Vol. 9, No. 1 | JANUARY 2017

NTI 2017: Registration Opens  Page 5
Testing Wrist Heart Rate Monitors  Page 8
Nurse Voices: Q&A With Emily Colyer  Pages 12-13
Renal Calculi Roller Coaster Ride  Page 15
Striving to Reduce ICU Delirium  Page 17
Popular AACN Resource Books Updated  Page 20

BOLD VOICES
High Acuity & Critical Care Nurses Make Their Optimal Contribution

AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES
Enhanced navigation to save you time and effort

More of the great clinical resources you've come to expect

New dashboard (My AACN) delivers the personalization you asked for

Nurse stories that will delight and inspire you

We’ve redesigned the AACN website for you and other members of our community. Come see what we’ve done to the place. Wherever you are in your critical care nursing journey, you can count on AACN for the inspiration and information you need.

See for yourself at: www.aacn.org/newaacn
Who but you?

You care for people threatened by critical illness and injury.

You radiate hope when others would rather surrender.

You inspire confidence when everyone else doubts.

You maintain life support equipment, but it’s you who supports life.

You comfort families, helping them to bear the unbearable.

You make the impossible seem effortless.

You are the cornerstone of acute health care.

A critical care nurse.

You make the critical difference.


2017: A Transformative Year

I love the growing list of AACN’s annual themes. I proudly display the poster of the spectacular artwork for this year’s theme on the door to my office, give themed magnets and coasters to my friends, and drink from coffee mugs embossed with the artwork. I know you love AACN’s themes, too, because you have told me so during many visits to AACN chapters this past fall. Courageous Care, Focus the Flame, Step Forward, Dare To, Rise Above, Bold Voices, Make Waves — the theme not only matches the personality of the president at the time, but also the needs and issues of those times.

Read more in my note on page 22.

Clareen Wiencek
AACN President

We live in worlds that our questions create.

—David Cooperrider
The American Association of Critical-Care Nurses is the world’s largest specialty nursing organization. AACN is committed to creating a healthcare system driven by the needs of patients and families where high acuity and critical care nurses make their optimal contribution.

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AACN Certification Corporation, the credentialing arm of the American Association of Critical-Care Nurses, maintains professional practice excellence through certification and certification renewal of nurses who care for or influence the care delivered to acutely and critically ill patients and their families. AACN Certification Corporation offers CCRN, CCRN-K, CCRN-E, PCCN, PCCN-K, CCNs, ACCNS-AG, ACCNS-P, ACCNS-N, ACCNP and ACNPC-AG certification programs in acute, progressive and critical care; and CMC and CSC subspecialty certification in cardiac medicine and cardiac surgery.

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Associate Professor
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Critical Care Nurse Specialist Program
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Clinical Nurse Specialist
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NTI 2017: Registration Opens This Month – Make Your Case and Start to Plan

Begin your journey by discussing the value of attending NTI with your manager, view the educational program and ROI toolkit, and book your hotel.

AACN’s National Teaching Institute & Critical Care Exposition (NTI) is May 22-25, with preconferences May 21, in Houston. At the premier conference for high acuity and critical care nurses, earn more than 37.5 hours of continuing education (CE) contact hours via live sessions, plus additional hours of self-study during and for a limited time after the conference.

Your NTI journey can begin now. Secure funding or save for the trip, request time off and start planning, which will make your time at NTI more fulfilling and productive:

- Register beginning in mid-January if you already plan to attend, and learn more about our exciting plans for Houston 2017 at www.aacn.org/ntitx17.
- If you are still deciding, discuss the value of attending NTI with your manager to request professional development funds and to schedule time off. Access our ROI toolkit for a template request letter and planning worksheets. Focus on what you will specifically bring back to your unit or hospital in return for the opportunity to attend.
- Search the NTI educational program online, and personalize your program with a combination of sessions tied to your unit’s or hospital’s strategic initiatives and your professional development goals.
- View the list of hotels, and book your hotel early for the best selection and discounted rates, since reservations are assigned on a first-come, first-served basis.
- Houston, our host this year, is a big city with Southern charm. It’s a hub for healthcare innovation and home to the largest medical complex in the world. A renowned culinary destination, Houston also boasts a reinvented downtown and has 18 world-class museums within walking distance of each other. You can reach Houston easily via 170 direct flights from across the U.S.

CRITICAL CARE RNs AND NURSE PRACTITIONERS

Join Advanced ICU Care, the leading tele-ICU provider, and be a part of the cutting edge in critical care telemedicine. Our collaborative approach allows you to leverage your critical care expertise to assess, interact with, and care for patients in coordination with bedside teams.

**JOB OPPORTUNITIES OFFER**

- Full Time (36 hours/week) • Flexible Schedule • Competitive Pay
- Work in thriving healthcare markets: Houston, Irvine, New York, Honolulu, and St. Louis!

**QUALIFICATIONS**

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<thead>
<tr>
<th>Critical Care RN position:</th>
<th>Nurse Practitioner position:</th>
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<td>+ 2 years of Critical Care experience</td>
<td>+ Acute Care NP certification</td>
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<tr>
<td>+ Willing to obtain CCRN</td>
<td>+ ICU experience as NP strongly preferred</td>
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amber.chavez@advancedicucare.com
www.advancedicucare.com
Voices of Certification

Certified nurses share their insights and experiences.

What does being certified mean to you?

Laura Diehl, CCRN, shift coordinator, Indiana University Health-Methodist Hospital, Indianapolis
“I just became certified late last year. I decided to get certified because I’m on a unit where there are a lot of new graduates and, as one of the more experienced nurses, I wanted to be an example for them. Becoming certified has given me extra drive, and it’s made me very proud to be a nurse and have those extra letters behind my name.”

Susan Miner, CCRN, clinical educator, St. Mary’s Hospital, Richmond, Virginia
“Certification is important to me because I wanted to feel good about what I had to offer the patient. I’m proud that I’ve had it for 37 years. I love when a patient asks me, ‘What does it mean to be certified?’ I tell them I took a test that demonstrated my knowledge and talk about what I do to maintain it. It demonstrates to them that I have a high level of professionalism, keep my knowledge base current and do a good job taking care of them.”

Lynn Orser, CCRN, PCCN, critical care educator, St. Vincent’s Medical Center, Bridgeport, Connecticut
“To be certified is probably my greatest professional achievement. My first certification was CCRN, and the day the woman handed me the sheet of paper that said I had passed, I cried. For me, certification is not about the end, getting your certification, but about the journey to become and remain a certified nurse.”

