theta Tau International (STTI) members are also eligible to apply for the AACN-STTI grant.

All research grant applications must be submitted online by 5 p.m. PT, Oct. 13.

For more information, including award criteria and supporting documents, visit www.aacn.org/grants, or email research@aacn.org.
CDC Issues Interim Guidelines for Zika Virus

Although Zika virus is mainly spread by the bites of infected mosquitoes, exposure to an infected person’s blood or other body fluids may result in transmission.

The Centers for Disease Control and Prevention (CDC) released interim guidelines to protect healthcare personnel who treat patients exposed to Zika virus.

“Interim Guidance for Protecting Workers From Occupational Exposure to Zika Virus” notes that the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health are monitoring the situation. There is neither a vaccine to prevent Zika virus nor a specific treatment.

Among the guidelines: Healthcare personnel must use standard precautions such as full hand-hygiene compliance and personal protective equipment (PPE) during contact with potentially hazardous materials such as blood or laboratory samples. Hand-hygiene protocols include hand rubs that are at least 60 percent alcohol or, for visibly soiled hands, soap and water, reports a related article in FierceHealthcare.

Healthcare personnel must properly dispose of sharps that may be contaminated and report needlesticks or lacerations to supervisors, the guidelines add. In situations where risk of exposure may be higher, healthcare personnel must follow standard precautions even if they only suspect the presence of Zika.

Although there are no known cases of Zika transmission through aerosol exposure, personnel must “minimize aerosolization of blood or other bodily fluids during patient care and laboratory tasks.” Additional protection, including engineering controls to contain pathogens or wearing PPE, may be necessary during aerosol-generating procedures or related tasks.

Laboratories should ensure their facilities and practices meet the appropriate biosafety level for the type of work being conducted, including biological agents — in this case, Zika virus.

Although Zika virus is mainly spread by the bites of infected mosquitoes, exposure to an infected person’s blood or other body fluids may result in transmission. These interim guidelines “may be updated as additional information becomes available.”

Lab-Grown Skin Could Benefit Burn Patients

The study predicts application of the process for patients with scars and alopecia as well as burns, and possible uses for testing drugs and cosmetics.

Skin with sweat glands and hair follicles — which holds the promise of improved regenerative therapy for burn patients — has been successfully grown in the lab.

“Bioengineering a 3D Integumentary Organ System From iPS Cells Using an In Vivo Transplantation Model,” in Science Advances, describes how a three-dimensional integumentary organ system was bioengineered using cells from mouse gums and transplanted back on mice with full functionality. The study predicts application of the process for patients with scars and alopecia as well as burns, and it might have uses for testing drugs and cosmetics.

The study contends its method improves upon current artificial skin, which cannot provide the same physiological responses because of its impermeability. The new skin connects to surrounding tissue, including nerve fibers.

“With this new technique, we have successfully grown skin that replicates the function of normal tissue,” study leader Takashi Tsuji, RIKEN Center for Developmental Biology, Japan, says in a related news release. “We are coming ever closer to the dream of being able to re-create actual organs in the lab for transplantation, and also believe that tissue grown through this method could be used as an alternative to animal testing of chemicals.”

Distracting Patients From Their Pain

Southern Hills Hospital in Las Vegas conducted a pilot program that helped distract patients from their pain.

“Nevada Hospital Tests EEG Headbands, Tablet Apps for Pain Management,” in MobiHealthNews, notes that the six-month program — in collaboration with Samsung, AT&T and AccendoWave — involved nearly 1,000 volunteer emergency department patients who were given specially equipped tablets. They wore headbands and earbuds that transmitted EEG data to the AccendoWave software on the tablet; a sensor estimated pain level and displayed a corresponding facial expression on the screen.

Patients then ranked the accuracy of the expression with a thumbs-up, thumbs-down or emojis, or they chose a different face to express how they felt. “The technology tries to sense the patient’s level of discomfort and identify content that relaxes each individual,” AccendoWave CEO Martha Lawrence adds in a company news release.

Although the tablet also offers games, movies, music and other forms of diversionary content, the program sought further results. The article in MobiHealthNews notes that a 2012 study in Current Biology finds distraction could trigger a built-in mechanism that releases a natural opioid to reduce pain.

Overall, the response to the program is positive, according to exit surveys. About 90 percent of the patients indicate they enjoyed using the technology, and 87 percent are happy with the content shown to them. More importantly, 81 percent say the system helped them feel more comfortable, and 77 percent say it accurately understood and expressed their discomfort.

