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Come Explore

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
What makes a great nurse? It takes more than knowledge or skill and it's not enough to be caring in the sentimental sense of the word. I think of Maria and other nurses like her. Do they love nursing? They probably wouldn't express it like that. Some would laugh off that word; it might make them uncomfortable — but to be a great nurse takes intelligence, energy, imagination, integrity, and at the risk of sounding unscientific and unprofessional, I've come to the conclusion that an additional element is required: love. How could you do this work otherwise?

Love is a lot to ask, but there's no way around it.

You have to add love to the mix.


—Tilda Shalof


Another Angle

The Whole Is Greater Than the Sum of Its Parts

Which organ in the body matters most? ICU teams have bantered about this for a long time, so I conducted a small review of three journals to answer the question. Is it the heart — that hardworking pump? Or is it the lungs and pulmonary system — that portal to the most vital substance, oxygen? Or perhaps the brain and its 100 billion neurons that control the other organs and our very humanness?

Read more in my note on page 22.

Clareen Wiencek
 AACN President

You know you can’t really live without all your organs. They all work together, just like nurses.

—Lisa Harrison, President, AACN Monticello Chapter
AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES

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, ACNPC 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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NTI Registration Opens: Start Planning Your Houston Trip

NTI’s outstanding and diverse learning opportunities and inspirational gatherings promise to reignite your passion for practice and commitment to our profession.

Join us May 21-25 for the National Teaching Institute & Critical Care Exposition (NTI) and Advanced Practice Institute. NTI’s outstanding and diverse learning opportunities and inspirational gatherings promise to reignite your passion for practice and commitment to our profession.

The premier conference for high-acuity and critical care nurses, NTI is the most valuable conference you will attend this year:

• Take home evidence-based best practices with more than 300 concurrent sessions on topics that high-acuity and critical care nurses need in today’s diverse and challenging healthcare environments.
• Pass along knowledge gained through in-depth preconferences and inspirational SuperSessions.
• Network on-site and online. MyNTI, our new scheduling tool for attendees, makes it easy for you to plan and personalize your experience.
• Celebrate and enjoy a spectacular Nurses’ Night Off at the Houston Museum of Natural Science.

Learn more and find everything you need to discuss NTI with your manager, register and start planning at www.aacn.org/ntitx17.

Chapter Leadership Development Workshop Focuses on Authentic Leadership

The annual Chapter Leadership Development Workshop (LDW) focuses on critical skills that seasoned and novice chapter leaders need to successfully manage and lead a chapter in fulfilling AACN’s mission. This year’s workshop will be held Sunday, May 21, from 8 a.m. to 5 p.m. at the Marriott Marquis Hotel, Houston.

Are You Ready for Certified Nurses Day, March 19?

If not, there’s still time! For ideas on how to recognize, honor and celebrate certified nurses March 19, visit www.aacn.org/certnursesday and also read the article on page 7 of January’s Bold Voices. We love learning about your ideas, strategies, stories and photos in recognition of Certified Nurses Day, too. Please email us at certification@aacn.org with “Celebrate Certified Nurses” in the subject line.

American Nurses Credentialing Center, Silver Spring, Maryland, initiated this special day to honor the birthday of the late Margretta “Gretta” Madden Styles, an international pioneer in nursing certification and longtime friend of AACN. Styles designed the first comprehensive study of nurse credentialing.

Don’t miss what is sure to be an unforgettable day of learning, networking and celebration.

The workshop will be devoted to authentic leadership — one of AACN’s Healthy Work Environment standards — and will feature Connie Barden, AACN chief clinical officer, and Teri Lynn “TK” Kiss, past AACN president, as keynote speakers.

It will also include current and former chapter advisors discussing their leadership journeys, as well as breakout sessions devoted to the basics for new officers, lessons learned, knowing members’ needs, succession planning, skilled communication, authentic leadership and best practices.

Don’t miss this unforgettable day of learning, networking and celebration! If you have considered becoming more involved in your chapter, this is the workshop to attend. It will help you build new skills related to chapter management and leadership in healthy chapter work environments.