Ellen Prewitt, CCRN, critical care flight nurse practitioner, Cleveland Clinic, Cleveland
Prewitt is one of AACN’s original CCRN certificants and has maintained her credential for 40 years.
“As a young nurse in an ICU with senior nurses, I felt like I didn’t know enough. I thought, ‘If I study for this and take the [certification] test, maybe I’ll have more confidence.’ And, in reality, I did. It gives you the confidence that you can go in there and take care of this patient, you’ve got the background, you’ve got the knowledge and you’ve proven it. I keep it up because I want to maintain that standard for myself — to stay on top of things and incorporate changes into my practice.”

New Year’s Certification Reminders
The start of the new year is a good time to review your certification status and ensure you’re on track for maintaining your credential.

☑️ Check your RN/APRN license renewal date(s) at www.nursys.com.

☑️ Confirm your AACN certification renewal date(s) on AACN’s website by signing in and clicking Dashboard from the drop-down menu under your name.

☑️ Verify your progress toward CERP/CE renewal requirements on AACN’s website by clicking Certification from the drop-down menu below your name after signing in.

☑️ Mark your calendar for March 19, Certified Nurses Day!
How Will You Celebrate Certified Nurses?

Honor, recognize and celebrate certified nurses March 19.

Achieving and maintaining certification in your nursing specialty is no small feat — it’s a personal accomplishment and professional milestone worthy of ongoing recognition. For certified nurses, however, March 19 is extra special. It’s one day set aside each year to publicly honor, recognize and celebrate certified nurses. Hospitals and healthcare facilities around the country take time to show their appreciation for these professionals dedicated to upholding national standards of excellence in nursing practice.

How will you and your unit celebrate Certified Nurses Day 2017?

Every year, we hear from nurses in AACN’s community about the ways their units and hospitals celebrate certified nurses. What will you do?

Start planning now

Put the wheels in motion for arranging a celebration certified nurses will appreciate. Here are some ideas and resources to help spark your creative thinking. Find even more at www.aacn.org/certnursesday.

- Host a breakfast, lunch, afternoon reception or dinner for certified nurses.
- Display signs/banners celebrating Certified Nurses Day.
- Provide gifts or giveaways with credentials on them for certified nurses.
- Give away buttons or ribbons with certification credentials.
- Send a card or email from your administrator/manager to recognize and honor certified nurses.
- Create a wall of honor, and take pictures of certified nurses in front of the wall.
- Write an article recognizing certified nurses for your hospital newsletter.
- Send short testimonials about your pride in being certified to certification@aacn.org with Cert Testimonials in the subject line for possible posting on AACN’s social media or website.

AACN Central New Jersey Chapter hosted a dinner celebration in honor of their certified members.

Baylor Scott & White All Saints Medical Center, Fort Worth, Texas, gifted certified nurses with scrub jackets.

NewYork-Presbyterian Hospital, New York, honored certified nurses with a celebratory breakfast.
Angioplasty, Stents Improve Survival After Myocardial Infarction

All-cause mortality after 180 days decreased from 10.8 percent to 7.6 percent across the 10-year period.

Consistent survival rates of patients with myocardial infarction (MI) may be attributed to increased use of more aggressive interventions, such as angioplasty, stents and bypass.

“Association of Clinical Factors and Therapeutic Strategies With Improvements in Survival Following Non-ST-Elevation Myocardial Infarction, 2003-2013,” in JAMA: The Journal of the American Medical Association, which reviewed almost 400,000 patient histories, notes that reduced clinical risk and pharmacological therapies alone do not explain improved six-month survival rates. The 3.2 percent yearly improvement in survival among non-STEMI patients in England and Wales from 2003 to 2013 was “significantly and independently associated with use of an invasive coronary strategy.”

While angioplasty, stents and bypass procedures are common with the more severe half of MIs (STEMI), in cases of non-STEMI there has been less evidence supporting such interventions, even though international guidelines recommend them. “This data suggests the intervention probably has a little better outcome from the standpoint of survival than just pure medical [drug] therapy alone,” Alfred Bove, emeritus professor of cardiology at Temple University Medical Center in Philadelphia, says in a related article in WebMD News.

The study, which included 389,057 patients, 63.1 percent male with a median age of 72.7 years, in 247 hospitals, finds that all-cause mortality after 180 days decreased from 10.8 percent to 7.6 percent across the 10-year period. Patients who died in the hospital or whose post-discharge data were unavailable were excluded from the study.

The study credits earlier diagnosis and medical therapies for part of the decrease in deaths but notes that although more than 80 percent of the patients had at least intermediate risk of death, fewer than half received aggressive interventions. “This finding is in keeping with the well-known risk-treatment paradox whereby the highest frequency of treatments were seen among patients in the lower risk category,” the study explains.


Testing the Accuracy of Wrist Heart Rate Monitors

Although chest-strap, electrode-based heart rate (HR) monitors are accurate for clinical purposes and useful for fitness, a study aimed to test the accuracy of wrist monitors.

In “Accuracy of Wrist-Worn Heart Rate Monitors,” researchers from Heart and Vascular Institute at the Cleveland Clinic compared two traditional chest-mounted HR monitors with four optically based wristband monitors. “Assessment of the monitors’ accuracy is important for individuals who use them to guide their physical activity and for physicians to whom these individuals report HR readings,” the article adds.

Fifty healthy adults — with a mean age of 37 — were in the study and exercised on a treadmill for three minutes at various speed settings to establish a steady state. Exclusions included adults with cardiovascular disease, heart rhythm medication or pacemakers.

Participants were also connected to an electrocardiogram that provided a baseline reading. For all devices, 1,773 HR values were recorded with a range of 49 to 200 beats per minute.

Compared to an electrocardiogram, wrist monitors provided 83 to 90 percent accuracy, their best reading, while at rest. However, accuracy declined as the intensity of activity increased, the study explains. In comparison, chest-mounted monitors reliably hit 99 percent accuracy.

Study limitations include testing only four HR wrist monitors, and the subjects were healthy adults exercising on a treadmill. “Body mass index, age, and sex did not influence monitor accuracy,” the study adds. “Results should be confirmed with different types of exercise and with other devices.”

Is Vaping a Gateway Drug for Adolescents?