“If we keep using this therapy,” Dorita Sondereker, director of emergency services at Southern Hills, adds in MobiHealthNews, “nurses could monitor the AccendoWave data and see when the patient’s pain is increasing, and we could intercept to get pain meds to them sooner.”

Nurses could monitor the data, see when the patient’s pain is increasing and get meds to them sooner.
Derek Florence had it all figured out. The self-proclaimed sports nut was sure about what he wanted to do with his life. He’d be a basketball player. But after he stopped growing, he realized there weren’t a lot of slow 5-foot-10-inch players in the NBA. So he figured he’d become one of the talking heads on SportsCenter. That’s when nursing came into his life and never left. Once he was exposed to it, he was hooked.

Why did you become a nurse?
My senior year of high school some family friends from church were raising money and planning on visiting an orphanage in Africa. It was an orphanage that existed to give abandoned children a home. I felt a really strong pull to go with them on this trip, so my spring break senior year I traveled with them to Nairobi, Kenya, to spend three weeks volunteering in this orphanage. The trip radically impacted my life and completely changed my worldview. Upon returning home, I realized that I wanted to spend my time investing in and taking care of sick and hurting people. So after talking with my parents and taking a few internships in different hospitals, I decided nursing was the route to take. I thought about medical school but realized that nurses spend their time at the bedside and in the trenches — and that’s where I wanted to be.

What is it about nursing that is so attractive to you?
It doesn’t take long to see that nursing is a challenging field that’s not always for the faint of heart. It is at times a thankless job, and it’s exhausting, but as nurses you also have the greatest opportunity to impact patients’ lives. We are at the bedside countless hours a day. We don’t just see the roller coaster our patients are on, but we ride it with them. I didn’t know at the beginning what being a nurse truly meant, but I’m thankful it’s where I’ve ended up.

What do you like about what you do?
Talking. [laughs] Getting me to talk to someone’s not the hard part. It’s getting me to stop talking to them that’s the
trick. I just want to know, like, what makes you tick, what makes you you. I know I’ve only known someone for five seconds, but tell me your hopes and dreams. You know, I wanted to change the world, and how better to do that than getting to have an impact on people’s lives? Especially when they’re in the hospital, and it can be some of their hardest and their most difficult moments.

You are a travel nurse. Talk about that experience.
Over the last year I’ve explored a new avenue in nursing in deciding to become a travel nurse. I’ve always loved traveling and have had an insatiable desire to do and see everything I can. Leaving a permanent position is tough, especially leaving the cardiac ICU and Cincinnati Children’s Hospital Medical Center, where I’d worked previously. They are an incredible group of doctors, nurses and patient care assistants there, and it was a blessing to get to work with them for a few years.

How did this all get started?
I think the trip to Kenya really placed a desire in my heart to travel overseas and help people, whether it’s building a house, filling a role as a nurse or holding babies in an orphanage. Nursing has given me the opportunity to travel all over the world: Africa, Jamaica, Ecuador, Trinidad, Haiti, Bolivia, Mongolia.

After working as a nurse for two years, I decided I wanted to take on a bigger role in Haiti and spend more than just a week or two overseas. I was working in the PICU at the University of Kentucky Children’s Hospital at the time and decided to leave and go work for Mission of Hope Haiti. Mission of Hope was and is doing amazing things in Haiti. They are focused on changing the outcome from the ground up. And being right in the middle of it all for a time was amazing and really helped to affirm in me that this is what I really always wanted to do.

You have CCRN certification. How important is that?
I’m a big fan and a big proponent of certification. If you can get it, I want it, I want to have it. I don’t think necessarily that being a CCRN makes you inherently a better nurse. But I do think that you can learn so much through studying, through the process. And it’s very rewarding to have that, I know, like having the CCRN after my name; it’s nice because I know how hard I work. I know that I take this job home with me, and I study, and I try to learn, and I want to know everything I can, and it’s rewarding to have that, so that way I can kind of reflect that to other people that I work with.

I believe it has made me a better nurse. And I’m a huge, huge proponent and want to encourage everyone to study for that and get their CCRN — whether it’s adult, peds, NICU, whatever.