The LDW is open to all chapter members, officers, leaders and potential future leaders; there is no limit to the number of chapter members who may attend for $110 each. Each AACN chapter that attends LDW will receive a one-time $450 grant to help defray the cost, and we highly recommend that each chapter’s president-elect attend. Houston residents: Even if you can’t attend the full NTI, consider joining us for LDW. Register for class code PC125.
Validating the Unique Contributions of Knowledge Professionals

Nurses who were not previously eligible to obtain or maintain CCRN or PCCN certification due to direct-care hour requirements may now be eligible for CCRN-K or PCCN-K.

With the increasing acuity of hospitalized patients, a growing number of acute and critical care nurses are shifting to roles where they influence patient outcomes by sharing their unique clinical knowledge and expertise rather than providing care directly.

Many of these nursing knowledge professionals — who work in a variety of roles, including educators, researchers, administrators, care coordinators and managers — find certification as relevant to their current practice as it was to direct care, but they are challenged with accruing the required direct-care hours.

AACN’s CCRN-K (critical care) and PCCN-K (progressive care) credentials acknowledge and validate the distinct contribution of knowledge professionals to patient welfare and provide these valuable nurses with the opportunity to obtain or maintain certification.

Leslie Foran-Lee, an advanced clinical educator at Virtua, a community-based health system in New Jersey, is one of the first progressive care nurses to earn the PCCN-K credential.

“As nursing educators, we’re helping shape the nurses at the frontline of care,” Foran-Lee says. “Throughout the health system, our education and clinical staff work hand-in-hand to apply evidence-based practices at the bedside and deliver the best care possible to our patients. That means we all need top-notch knowledge and skills, and certification is an excellent way to validate our practice against national standards.”

Katherine Tryon, a CCRN-K-certified clinical educator II at Baptist Health South Florida in Miami, is part of the department of clinical learning.

“I’m contributing to the care of patients by educating our staff nurses and collaborating with them about how to provide the best care,” Tryon says. “Our efforts are distinct but connected, and we all have an impact on patient outcomes. A nurse is a nurse, regardless of whether they provide direct care. You never lose that focus on the patient.”

“Getting the needed practice hours to maintain my CCRN became an ongoing challenge when my role changed to focus on education instead of direct care. CCRN-K solved that dilemma and better reflects the role I’m in now.”

Sharing those sentiments is Telly deBoarts, who holds a CCRN-K credential. She is director of professional development and nursing excellence at Rose Medical Center, a community-based teaching hospital in Denver.

“Being the conduit for education and development of our critical care nurses is how I continue to serve patients,” deBoarts says. “Now, I take care of the nurses who take care of the patients. We all have the same goal: to get our patients back to their life. Together, we can reduce errors and tighten up processes. All that helps improve patient outcomes.”

When deBoarts didn’t have enough direct-care hours to maintain her original CCRN certification, she was more than disappointed. “My certification was an integral part of my identity as a nurse, and I couldn’t just give up,” deBoarts adds. “When CCRN-K was launched, I immediately signed up. Earning my CCRN-K has allowed me to pick back up part of my self-image as a critical care nurse.”

Nurses who were not previously eligible to obtain or maintain CCRN or PCCN certification due to direct-care hour requirements may now be eligible for CCRN-K or PCCN-K.

As with all other AACN certifications, there are specific eligibility requirements, including practice hours, for these credentials. Learn more in the Certification section of AACN’s website.
Banner Health Hospitals Focus on Improving Communication for CSI Academy Projects

The health system’s participation marks the first time AACN selected an individual health system to participate in the CSI Academy program.

Improving communication as a way to enhance the patient and provider experience was a common theme when nine Banner Health hospitals recently participated in AACN Clinical Scene Investigator (CSI) Academy projects.

Banner Health — one of the largest nonprofit health systems in the country — has multiple hospitals in the Phoenix-area that participated in the CSI Academy program. Their participation marks the first time AACN selected an individual health system to participate in the CSI Academy program, which is designed to equip bedside nurses to serve as clinician leaders whose initiatives measurably improve the quality of patient care with bottom-line impact to the hospital.