The popularity of e-cigarettes among U.S. adolescents may pose significant health consequences.

An extremely high number of adolescents who have used e-cigarettes have also smoked, which may suggest a causal relationship.

The long-term consequences of e-cigarette use are not well understood, which is why “Potential Consequences of E-Cigarette Use: Is Youth Health Going Up in Smoke?” by CNA Corp., a nonprofit research firm in Arlington, Virginia, explores the risks and relationships of e-cigarettes. Vaping is outpacing traditional smoking with adolescents who believe that it is a less harmful alternative to smoking, and this perception “may have significant health consequences.”

In fact, the Centers for Disease Control and Prevention identifies “e-cigarettes as the most common tobacco product used by American middle and high school students.”

Studies suggest that once initiated, new users become more open to the idea of using a traditional tobacco product. “Young people who participated in vaping were 2.5 times more likely to smoke or chew tobacco, despite tobacco use among teens in general falling from 1999 to 2014,” adds a related article in CSP Daily News. Many adolescents who vape think they are using flavor-only liquids that do not have nicotine, “even though these products often contain trace amounts of the addictive chemical,” the study adds.

Vaping is also attracting many adolescents who have never smoked and who may have otherwise never used traditional tobacco products. Adolescents who never vaped have a “very low rate” of cigarette use.

The study analyzed 12 years of data from the annual National Youth Tobacco Survey and predictive analysis to predict usage outcomes. Although e-cigarettes may act as a “gateway drug,” the study adds that more research is required to establish a conclusive link.
Take Action to Prevent Patient Falls

A typical 200-bed hospital that follows this approach could expect 72 fewer injuries and to save $1 million.

To reduce patient falls and injuries, hospitals must first analyze contributing factors and then take specific actions to develop a “culture of zero falls.”

“Preventing Patient Falls: A Systematic Approach From the Joint Commission Center for Transforming Healthcare Project,” a report by the American Hospital Association’s Health Research & Educational Trust, presents case studies from five hospitals that followed Joint Commission recommendations and used the Robust Process Improvement methodology to pinpoint contributing factors and target solutions.

The five hospitals achieved a 62 percent reduction in falls with injury and recorded 35 percent fewer falls overall. A typical 200-bed hospital using this methodology could expect 72 fewer injuries and save $1 million in costs.

Key elements for success include adequately measuring and analyzing contributing factors and focusing on solutions such as consistent use of fall-risk assessment, proactive toileting and patient education. Support from leadership and key hospital groups is also imperative.

“Successful organizations developed a culture of pride and ownership about having zero falls, and preventing falls became a mission that resonated on each participating unit or throughout the entire hospital,” the report states.

A related article in FierceHealthcare summarizes best practices developed by the five hospitals featured in the report, including a “Call, Don’t Fall” campaign at Bassett Medical Center in Cooperstown, New York. The hospital placed signs to remind patients to summon help before getting out of bed, bought chair-seat alarms to alert staff when patients stood up and organized two daily fall-prevention team huddles to identify patients at risk.

Safety measures at other hospitals include conducting hourly rounding to offer bathroom assistance, using bed alarms and a video system to monitor patients from the nurses’ station.


STEADI Helps Prevent Falls

Even though falls are the leading cause of death and injury among older adults (65 and older), many seniors won’t discuss them with their healthcare provider, often because they fear losing their independence.

“Falls and Fall Injuries Among Adults Aged ≥65 Years – United States, 2014” in Morbidity and Mortality Weekly Report, states that nurses and other healthcare providers can play an important role in preventing falls by discussing appropriate interventions.

STEADI (Stopping Elderly Accidents, Deaths & Injuries), an initiative from the Centers for Disease Control and Prevention (CDC), offers tools and educational materials to aid in assessing gait and balance, reviewing medications and recommending vitamin D. “This type of approach has been estimated to be capable of reducing falls by 24 percent,” the report states.

Falls are frightening for older adults, who often think mentioning them will “start the ball rolling” toward a nursing home or home aide, Gisele Wolf-Klein, director of geriatric education at Northwell Health in Great Neck, New York, says in a related article from CBS News.

“During 2014, approximately 27,000 older adults died because of falls; 2.8 million were treated in emergency departments for fall-related injuries, and approximately 800,000 of these patients were subsequently hospitalized,” the CDC report states.

Overcoming the stigma of falls is another challenge. “It’s nice and fancy to have a heart attack, it’s very acceptable in our social world, but having a fall is not,” Wolf-Klein says in the related article. “But falls are actually preventable in the vast majority of cases. There are things we can do.”
Rethinking Early Goal-Directed Therapy for Sepsis

Clinicians should consider the physiology of each unique patient in determining when to use the elements of EGDT.

A review of three clinical trials for sepsis protocols reveals that patients do not benefit from strict adherence to early goal-directed therapy (EGDT), which has guided practice since 2001.

“The Physiology of Early Goal-Directed Therapy for Sepsis,” in Journal of Intensive Care Medicine, explores the physiology of emergency sepsis treatment that led to both the Rivers EGDT protocol and the contradictory results of the randomized controlled trials. “As a result of these recent trials, consensus opinion is that there is no longer a need for the routine of protocolized placement of central venous catheters and measurement of CVP (central venous pressure) in all patients with sepsis,” the review explains.

Acknowledging that the Rivers EGDT greatly improved early intervention, the review advises clinicians to note the “physiology of each unique patient in considering when to use the elements of EGDT.” The review recommends that clinicians examine the individual evidence and base decisions on which aspects of EGDT will effectively raise oxygen levels in the patient and provide accurate monitoring, “based on local skill and resources.”

Reconciling results from the trials in 2014 and 2015 led the researchers to re-evaluate the assessment of hypoperfusion and how EGDT impacts it. If signs of hypoperfusion persist despite adequate fluid resuscitation, additional hemodynamic monitoring should be considered.


No Major Benefit of Hydrocortisone Treatment in Preventing Shock

A clinical trial finds no benefit to hydrocortisone therapy over placebo in preventing the development of shock in patients who have severe sepsis but are not yet in septic shock.

“Effect of Hydrocortisone on Development of Shock Among Patients With Severe Sepsis,” in JAMA: The Journal of the American Medical Association, explains that a group of 380 German patients received either intravenous hydrocortisone for five days followed by tapering through day 11 or a placebo under the same protocol. The double-blind trial resulted in 21.2 percent of patients with hydrocortisone (36 of 170) and 22.9 percent of patients with placebo (39 of 170) going into septic shock within 14 days.