And you’ve found a way to keep sports in your life. But triathlons?
I broke my foot during college. At the time, I was playing lacrosse and after breaking my foot I chose to just focus on school. I got into triathlons, looking for something to do to get back into shape and have some way to compete. I’ve always enjoyed trying to find some way to push myself, and there’s a complete satisfaction in hitting a wall of physical exhaustion and finding a way to push through. I started out competing for fun but have actually qualified for the amateur national championships every year since I started racing.

The thing I love about triathlons is that, yes, you are competing against other people and the field but more so against yourself. You’re competing against the desire to quit … to sit on the couch instead of getting out and training. You are competing against your own personal records. There’s such a satisfaction in crossing a finish line and hearing people you’ve never met cheering you on.

And now scuba diving?
Diving has become a huge passion of mine over the last year. I really enjoy shark diving and wreck diving and have dabbled a little in underwater photography. I just recently finished my master diver certification. To achieve a status of master diver you have to log so many dives and complete a certain number of certification courses. One of these courses is stress and rescue. It’s like ACLS and PALS but under the water. There are different levels of the stress and rescue certification, but it’s a really fun course. You run through different scenarios of emergency management on the surface and then replicate some of these scenarios underwater. My favorite thing we did was rescue patterns for searching for a lost diver.

Is there something you bring to the nursing profession that’s unique?
I think sometimes I can bring a unique perspective, especially as a male. A lot of times we have the perception that we’re not as caring as our female counterparts, but I don’t really find that always to be true, and I think it just brings me a unique opportunity, especially with male patients that we have, kids in their teens, just an opportunity to connect with them and just to invest in them more so than just taking their vitals and doing assessment and giving them their meds.

You know, as a nurse you’re not just a bedside nurse, you’re a counselor, you’re a confidant. Sometimes you’re the patient’s voice when they don’t have one. And so to get to connect with them and try to make the hospital the best experience you can for them is very important.

Interview by Paul Taylor, paul.taylor@aacn.org
Illness Understanding Matters

The relatively low incidence of thorough illness understanding highlights a communication gap. Patients with advanced cancer who had recent discussions with oncologists about their prognosis significantly improved their illness understanding to make better-informed decisions on end-of-life care.

“Discussions of Life Expectancy and Changes in Illness Understanding in Patients With Advanced Cancer,” in *Journal of Clinical Oncology*, finds that scores on a four-question survey of illness understanding improved among patients with both recent or recent and past discussions on life expectancy. However, of the 178 patients with a life expectancy of six months or less, 38 percent never had these discussions.

The relatively low incidence of thorough illness understanding highlights a communication gap. “Consideration of prognostic understanding as an evolving awareness of one’s changing health empowers patients, their loved ones, and their healthcare team to make informed decisions,” the study explains.

The survey evaluated illness understanding through patients’ acknowledgement of terminal illness, recognition the disease is incurable, correct evaluation of the stage of the cancer, and expression of life expectancy in months rather than years. A limitation is that “patients who do not know their cancer stages or prognoses might also inaccurately recall whether their doctors have talked with them about such topics.”

The study adds that future research should identify the most effective methods for communicating prognostic information.


Mindfulness: A Life-Changing Perspective

Nurse practitioners are in an ideal position to identify patients who may benefit from mindfulness-based interventions.

Mindfulness practices such as meditation, body recognition and yoga can reduce anxiety and depression.

“Mindfulness: An Effective Prescription for Depression and Anxiety” in *JNP: The Journal for Nurse Practitioners*, states that these practices focus on patients being “present in the moment,” and evidenced-based research has demonstrated the benefits.

“In addition, research suggests that an understanding of Buddhist philosophy, and how it complements Western psychology, can help maximize the role of mindfulness in the treatment of mental illness.” Nurse practitioners are in an “ideal position to identify patients who may benefit from mindfulness-based interventions.” Still, they must ensure patient suitability before initiating such treatments.

As an example of how mindfulness plays a role in reducing anxiety, keynote speaker Dan Harris of ABC News told attendees at the National Teaching Institute & Critical Care Exposition (NTI) in New Orleans about a sudden on-air panic attack that left him feeling vulnerable, according to an article in *NTI Voices*. He explored world religions and discovered mindful meditation as a way to quiet the “inner voice” that had nagged him for years.

“Most of us assume, consciously or subconsciously, that happiness is contingent upon external factors, like the quality of our childhood, the quality of our work life, the quality of our marriage,” Harris explains. “In fact, the science is showing us that happiness is a skill that can be generated just the way you work on your bicep at the gym. And that is a life-changing perspective.”