Of the nine Banner Health CSI Academy projects, five focused on improving communication. Three looked specifically at patient communication (improving patient education to reduce readmissions and including patients in bedside report) and two on improving nurse-to-nurse communication during handoffs.

“We’re not surprised that half our CSI Academy projects centered on communication,” says Karen Johnson, research director of nursing for Banner Health. “Our nurses recognize the inherent value of skilled communication and continue to improve their communication with patients and each other to improve patient outcomes and foster a healthy work environment.”

Standardized shift reports, handoff tools and other efficiencies contributed to reduced incidental overtime and higher staff morale for the health system.

“As a large not-for-profit healthcare system, it is our responsibility to lead the way for improving nurse and patient outcomes,” says Neva Spencer, senior director of professional practice for Banner Health. “We need to lead the evolution of nursing through healthcare innovation. The CSI program helped us to challenge our traditional paradigms of nursing productivity to refocus and retool to meet the challenges of the current healthcare environment.”

Johnson agrees. “This is valuable work we need to capitalize on,” she says. “The CSI program and structure allowed for ease of use and application to change practice based on current literature. These projects cannot be one and done. We are evaluating our structures and processes on how best to implement the results of our CSI projects across our company, spreading this work to over 18,000 nurses who work at Banner Health.”

Johnson also notes that participating in CSI Academy aided nurses in assuming leadership roles and acting as change agents in their hospitals. “Several of our CSIs during and since completion of the program have entered into leadership positions.”

Projects from the Banner hospitals are now part of the CSI innovation project library, which has become a resource for hospitals throughout the United States and abroad, as healthcare administrators and clinical leaders seek solutions to improve patient outcomes and reduce costs. Access all CSI projects from the AACN CSI Academy webpage or www.aacn.org/csiprojects.
Nurses’ Scrubs Can Pick up Antibiotic-Resistant Bacteria

Infection control strategies can help stop and prevent the transmission of antibiotic-resistant bacteria from patients to healthcare personnel in hospital settings. “Nurses Scrubs Often Contaminated With Antibiotic-Resistant Bugs,” in CBC News, notes that preliminary data, presented at IDWeek — the annual meeting of the Infectious Diseases Society of America, the Society for Healthcare Epidemiology of America, the HIV Medicine Association and the Pediatric Infectious Diseases Society — in New Orleans, discovered 22 instances (18 percent) where the same strain of bacteria was transmitted from patients to nurses through commonly contaminated surfaces, such as nurses’ scrubs and patients’ bed rails. The types of bacteria included methicillin-resistant Staphylococcus aureus and Klebsiella pneumoniae.

Roughly 45 percent of bacteria was transmitted from patients to their rooms, and 27 percent from patient to nurse. No transmission from nurse to patient was identified, although the article notes, “This kind of transmission likely occurs in hospitals.”

Funded by the Centers for Disease Control and Prevention, the study tracked 167 patients and 40 nurses who cared for them over three separate, 12-hour intensive care shifts. Cultures were taken twice daily from nurse sleeves, pockets and the midriff of their scrubs. Patients' rooms, bedrails and supply carts were also tested.

Even after daily room cleanings, significant amounts of bacteria were found, which is why the preliminary study stresses the importance of a comprehensive strategy. “Cleaning of the room while the patient is still there may not be as meticulous as it is after a patient is discharged, and that needs to change,” explains lead author Deverick Anderson, associate professor of medicine, Duke University Medical Center, Durham, North Carolina.

“To prevent spread of these bugs, three components are especially important,” Anderson adds in a related news release. They are as follows:

- Hand-washing after all encounters with patients
- Using disposable gloves and gowns when treating patients with specific infections
- Regular, meticulous cleaning of patients’ rooms

Link Between Constipation and Chronic Kidney Disease

Patients with constipation had a 13 percent greater likelihood of CKD and a 9 percent greater likelihood of end-stage renal disease.

A large observational study finds an association between constipation and both chronic kidney disease (CKD) and end-stage renal disease, with severity linked to increased risk, although causation is unknown.