There were no significant differences in secondary outcomes (mortality at defined periods or ICU or hospital stay), although the hydrocortisone group experienced more hyperglycemia (90.9 to 81.5 percent) and less delirium (8.5 to 19.2 percent). Even with the identified limitations, which include a requirement for informed consent that could exclude patients who developed septic shock early, the trial finds “no indication of a clinically relevant major benefit of hydrocortisone treatment, which it was designed to detect.”

There isn’t much that Emily Colyer has not seen or done in her near-20-year career. Married to a park ranger and a mother of two, Colyer worked in several states as a licensed paramedic, before combining it with nursing. She’s now a transport nurse. Oh, the stories she could tell ... and did — including how she received a scholarship to attend AACN’s National Teaching Institute & Critical Care Exposition for the first time.

How did you get started in nursing or decide to become a nurse?

I went to nursing school intending to become a midwife. Midway through school, I took an EMT course to fulfill my elective requirements, and then I was absolutely hooked on emergency medicine. Following graduation, my first position was in a very busy Level I trauma center/emergency department in Detroit. It was an amazing experience and the best education I could have asked for. I learned evidence-based practice from incredible nurses and physicians, and, looking back, it was the best decision I could have made. It was a trial by fire, jumping straight into that as a brand-new nurse, but I loved taking care of anyone who walked (or rolled!) in the door — not knowing whether you were going to receive a patient with an MI, a gunshot wound to the chest, or both, in the same hour. I loved it.

After Detroit, I began traveling and doing short-term contract work in emergency departments around the country. My first move was to Yellowstone National Park, to work in the seasonal hospital there. It was a dream job: work with amazing people all day, hike the backcountry all weekend. As life has it, I met my husband there. He is a park ranger with the National Park Service, and we have since moved around the country to some incredible park locations. Nursing gave me the flexibility to pick up and move when we needed to and to continue starting over in many brand-new, beautiful places. I have met so many wonderful people along the way.

You’re a transport nurse. How did that come about?

Our last Park Service duty station was a small town that didn’t really need another ED nurse. So, since I had that old, unused EMT license from back in nursing school, I called up the local EMS agency and asked them if I could come learn to work for them as an EMT. And I did! On hiatus from nursing, I worked for two years as an EMT, and it was another incredible learning experience. Instead of having my patients brought to me and settled on an ED stretcher, I was now going into patients’ homes and on the highway, into the forest and onto the snowmobile/ATV trail to retrieve my patients. It was a humbling learning curve, but once again, I worked with amazing people who taught me a lot about rural EMS. After two years, my department sent me to paramedic school. I finished out my last couple years there working as a paramedic.

We moved to Omaha, Nebraska, a few years ago and I had to decide: Continue working in EMS or go back to nursing? I decided to go back to nursing, but knew I would miss working in the field and on the ambulance. Again, as life has it: There
Transport nursing is the best combination of emergency and critical care nursing: You never quite know what you are going to get, but you show up and you begin providing definitive care for your patients and safe passage to whatever comes next for them. And honestly, taking care of kids is awesome. Being able to laugh and make transport into a game for young kids, or to snuggle babies who don’t feel good — every day, I feel like I have the best job in the world.

Aside from the logistics, are there major differences between being a transport nurse and traditional bedside care?
The primary difference in our subspecialties is that we are delivering care outside the traditional hospital environment. When we administer critical medications, they are infusions we are preparing ourselves, without a pharmacist. When our patients require airway management, we are responsible for the intubation, for assessing the chest radiograph for tube placement, for drawing and interpreting the point-of-care blood gas and adjusting the ventilator accordingly, without a respiratory therapist or a resident next to us — and then communicating the patient’s clinical course to the receiving intensivist over the phone, in the middle of the night. When that patient who doesn’t tolerate suctioning is desaturating 10,000 feet in the air, there are only two people at the “bedside” and since you’re working in the confines of a small aircraft, you had better hope you prepared your emergency equipment before takeoff.

Transport nursing is a magnificent challenge. Taking care of acutely and critically ill patients is rewarding — and doing it at altitude or while going 70 mph down the highway is so rewarding.

Why do you think being a nurse is so great?
I love people. And you meet the best, most interesting people as a nurse. I love hearing people’s stories. Working with children, I have really come to realize that there is no such thing as other people’s children. We belong to each other. When parents release their child into my arms for an hour-long transport, I believe that must feel like an eternity to them. I hope they know that we care for their children as we do our own.

Why critical care?
Critical care is enormously interesting. I love the science; I love research, and critical care has no end to the questions we don’t even know to ask yet: Why does this work, and not that? What about this treatment, instead of that? I love the questions, and I love considering the answers.

And, for the first time, my hospital is funding bedside nurses to conduct original research. What an amazing opportunity this was! I had a very difficult time narrowing down all the questions I wanted to ask, and the most difficult part of the fellowship was deciding exactly what I wanted to study. I ultimately decided to study the effect of team configuration on the rate of adverse effects in pediatric critical care transport. First, pediatric critical care transport is a little different than general critical care transport; second, the optimal team configuration hasn’t yet been determined in the literature. I wondered, though, how can we assess this? And with what variables will we measure the effect? I decided to start with the rate of occurrence of selected adverse events, narrowing down over a hundred variables to a dozen key measures. I expect to begin gathering data this winter. I am ridiculously excited.

You were an NTI scholarship recipient and attended NTI for the first time last year. What was that like? NTI was incredible. I was blown away by the possibilities at NTI. When I looked online at all of the courses available, I felt like the proverbial kid in a candy store. There was so much to choose from, and my only regret was that I couldn’t sign up for all of the sessions. When I actually arrived in New Orleans, I couldn’t believe it: The energy and excitement of having thousands of likeminded nurses all together, in one place, was incredible. It was even better than I had imagined.

The educational sessions were outstanding. The quality of the presentations was excellent, and I took so much material away that I have been able to directly apply to my practice on a regular basis and share with my team. Meeting other critical care transport staff from across the country was one of my favorite parts of NTI. Having conversations about the similarities and differences between our workplaces was extraordinary — we really are more alike than we are different and share the same goals: to take the best care of our patients that we can, no matter what the circumstances. I left inspired and energized!