Opioid Overdoses Impacting ICUs, Increasing Costs

Hospitals with rising overdose and opioid-dependent admissions can increase clinician training in addiction management and devise strategies to support patients and families.

With both hospital and intensive-care admissions and mortality rates for opioid overdoses increasing dramatically, hospitals face strained resources and the challenge of developing appropriate strategies.

“ICUs Strained by Increased Volume and a Near Doubling of Opioid-Related Deaths,” a news release from the American Thoracic Society (ATS), notes that “new research from Boston’s Beth Israel Deaconess Medical Center, University of Chicago, and Vizient Inc., presented at the ATS 2016 International Conference, shows the strain America’s opioid crisis is putting on ICUs and the critical care teams who care for these patients and calls attention to efforts needed to meet the demands of this expanding population.”

The research involved data from a nationwide hospital system, where hospital mortality among patients with opioid overdose increased from 3.7 per 10,000 admissions in 2011 to 7.3 per 10,000 in 2015 — a 97 percent increase — compared to overall ICU admissions.

According to the release, “Despite the availability of treatment facilities and the widespread use of a medication called Naloxone that can reverse the effects of overdose, ICUs are seeing a rise in admissions of very sick overdose patients. For example, these patients are 30 percent more likely to need acute dialysis.”

The release indicates that opioid overdose is disproportionately higher in some states, adding that “Pennsylvania and North Carolina have nearly doubled the number of ICU discharges for opioid overdose in the past seven years.” Another study from Beth Israel, published earlier this year, finds that opioid-related hospitalizations rose 72 percent from 2002 to 2012, at a cost of $15 billion in 2012, according to a related article in Medical Daily.

“Hospitals that are seeing rising volumes of overdose and opioid-dependent admissions can help by increasing training for clinicians in addiction management, and by working to devise strategies that support patients and families in the hospital, and as they transition loved ones from the critical care environment to outpatient addiction treatment,” study co-author Michael Howell, chief quality officer at University of Chicago, adds in the article.

“Greater national funding to support community efforts that help survivors and improve resources for patients and families is essential for these efforts to move forward and succeed,” Howell adds. ☛
XStat Syringe: A Game-Changer in Wound Care

The syringe injects a wound with small, cellulose sponges that expand to stem arterial bleeding.

A sponge-filled syringe used for the first time by military surgeons to stem a wounded soldier’s bleeding may have significant implications for civilian use, according to “Wound-Plugging XStat Syringe Saves Its First Life on the Battlefield,” in gizmag.

First approved for military use in 2014, the XStat syringe, made by RevMedx, injects a wound with small, cellulose sponges that expand to stem arterial bleeding. The sponges are covered in chitosan, an antimicrobial compound that fights bacteria while also causing blood clotting.

In December 2015, the Food and Drug Administration cleared the civilian version, XStat 30, for general use. Effective for up to four hours, the XStat dressing could help first responders limit deaths from hemorrhaging before patients reach the hospital. “With the capacity to stem severe bleeding within around 20 seconds, the XStat sponge-filled syringe could be a real game-changer when it comes to medical care,” the article notes.

In the battlefield incident, a coalition-forces soldier had a gunshot wound to the left thigh, opening the femoral artery and vein. Despite several attempts during seven hours of surgery, physicians could not stem residual bleeding until using the XStat syringe, which stopped the blood flow almost immediately.

“We are pleased to see XStat play a critical role in saving a patient’s life,” Andrew Barofsky, president and CEO of RevMedx, says in the article. The company, he adds, hopes “to see significant advancement toward further adoption of XStat as a standard of care for severe hemorrhage in pre-hospital settings.”

Ship Named in Higbee’s Honor

For the second time, Navy Chief Nurse Lenah H. Sutcliffe Higbee (1874-1941) will have a U.S. Navy combat ship named for her, according to “Secretary Mabus Names Destroyer After Pioneering United States Navy Nurse,” a news release from the Department of Defense.

Expected to join the Navy fleet in 2024, the 509-foot-long Arleigh-Burke class destroyer, DDG 123, will honor Higbee, who was superintendent of the U.S. Navy Nurse Corps during World War I. The first woman to receive the Navy Cross, Higbee was also the first female member of the Navy to have a ship named in her honor, when the original USS Higbee (DD-806) was commissioned in 1945.