You have a very healthy life outside of work. Is it easy for you to balance the two? I have a wonderful family. My husband and I support each other’s career paths, and we’ve had an incredible ride so far. Our kids are awesome and are always up for chasing new trails and family adventures. My best day is an afternoon in a pine forest and an evening with a campfire and people I love. I am so grateful to them and for the rare privilege of doing this work. 🖤

Interview by Paul Taylor, paul.taylor@aacn.org
Copper Fixtures May Reduce Hospital Infections

Bacterial concentrations on fixtures in copper-equipped rooms averaged about 98 percent lower than in rooms with traditional equipment.

Copper alloys can significantly decrease bacteria on high-touch surfaces and should be part of an infection control strategy at rural hospitals.

“Copper Alloy Surfaces Sustain Terminal Cleaning Levels in a Rural Hospital,” in AJIC: American Journal of Infection Control, finds that components made from copper alloys had significantly lower concentrations of bacteria after terminal cleaning.

The study goal was to assess the ability of copper alloy surfaces to mitigate the bacterial burden associated with commonly touched surfaces in conjunction with daily and terminal cleaning in rural hospital settings. The study was conducted at Grinnell Regional Medical Center, a 49-bed hospital in Grinnell, Iowa.

Nine rooms were equipped with “copper faucet handles, toilet flush levers, door handles, light switches and other commonly touched equipment.” Nine other rooms retained their “plastic, porcelain and metal surfaces,” reports a related article in The New York Times.

Bacterial contamination was measured by “taking swabs and culturing them in Petri dishes to see if bacteria would grow.”

On average, fixtures in copper-equipped rooms had bacterial concentrations “about 98 percent lower than in rooms furnished with traditional equipment, whether the rooms were occupied or not.” No bacteria grew on half of the copper components.

Vacant rooms had components with significant concentrations of bacteria, whereas components made from copper alloys were at or below the concentrations prescribed after terminal cleaning.

“Copper in hospital rooms is not yet common,” says lead author Shannon Hinsa-Leasure, associate professor of biology at Grinnell College. “Most bacteria in hospital rooms are not that harmful, but there are dangerous bacteria, and copper can be useful in minimizing them.”


Copper alloys can significantly decrease bacteria on high-touch surfaces and should be part of an infection control strategy at rural hospitals.

In-Hospital Therapeutic Hypothermia

A randomized clinical trial is recommended to assess therapeutic hypothermia for patients with in-hospital cardiac arrest.

Therapeutic hypothermia was not associated with increased survival or better neurological outcomes for in-hospital patients with cardiac arrest.

“Association Between Therapeutic Hypothermia and Survival After In-Hospital Cardiac Arrest,” in JAMA: The Journal of The American Medical Association, reviewed data on patients who were resuscitated after experiencing cardiac arrest in a hospital setting to determine whether cooling therapy was as effective as proven in out-of-hospital studies.

Out of a potential group of 26,183 patients, 6 percent of patients received therapeutic hypothermia and had in-hospital survival rates of 27.4 percent, compared to non-hypothermia patients who had a survival rate of 29.2 percent.

The comparisons are from a group of 1,524 patients who received therapeutic hypothermia and 3,714 patients who did not, with similar average age (61.6 to 62.2 years) and gender breakdown (58.5 percent men, 57.1 percent women). Survival and neurological outcomes “were similar for both shockable and non-shockable cardiac arrest rhythms.”

With no survival advantage to therapeutic hypothermia even a year out, the study suggests that a randomized clinical trial is necessary to assess the impact of shorter response times in the hospital. One possible explanation is that 21 percent of in-hospital patients were cooled below the guideline temperature of 32 degrees Celsius; other limitations that could affect the findings include some variation in collected data, lack of consistent implementation and misclassification of some patients being in comas.

Roller Coasters Can Ride Out Renal Calculi

A ride on a moderate-intensity roller coaster could benefit some patients with small kidney stones.

For patients with renal calculi, riding a roller coaster may help with passage, particularly if passengers choose a backseat.

“Validation of a Functional Pyelocalyceal Renal Model for the Evaluation of Renal Calculi Passage While Riding a Roller Coaster,” in *The Journal of the American Osteopathic Association*, used a silicone model containing three different-sized renal calculi suspended in urine. The model was tested on Big Thunder Mountain Railroad at Walt Disney World in Orlando, Florida. “They placed the kidney model in a backpack and took it on 60 roller coaster rides,” adds a related article in *WebMD News*.

According to the study, the rides were analyzed using the variables of renal calculi volume, calyceal location and the model’s position on the ride. Front seating resulted in a passage rate of four of 24, or 16.67 percent. The rate for rear seating increased to 23 of 36, or 63.89 percent.

“A ride on a moderate-intensity roller coaster could benefit some patients with small kidney stones,” David Wartinger, professor of urology at Michigan State University College of Osteopathic Medicine, East Lansing, says in the related article.

“Passing a kidney stone before it reaches an obstructive size can prevent surgeries and emergency room visits,” Wartinger adds. “Roller coaster riding after treatments like lithotripsy (using sound waves to break up stones) and before planned pregnancies may prevent stone enlargement.”


Potential Effects of Calcium on Coronary Artery Calcification

Calcium-rich foods may help decrease the risk of coronary artery calcification (CAC).

A calcium-rich diet may decrease the risk of developing atherosclerosis, if food, rather than supplements, is the primary source, but a causal relationship has not been proven.

“Calcium Intake From Diet and Supplements and the Risk of Coronary Artery Calcification and Its Progression Among Older Adults: 10-Year Follow-up of the Multi-Ethnic Study of Atherosclerosis (MESA),” in *Journal of the American Heart Association*, explains that the study at Johns Hopkins School of Medicine, Baltimore, involved 2,742 adults ages 45-84 who completed dietary questionnaires and two CT scans 10 years apart.

After adjusting for lifestyle factors, the longitudinal cohort study finds that participants with the highest total calcium intake (> 1,453 mg) were 27 percent less likely to develop heart disease than those with the lowest daily calcium intake (< 434 mg). “However, when considering supplement use, the risk of developing incident CAC was 22 percent higher in those who used supplements than those who did not.”

A related article in *News Medical* notes that the “study adds to the body of evidence that excess calcium in the form of supplements may harm the heart and vascular system,” says Erin Michos, associate director of preventive cardiology at Johns Hopkins.

Telehealth Partnership to Help Children in Rural Areas

Through the initiative, children in rural communities will benefit from medical consultations.