“Higbee’s professionalism, leadership and selfless dedication to her nurses and patients reflect the highest standards of naval service. She and her nurses provided the best treatment possible often under some of the worst conditions. Higbee will continue to inspire all who learn of her courage, honor and commitment,” naval historian Regina Akers adds in the article.

The announcement that the new ship would bear Higbee’s name occurred during a ceremony in Arlington, Virginia, honoring women who served in the U.S. Navy and Marine Corps.
Evidence-based Recommendations for Cardiac Ultrasonography

Twenty-four of the 45 statements were approved as strong recommendations, and 15 were conditional.

New evidence-based guidelines for the use of bedside cardiac ultrasound (BCU), echocardiography, in the ICU are based on the concept that ultrasound information complements a physical examination and intensivist clinical judgment.

Although there are other effective technologies to evaluate cardiac function, including pulse contour analysis and transpulmonary thermodilution, BCU is an established technique that can improve patient outcomes in critical care practice, according to “Guidelines for the Appropriate Use of Bedside General and Cardiac Ultrasonography in the Evaluation of Critically Ill Patients - Part II: Cardiac Ultrasonography,” in Critical Care Medicine.

Each recommendation is based on the Grading of Recommendations, Assessment, Development and Evaluation system, which ranks the quality of evidence and the strength of the recommendation, and indicates whether the information applies to a basic or expert practitioner.

An international panel of experts considered 45 statements. Fifteen statements were approved for conditional recommendations based on the RAND Appropriateness Method of at least a 70 percent majority. Twenty-four were approved as strong recommendations.

Hospitals Buck Tradition, Allow Patients’ Family and Friends Unrestricted Visitation in ICU

An article in The Wall Street Journal cites an AACN Practice Alert on family visitation and says research supports that ICU patients may fare better with unrestricted visitation.

A n article in The Wall Street Journal says that hospitals are bucking tradition by allowing patients’ family and friends to visit in the ICU for unlimited hours.

“ICUs Ease Restrictions on Visitors” cites an AACN Practice Alert, “Family Visitation in the Adult Intensive Care Unit,” and says research shows ICU patients may fare better with unrestricted visitation. According to the alert, “Flexible visitation decreases anxiety, confusion and agitation, reduces cardiovascular complications, decreases length of ICU stay, makes the patient feel more secure, increases patient satisfaction, and increases quality and safety.”

The article also notes that some advocacy groups — and ICU physicians and nurses — also have pushed for changes in visitation.

Patients “do better when families are at the bedside holding their hand or being there,” says Bettyann Kempin, an assistant vice president who oversees the ICU at Valley Hospital in Ridgewood, New Jersey. The hospital introduced an open-visitation policy in March 2015. “You will see a calm come over them. Their vital signs look a little better.”

In the article, Kempin adds that when the new policy was instituted, nurses feared “the ICU would be overrun with patients’ families and friends.”

Before implementing the new policy, ICU visitors were permitted between noon and 8 p.m., and family members were prohibited from spending the night at the bedside. But she says her nurses adjusted after scanning the medical literature and reviewing the experience of another New Jersey hospital with open visitation.

According to the article, the nurses in the unit realized visitors weren’t “going to have parties at the bedside with 20 people and pizza.”

The article also cites a study published in 2013 in Critical Care that surveyed more than 600 hospitals and found that nearly 90 percent of ICUs in the U.S. had restrictions on visitation, including what time visitors could be at a patient’s bedside and for how long.

The study’s lead author, Vincent Liu — an intensive-care physician and research scientist at Kaiser Permanente Northern California, who helped collect the data between 2008 and 2009 — says in the article that he hopes to update the survey but suspects that not much has changed.

“There are still large degrees of restrictions on visitation policy,” he says.

Beverley Johnson, president and chief executive of Institute for Patient- and Family-Centered Care, is quoted as saying that loved ones and friends who know a patient intimately and are involved with their care “are not visitors” and should be seen as “care partners.”

If hospitals “viewed them as allies, we would reduce harm,” she adds.


AACN Resources on Family Visitation

AACN Practice Alert: “Family Visitation in the Adult Intensive Care Unit”

AACN Practice Alert: “Family Presence During Resuscitation and Invasive Procedures”

“Satisfaction With Elimination of All Visitation Restrictions in a Mixed-Profile Intensive Care Unit,” American Journal of Critical Care, January 2016


“Family Presence: Visitation in the Adult ICU,” Critical Care Nurse, August 2012
Nurse Leaders Strengthen Service Lines

For clinical service lines, a nurse leader — rather than a nonclinical or business leader — should oversee the practice of nursing.

As more hospitals embrace service lines to satisfy the demand for demonstrable value at a fixed cost, nurse leaders are playing an increasing role in this management structure.

“Nurse Led, Nurse Driven Service Lines: How Nurse Leaders Are Navigating Change,” in Nurse Leader, recommends that for clinical service lines, a nurse leader — rather than a nonclinical or business leader — should oversee the practice of nursing.

“Nursing strategy, standards, and practice should be governed by nurses who are committed to establishing efficient, effectual, and service-driven nursing care,” according to the article, written by three nurse executives from Trinity Mother Frances Hospitals & Clinics in Tyler, Texas.

In 2014, Trinity’s integrated healthcare system redesigned service lines, deciding to use existing nurse leaders rather than hiring from outside the system. Nurse leaders partnered with their respective physician dyads to design strategic plans that included quality metrics, service data, financial forecasts, and organizational health and growth.

The model proved effective, as measured by increased physician/nurse satisfaction, growth of volume in the service lines, program expansions and new initiatives. “Nurses leading a service line need to understand the specific service line competencies such as proforma, market share data interpretation, growth patterns in service areas, and enhanced dyad relationship with physicians that move beyond the clinical aspect into the business realm,” the article notes.

Nurse leaders were required to maintain current responsibilities while taking on leadership roles, a factor that fostered additional multitasking skills, resulting in more well-rounded leaders. “The ability for nurse leaders to expand, not only their sphere of influence, but also interact with other members of the organization was a valuable part of the process.”


given all the changes in today’s healthcare environment, it’s important for nurses to expand their expertise through professional development. Yet, the question, What’s in it for me (WIFM)? must be considered. So writes Rose O. Sherman, in “The What’s in It for Me Dilemma,” on her blog, Emerging RN Leader.

A professor of nursing and director of the Nursing Leadership Institute, Florida Atlantic University, Boca Raton, Sherman has worked in the area of nursing leadership development for the last 25 years.

She poses the following questions: “Should everything be done on the clock or should professionals be expected to sometimes go above and beyond? What is the best response when a professional staff member answers a leader’s request to go a little above and beyond with the question ‘What is in it for me?’

“Taking personal time to participate in professional activities that go above and beyond the job should be presented as an investment in themselves. This investment is especially important at this time of health reform when there is an increasing focus on value at every level,” she writes.

“Over time, we have created a professional environment in which many nurses expect to be paid for everything they do. To change this dynamic, we need to do a better job of conveying how certain unpaid, professional opportunities offer powerful personal development that could be important to the future of the nurse.”

Turn on the WIFM Channel

Taking personal time for professional activities beyond your job is an investment in the future.
AACN Events Near You
Support your local AACN chapter, and benefit from networking, education and sharing evidence-based practices with other nurses.

Are you looking for local education and networking with your AACN peers, or maybe a volunteer opportunity?

Support your local AACN chapter, and benefit from networking, education and sharing evidence-based practices with other nurses by attending a meeting, an educational event or a community outreach event. Chapters are organized and led by national members who volunteer their experience and expertise to bring AACN’s mission to their communities. All AACN members are welcome.

To find a chapter in your area, visit www.aacn.org > Find a Chapter (at the top, right corner of the AACN home page). And be sure to regularly check www.aacn.org/chapters > Events Calendar (left navigation bar), as events are added throughout the year.

Journals Lauded for Excellence and Achievement in Healthcare Publishing

Two AACN journals — Critical Care Nurse (CCN) and American Journal of Critical Care (AJCC) — were honored recently by three leading industry groups.

AJCC co-editors Cindy Munro, associate dean for research and innovation at University of South Florida College of Nursing, Tampa, and Richard Savel, director of adult critical care services at Maimonides Medical Center, Brooklyn, New York, and professor of clinical medicine at Albert Einstein College of Medicine, received awards for three of their 2015 editorials.