The Children’s Hospital of Philadelphia (CHOP) and Indian Health Services (IHS) are exploring the creation of a telehealth program for American Indian and Alaska Native children. “CHOP, Indian Health Services Exploring Telehealth Partnership,” in Philadelphia Business Journal, notes that as part of a memorandum of understanding, CHOP and IHS will develop a pediatric telemedicine plan for the IHS Navajo, Phoenix, Tucson and Albuquerque areas, as a first step.

The initiative’s goal is to create a model for physician-to-physician consultation services that will have CHOP physicians advise IHS healthcare providers on “challenging and unusual cases, including diagnoses and courses of treatment.”

Through the initiative, children in rural communities will benefit from medical consultations “provided directly, securely and effectively” by CHOP pediatric care experts, says Joseph St. Geme, physician-in-chief and chairman of the department of pediatrics at CHOP.

IHS Principal Deputy Director Mary Smith adds, “Through this memorandum of understanding, we will be able to design and develop a service specifically for pediatric care and consultation for our patients that live in very rural areas and may not be able to travel long distances to a facility to see a specialist.”

Telemedicine May Increase Family Participation in ICU Rounds

Virtual participation in ICU rounds offers a supplemental way to improve communication between clinicians and families.

“Perceptions of Family Participation in Intensive Care Unit Rounds and Telemedicine: A Qualitative Assessment,” in American Journal of Critical Care, finds that family participation in ICU rounds is a critical component of patient-centered care, and telemedicine is a viable option to bedside interaction.

While interviewing family members and other stakeholders, researchers from the University of Pennsylvania, Philadelphia, determined that, much of the time, practices surrounding family participation in ICU rounds is inconsistent. Barriers include the inability of families to travel to the hospital, work-related and other obligations, and the rounding schedule.

Family members were supportive of telemedical technology, because it could reduce trips to the hospital and help them fit participation into their schedules.

Despite these possible benefits, healthcare providers and patients’ family members voiced concerns about virtual presence. Family members most often cited unfamiliarity with audiovisual platforms as a potential barrier, whereas providers were largely concerned with the technical aspects of implementation.

“Virtual participation in ICU rounds would not replace a family member’s presence at the bedside but could offer a supplemental way to improve communication between clinicians and families,” study co-author Daniel Holena, assistant professor, says in a related article in FierceHealthcare, adding that the future of using telemedicine for virtual family participation will depend on user-friendly and reliable platforms.

Campaign Strives to Reduce ICU Delirium

Physicians and nurses across the country are taking part in a campaign to change practices to reduce cases of ICU delirium.

“Hospitals Struggle to Address Terrifying and Long-Lasting ‘ICU Delirium,’” in STAT, explains that Wes Ely, a pulmonologist and professor of medicine and critical care at Vanderbilt University Medical Center, Nashville, Tennessee, is asking ICU specialists to reduce the use of sedatives and ventilators and get patients back on their feet as soon as possible to minimize delirium.

Ely co-chairs the ICU Liberation Campaign, which is organized by the Society of Critical Care Medicine, Mount Prospect, Illinois. The campaign strives to improve patient outcomes and lower hospital costs.

Efforts related to the campaign have produced results. For example, medical ICU care teams at Beth Israel Deaconess Medical Center, Boston, have reduced the number of patients with delirium 60 percent since 2012. They carefully assess patients for delirium, make sure team members agree on the assessments, and then reduce sedation and particularly benzodiazepine use when possible.

“We discuss every patient every day, and delirium is part of the discussion,” says project leader Justin DiLibero, a clinical nurse specialist at Beth Israel. Because the project worked so well, it has been adopted by ICUs at other hospitals. It was funded by a grant from the American Association of Critical-Care Nurses, which also offers a practice alert on delirium assessment and management.

Assessing for delirium is especially important in older patients, the article adds. Without careful assessment, older patients with delirium may be misdiagnosed with dementia and discharged to nursing homes unnecessarily.

Can Reducing High BP Decrease Cognitive Impairment Later in Life?

A strong association exists between high blood pressure (BP) in midlife and the later onset of cognitive impairment, although no direct causal relationship has been identified.

“Impact of Hypertension on Cognitive Function: A Scientific Statement From the American Heart Association” in Hypertension, reviews observational study findings that high BP is a major risk factor for conditions such as Alzheimer’s disease and vascular dementia. Without clinical trials, however, the review cannot recommend a treatment that specifically reduces risk or improves cognition.

“We know treating high blood pressure reduces the risk of heart diseases such as heart attacks, congestive heart failure and stroke, and it is important to continue treating it to reduce the risks of these diseases,” lead author Costantino Iadecola, Weill Cornell Medicine, New York, says in a news release. “However, we need randomized controlled studies — which do prove cause and effect — to determine if treating high blood pressure, especially in middle age, will also decrease the risk of cognitive impairment later in life.”

Based on the evidence, the review identifies the effects of high BP on the brain and susceptibility to later diseases. Since treating patients with hypertension can be achieved effectively, the review notes that early preventive measures might reduce the later risk of dementia, too.

The review adds that although pediatric hypertension is associated with later vascular problems, studies on pharmacological treatments of children are limited, and alternative approaches such as obesity prevention might be preferable.

Among older people, some studies show a relationship between low BP and cognitive decline, so “aggressive treatment may be more problematic than helpful,” the review explains. Far more remains to be understood about causality, particularly over the life span.

Certification Support Program Helps Hospital Achieve Significant Improvements

Nurse education, including certification, was prioritized as a vehicle to improve outcomes. A recent article in Nurse Leader credits the development of a certification support program for achieving significant improvements in patient outcomes, staff satisfaction and patient experience at the nation’s first hospital, Pennsylvania Hospital in Philadelphia.

“A Certification Support Program: Impact on Nursing Autonomy, Nursing Practice, Outcomes and Culture” looks at the 500-bed teaching hospital’s patient care initiatives, which draw from national recommendations and databases. It cites sources such as a 2010 report, “The Future of Nursing: Leading Change, Advancing Health,” which recommends higher levels of nurse education and training.

The article credits the hospital’s five-year strategic plan to “improve patient outcomes, nurse satisfaction, patient experience, and ultimately, become one of the 7% of Magnet organizations in the country” as being a crucial driver in developing these initiatives.

The hospital also formulated a phrase — “Keep the main thing the main thing” — that became the mantra for the nursing department. Compassionate patient care was elevated as the “main thing” and became the foundation for all the other initiatives.