Western Publishing Association — which bestows annual awards on individuals and companies whose work is deemed “Best in the West” in a wide variety of publishing categories — presented its Maggie Award for “Best Signed Editorial or Essay/Trade” to AJCC for its May 2015 editorial, “Measles 2015: Why Public Health Matters to Critical Care.”

The American Society of Healthcare Publication Editors, which annually recognizes excellence and achievement in healthcare publishing, presented AJCC with a silver award for the July 2015 editorial, “Moral Distress, Moral Courage.”

The January 2015 AJCC editorial on the Ebola outbreak, “Viral Outbreaks in an Age of Global Citizenship,” received an award of excellence for editorial or advocacy writing in the 28th annual Apex Awards for Publication Excellence, a competition for publishers, editors, writers and designers who create print, web and electronic materials, and social media.

In addition to the AJCC awards, the “Ask the Experts” column in each issue of CCN, AACN’s clinical practice journal, received an Apex award of excellence for best writing in departments and columns.

Print and online subscriptions to AJCC and CCN are benefits of AACN membership. Access the journals at www.aacn.org/publications.

Attend Nurse in Washington Internship With Scholarship
For the eighth consecutive year, AACN scholarships will help our members attend the Nurse in Washington Internship (NIWI).

Held annually — and sponsored by The Nursing Organizations Alliance (NOA), a collaborative that serves as a strong voice for nursing issues — NIWI teaches attendees how to advance healthcare agendas through the legislative process and influence health policy at local and national levels.

Participants also learn how to work with legislative staff and schedule meetings on Capitol Hill, understand key steps to bring about change in the legislative process, and “identify legislative, political, and economic forces driving health care policy and delivery changes today,” adds the NOA website, www.nursing-alliance.org.

NIWI is open to all RNs and nursing students who are interested in an orientation to the legislative process. It takes place March 12-14, 2017, at The Westin Crystal City, in Arlington, Virginia.

Visit the NOA website for further details on the 2017 program; registration is scheduled to open in the fall. Attendance requires registration (no application or acceptance process required) on the NOA website, which you can do after applying for an AACN scholarship.

When applying for a scholarship to attend NIWI, assess gaps in your health policy knowledge and skills, identify your learning objectives and explain how you will evaluate and apply your learning. AACN members should apply by Monday, Oct. 10.

Visit www.aacn.org/scholarships for more information, or email scholarships@aacn.org with your questions.
In Our Journals

Hot topics from this month’s AACN journal

Tele-ICUs offer an opportunity for remote specialists to support quality bedside care among geographically distant and culturally distinct groups. However, the benefits of tele-ICU care depend on effective collaboration. Researchers interviewed staff working at tele-ICU sites and affiliated hospitals to examine their experiences. They found barriers that included unrealistic expectations about operational capabilities, lack of trust, poorly designed leadership and a lack of communication policies. This research indicates that proper administration and attention to important cultural and teamwork factors are essential to making tele-ICUs effective, practical and sustainable.

(Wilkes et al., AJCC, September 2016) www.aajconline.org

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

Michele Balas, associate professor, The Ohio State University College of Nursing, receives the 2016 Norma J. Shoemaker Award for Critical Care Nursing from the Society of Critical Care Medicine.

Gladys Campbell, a leadership coach and healthcare consultant, past president of AACN and a member since 1982, presented “Nurses as Leaders: From the Individual to the Organization and Beyond” at the 27th Annual Pacific Northwest Ambulatory Care Nursing Conference.

Pamela Cipriano is reelected president of the American Nurses Association, which represents the interests of the country’s 3.6 million RNs.

Margaret Grey, professor of nursing at Yale School of Nursing, is appointed special adviser to the scientific director at the National Institute of Nursing Research to help develop the Intramural Science Center.

Tanja Gross (management/nurse executives category) and Juvel-Lou Velasco (medical-surgical nursing category), Mercy Medical Center, Baltimore, receive Baltimore magazine’s second annual Nursing Excellence Awards.

Linda Harrington, past chair of AACN Certification Corporation, presented “Cognitive Technologies: The Game Changers in Digital Health” at Harris College of Nursing & Health Sciences, Fort Worth, Texas.

Uletha Jones, assistant professor of nursing at Finger Lakes Community College, and a lieutenant commander in the Navy Reserve, is inducted into the Genesee Community College (Batavia, New York) Alumni Hall of Fame.

Nancy Redeker, professor of nursing at Yale School of Nursing, and editor of Heart & Lung, receives Eastern Nursing Research Society’s 2016 Distinguished Contributions to Nursing Research Award.

Kenneth Rempher, previously chief nursing officer at University of Iowa Hospitals and Clinics, and recipient of an AACN Circle of Excellence award, becomes executive vice president and chief nurse executive for Cone Health System, Greensboro, North Carolina.

Send new entries to aacnboldvoices@aacn.org. You may also honor or remember a colleague by making a gift to AACN at www.aacn.org/gifts.

Transitions

Annual training in basic and advanced cardiac life support does not ensure staff confidence and competence in providing these lifesaving interventions. Two progressive care units implemented a series of in situ mock codes that supplemented annual training with simulation experiences in their units. The program significantly reduced the time it took for staff to call for help, initiate compressions and provide the first defibrillation. In situ mock codes significantly improve response times and increase staff confidence levels. They are also a quick and efficient way to provide hands-on practice and help staff work as a team.

(Herbers and Heaser, AJCC, September 2016) www.aajconline.org

Identifying predictors of mortality in sepsis can assist clinicians and families in making care decisions. Researchers performed a retrospective analysis of patients with severe sepsis and hematological malignancies to determine if recent infection was a predictor of 30-day mortality. The authors developed a modified version of the SOFA, the SOFA-HM, which adds a score for recent infection. Use of the SOFA-HM in 196 patients with hematological malignancies and severe sepsis showed it was more accurate than APACHE II or SOFA in predicting 30-day mortality, but further testing is needed.

(Greenberg et al., AJCC, September 2016) www.aajconline.org

To see the table of contents for the September issue, please visit www.aajconline.org.

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.
Nurses have a long history of saving lives and doing what matters for our patients and families. But, as I reflect, I realize that our history also includes doing what doesn’t matter. It is just in that moment we thought a particular intervention, drug or workflow process did matter that a team member asked: Does this work? Does this make a difference?

As nurses and leaders, at the bedside or in the conference room, we need to ask both sides of the question: What does and doesn’t matter to our patients and families, our teams and ourselves? A recent editorial in *Critical Care Medicine* asked if there are treatments in widespread use that might be harmful. The *Journal of Hospital Medicine* has a new series based on the Choosing Wisely campaign titled “Things We Do for No Reason.” So, whether it’s simply ineffective, non-evidence-based or potentially harmful, I challenge our nursing community to ask what does and doesn’t matter at the point of care.

The more I consider this, I think being curious about routine activities or nursing and medical interventions may be part of the answer. Curiosity is at the heart of research, and research has changed — and will continue to change — our practice. Xigris (drotrecogin alfa) was used for about a decade to treat patients with severe sepsis before it was withdrawn in October 2011, because further research showed no statistical difference between Xigris and a placebo. Large tidal volumes were a mainstay of ventilatory support for patients with ARDS, until multiple studies showed that low tidal volumes were associated with lower mortality and more ventilator-free days. This research led to practice changes, and you know other examples — including tight glycemic control or the use of normal saline lavage during suctioning — that are no longer evidence-based.

Workflow processes should be questioned too. For example, double-checking insulin is a common procedure that nurses perform. In theory, independent double-checking should reduce insulin errors. Evidence to support this practice was lacking, so Mary Beth Modic and colleagues at the Cleveland Clinic analyzed over 5,000 insulin administration episodes. Double-checking led to fewer insulin-related errors overall, but it did not reduce timing errors, the most prevalent or wrong dose, or a combination of wrong time and wrong dose. Rather than recommend that bedside nurses refocus on this time-consuming process (the double-checking procedure averaged five minutes), the investigators asked what matters to patient safety. They concluded that work redesigns — ensuring all insulin products are readily available, providing detailed administration instructions, posting accurate meal delivery times and making patient assignments aimed at equitable distribution — could be more effective than the double-checking procedure.

I encourage you to ask questions to better understand what does and doesn’t matter in your own practice, and in the routines of your unit and organization. Participating hospitals in the Leadership Alliance, a program of the Institute for Healthcare Improvement, have designated a “Breaking the Rules Week.” Staff members are given the freedom to break rules if they are getting in the way of patient care.

Can you imagine? What a refreshing and empowering approach to look at what matters in giving outstanding patient care.

Let’s keep asking what does and doesn’t matter — and let me know what, in your opinion, does and doesn’t matter for great patient care at itmatters@aacn.org.