According to the article, nurse education — including certification — was prioritized as a vehicle to improve outcomes, and the hospital implemented this goal by empowering nurses at all levels of practice through a process that ensures lifelong learning.

One of the main barriers to ensuring lifelong learning is overcoming financial barriers that can keep staff from leadership roles. The article mentions the benefit of forward-thinking hospital executives who pay the fee for certification exams, whether nurses pass the first time or not.

A result of the initiatives is that the hospital did achieve its Magnet recognition, a designation “reserved for an elite group of hospitals throughout the country who have demonstrated their commitment to nursing practice, nurse satisfaction, and patient outcomes, which all have to exceed national benchmarks,” the article explains.

The article concludes that the certification support program was able to successfully identify and remove barriers associated with certification and provided the framework to achieve improved rates of nurse certification.

According to the article, the program can be easily replicated by other organizations intending to improve certification rates, nurse satisfaction and patient outcomes through certification. “Professional nurse certification has become the new norm, and nurses are encouraging other nurses through the certification process.”


Tips to Improve Civility in the Workplace

Most importantly, managers should create a safe forum for questions and discussion. Lack of civility can have a negative impact on the work environment and, inevitably, patient care.

“Promoting Civility,” in Emerging RN Leader, indicates that a lack of courtesy and respect in our society can set a poor example for healthcare teams, and the negative impact of incivility contributes to loss of productivity, staff disengagement and medical errors.

To improve civility in the work environment, the article recommends encouraging acts of kindness, forgiveness and graciousness and, most importantly, creating a safe forum for questions and discussion.

Specifically, the 10 tips for managers are as follows:

- “Examine your own behavior and how you contribute to civility or incivility.
- Take a temperature check in your unit to see how staff treat one another.
- Don’t listen to or tolerate rumors and gossip.
- Encourage staff not to jump to conclusions about the intent or motives of other staff, patients or families.
- Stop the blame game and encourage a solutions orientation to problems.
- Encourage acts of kindness among staff.
- Go out of your way to say thank you and promote this behavior in staff.
- Look for common ground in dealing with conflict.
- Encourage the practice of forgiveness.
- Make it safe for staff to ask questions and discuss problems.”
Video Shows Nurses Sharing Moments of Mindfulness

Mindfulness has clear implications for nursing leadership, workforce resilience and health promotion.

Clinical nurses share their personal experiences in a video that illustrates how they draw on mindfulness to build resiliency while delivering compassionate care.

“The Mindful Nurse Leader: Advancing Executive Nurse Leadership Skills Through Participation in Action Learning,” in Nursing Management, describes the process of producing video vignettes of nurses talking about the implications of mindfulness on nursing leadership. The article is the second in a three-part series on mindfulness written by five nurse leaders participating in the Robert Wood Johnson Foundation Executive Nurse Fellows program.

They describe mindfulness as “paying intentional attention to the present moment with an attitude of nonjudgment, acceptance, and awareness.” The goal of their 18-month project is to launch a national campaign to engage nurses through stories of mindfulness, compassion and presence.

While mindfulness traits are taught in workshops and classrooms, the team decided it would be more powerful to have nurses share a time “when being mindful made a positive difference in their experience with patients or colleagues” — to inspire others. “Nurses consistently recognized by their patients and peers as truly connecting with others and making a difference in their lives were selected for participation.”

The team believes the video, “In the Moment: Stories of Mindfulness in Nursing,” is valuable for all levels of practice. As they consider methods of national distribution, they’re engaging nursing colleges and healthcare organizations to use the video as a resource.

“Mindfulness has clear implications for nursing leadership, workforce resilience and health promotion, which benefits both patients and the healthcare team,” the article adds.


Social 10 Builds Nurse-Patient Relationships

A hospital’s patient satisfaction initiative included Social 10, a 10-minute uninterrupted personal conversation between the nurse and patient.

“Strengthen Nurse-Patient Communication With the ‘Social 10,'” in Nursing Management, describes how New York University Langone Medical Center formulated an “initiative to improve patient satisfaction and assess bedside care.” An acute medical-surgical unit with 31 beds introduced Social 10 to address nurse-patient interactions that seemed “automated, hurried, and disjointed” and replaced them with positive, patient-centered communication.

During Social 10, nurses engage patients in a personal conversation at the bedside to build rapport and gain “knowledge about their patients that may be useful in formulating a comprehensive, individualized care plan.” Nurses also have an opportunity to slow down, destress and be present to counterbalance the pace and intensity of their work.

A follow-up review of patient satisfaction scores showed higher ratings for nursing care and praise for authentic listening, compassion and undivided attention. Between the program’s introduction in third quarter 2014 and evaluations in the first half of 2015, scores rose in areas such as recommending the hospital, staff taking patient preference into account, pain management and nurses engaged in careful listening.

The article acknowledges that other areas besides nursing affected the scores but emphasizes that “nurses play the most prominent role in patient satisfaction because they’re at the forefront of patient care at all times.” Social 10 established a relationship from the outset with benefits ranging from improved outcomes to a more positive work environment for staff. Further studies “in different healthcare settings are recommended to confirm its positive impact.”

New Editions of AACN Books Offer the Latest Critical Care Procedures

Two popular resource books — “AACN Procedure Manual for High Acuity, Progressive, and Critical Care” and “Certification and Core Review for Neonatal Intensive Care Nursing” — have been updated.

AACN has just published new editions of two of its most popular resource books.


The title was changed to reflect the expanding use of many procedures in diverse settings. The updated edition guides readers through procedures unique to adult high-acuity, progressive and critical care environments. It also offers procedures used by all nurses, including advanced practice nurses, in an illustrated, step-by-step format.

“New and experienced nurses find the procedure manual to be a valuable, comprehensive and easy-to-use reference. Information on simple and complex procedures can be found quickly," says editor Debra L. Wiegand.

“Over 200 experts contributed to the development of this new edition.”

Additional features include rationales for interventions in patient and family education, assessments, patient preparation and monitoring to help nurses understand the reasons for every step.


The book prepares nurses for the exam with hundreds of study questions and test simulation.

In addition, the latest edition features:

- Updated review content that reflects AACN’s latest CCRN-Neonatal exam and National Certification Corporation’s latest Neonatal Intensive Care Nursing (RNC-NIC) exam
- The latest evidence-based guidelines for neonatal critical care
- Three new chapters: “Grieving Process,” “Quality Improvement” and Facilitation of Learning”
- A new focus on culturally sensitive care in an expanded chapter titled “Family Integration and Culturally Sensitive Care”

Please visit www.aacn.org/store to learn more and purchase these books.
Interventions to build resilience among critical care personnel can address the high rate of burnout, but finding time for them is challenging because patient instability makes workflow unpredictable. Researchers found that an intervention offering one hour of training per week for eight weeks improved work satisfaction scores. The intervention included instruction on yoga, mindfulness, a CD for home practice and was provided on-site during the hour used for staff meetings. There was 100 percent retention in the intervention group. Researchers noted that working with unit leadership to ensure coverage for patient care activities was essential.

(Steinberg et al, AJCC, January 2017)
www.ajcconline.org

Medical patients admitted directly from the emergency department are an important population in intermediate or progressive care units. To characterize these patients, researchers evaluated admission data, acuity scores and diagnosis, patient outcomes, mortality and length of stay. The unit’s structure, nursing ratios and policies for managing unstable patients were also described. They concluded that emergency medical patients with moderate severity of illness and comorbidity can be admitted to an intermediate level of care with relatively infrequent transfer to intensive care and relatively low mortality.

(Simpson et al, AJCC, January 2017)
www.ajcconline.org

In Our Journals

Hot topics from this month’s AACN journal

Early mobility is essential to prevent complications in intensive care, but its safety for patients receiving vasoactive medications is uncertain. Researchers assessed the safety of mobilizing patients receiving low-dose norepinephrine by examining mean arterial pressure and heart rate before and after activity. Study participants underwent ambulation or bed-to-chair transfers. Oxygen saturation and mean arterial pressure were not significantly altered following mobility, no dysrhythmias occurred and increased heart rate was an appropriate response to physical activity. These results suggest that stable low-dose norepinephrine is not a contraindication to early mobility.

(Nievera et al, AJCC, January 2017)
www.ajcconline.org

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To see the table of contents for the January issue, please visit www.ajcconline.org.

Transitions

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

Sandra Dunbar, associate dean of academic advancement and professor of cardiovascular nursing, Emory University’s Nell Hodgson Woodruff School of Nursing, Atlanta, and past AACN president, receives the Distinguished Graduate – Educator award from Florida State University College of Nursing.

Marjorie Funk, Yale School of Nursing, New Haven, Connecticut, and a recipient of AACN’s Distinguished Research Lectureship, receives the Mary Jane M. Williams Award for Lifetime Achievement in Nursing from the Connecticut Nurses Association.

Pamela Jeffries, dean and professor, The George Washington University School of Nursing, receives the National League for Nursing’s Mary Adelaide Nutting Award for Outstanding Leadership in Nursing Education.

Janie Heath, dean and Warwick Professor of Nursing, University of Kentucky College of Nursing, and past AACN board member, spoke at Advances in Pharmacy Practice: Annual Fall Conference, in Lexington, Kentucky.

Mary Naylor, professor of gerontology at University of Pennsylvania School of Nursing, and a recipient of the AACN Pioneering Spirit Award, receives the Distinguished Investigator Award from Academy Health for her research on the transitional care model, an evidence-based care management approach for older adults.

Christy Passion, critical care nurse and award-winning poet, participated in Out Loud in the Library, a literary and music event at Windward Community College, University of Hawaii.

Phyllis Wheatley, a critical care nurse at Nanticoke Memorial Hospital, Seaford, Delaware, who began her career at the hospital as a float nurse 35 years ago, is named Nurse of the Month. She is well known for her caring attitude.

Send new entries to aacnboldvoices@aacn.org.
AACN at www.aacn.org/gifts.
I love the growing list of AACN’s annual themes. I proudly display the poster of the spectacular artwork for this year’s theme on the door to my office, give themed magnets and coasters to my friends, and drink from coffee mugs embossed with the artwork. I know you love AACN’s themes, too, because you have told me so during many visits to AACN chapters this past fall. *Courageous Care, Focus the Flame, Step Forward, Dare To, Rise Above, Bold Voices, Make Waves* — the theme not only matches the personality of the president at the time, but also the needs and issues of those times.

And 2017 is one of those times.

If nursing ever mattered, *It Matters* now. If using your voice — a voice grounded in human-centered values and vision — ever mattered, *It Matters* now. In multiple regions across our country, we have experienced a year of natural disasters. As a global community, we have witnessed terrorism at the hands of our fellow humans and the selfless compassion of neighbors — stranger or friend — in response to that violence. As Americans, we have endured the divisiveness of a historic presidential campaign and affirmed our most fundamental institution: democracy itself.

One in every 100 Americans is a nurse. Think about the power we have to find common ground, to forge common purpose and to heal those who need our care. Nurses have always delivered on their social contract with America — to care for any person in need regardless of race, gender identity, political party, faith, socioeconomic status or country of origin. I dream of nurses leading this country in healing after a tumultuous year and share these hopeful words from Anne Frank: “How wonderful it is that nobody need wait a single moment to improve the world.”

Hope, kindness, compassion, inquiry, integrity: the highest of human virtues. These are also the core values of nursing. Yet, I realize our kindness and compassion may at times be tested. Human centeredness may sometimes get lost in the stresses of daily living and the flurry of the digital revolution.

But the questions we ask matter as we forge common ground. When I ask AACN chapter members, “What matters to you?” the answer is almost always love and family. No one mentions a bigger house or newer car. When I ask them to tell me about a time when they knew they mattered as nurses, the stories are always about patients saying, “You saved my life”; of physicians saying, “Your care rewrote the story of nurses for me”; of younger nurses saying, “You matter because you are my mentor.”

If it is true — as David Cooperrider, the father of Appreciative Inquiry, states — that we live in worlds created by our questions, then what question will you ask of yourself as this new year begins? What will matter to you in 2017?

There are moments of transformation when a new path appears and reveals new possibilities. Think about the moment when … you used your voice to advocate for a patient’s family member, you decided that bedside nursing was your highest calling, you realized your nursing efforts saved a life, you used the best available evidence in the care of your critically ill pediatric patient or you strengthened the health of your work environment by holding that crucial conversation.

As 2017 begins, AACN stands with you to ask questions and to uncover and ignite those moments of transformation. Share with me your moments that matter in 2017 at itmatters@aacn.org.
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