Researchers at Memphis (Tennessee) Veterans Affairs Medical Center reviewed a national cohort of over 3.5 million veterans, 93.2 percent male with a mean age of 60, with normal kidney function upon initial examination in 2004 or 2006 and a follow-up in 2013. Known CKD risk factors, such as diabetes, were adjusted for in the research. Patients with constipation had a 13 percent greater likelihood of CKD and a 9 percent greater likelihood of end-stage renal disease.

According to “Constipation and Incident CKD,” in JASN: Journal of the American Society of Nephrology, “More severe constipation is associated with an incrementally higher risk for each renal outcome,” measured as absent, mild or moderate/severe. The study concludes that further research is required to understand what might cause the connection.

A related article in Renal & Urology News, “Constipation Associated With CKD, ESRD Risk,” notes that other research has linked constipation to cardiovascular disease and suggests that gut bacteria could be a root cause in both scenarios. “Our findings highlight the plausible link between the gut and the kidneys and provide additional insights into the pathogenesis of kidney disease progression,” study co-author Csaba Kovesdy, a physician at the medical center, adds in a news release.

For clinical practice implications, the study recommends evaluating kidney function in constipated patients and evaluating the risk of certain anti-inflammatory medications on patients with any level of kidney disease progression. If causation can be confirmed, probiotics might be a possible therapy, along with lifestyle changes that protect kidney health.

Diabetes-Depression Combination Represents Higher Risk for Women

Because depression affects adherence to care of patients with T2DM, it is important to understand the connections when identifying potential predictors.

Almost 20 percent of women with type 2 diabetes mellitus (T2DM) have depression, with younger, less educated, less healthy and less physically active patients the most vulnerable.

According to “Predictors of Depression Among Adult Women With Diabetes in the United States: An Analysis Using National Health and Nutrition Examination Survey Data From 2007 to 2012,” in The Diabetes Educator, 19 percent of women ages 20 and older with T2DM also have depression, and some critical predictors differ from those for men. Because depression affects adherence to the care of patients with T2DM, understanding the connections in trying to identify potential predictors unique to screening women can be especially valuable.

Significant predictors for women also include pain that interferes with normal activity, whereas marital status, years with the disease, family history and insulin use were not effective predictors for women alone. “The diabetes/depression comorbidity is associated with greater healthcare costs, poorer self-care, less medication compliance and dietary adherence, a greater diabetes symptom burden, poorer quality of life, and premature mortality,” Shiela Strauss, associate professor of nursing at NYU Rory Meyers College of Nursing, says in a related NYU news release.

With an estimated 1.7 million out of 9 million women with T2DM having clinical depression, the ability to target the most vulnerable populations can assist caregivers in screening and focusing treatments effectively. “What’s particularly salient to me is that women who were limited in their ability to carry on their usual activities because of pain, or who were inactive due to poor health, were especially likely to have comorbid depression,” Strauss adds.


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Nurses’ Health Study Celebrates 40 Years

An estimated 94 percent of the original nurse participants are still participating since the study began in 1976.

AJPH: American Journal of Public Health celebrates the 40th anniversary of the Nurses’ Health Study (NHS), the largest, longest-running investigations into women’s health and risk factors for chronic diseases.

The September 2016 issue delves into the origins of the NHS and its influence across all areas of healthcare. “Nurses joined, persisted, and used their unique and essentials skills to make this cohort study an exemplar,” notes “120 000 Nurses Who Shook Public Health,” an editorial by Alfredo Morabia, AJPH’s editor-in-chief.

The original focus of the study was on contraceptive methods, smoking, cancer and heart disease in women. It launched in 1976 with over 121,700 nurse participants selected because of their ability to apply their education, skills and experiences to describe health issues on the questionnaires. They are also a very committed cohort: An estimated 94 percent of the original study population is still participating.

The study has been updated and expanded to include other lifestyle factors, behaviors, personal characteristics and more than 30 diseases. Volunteer participants receive follow-up questionnaires every two years with questions about smoking, hormone use and menopausal status. Since 1980, participants also receive a food-frequency questionnaire every four years to collect data on diet and nutrition.

The original study led to the creation of NHS2 in 1989, NHS3 in 2010 (which includes male nurses since 2015; enrollment is still open) and the Growing Up Today Study. The latter is aimed at a “deeper understanding of the factors that affect health throughout the life course.”

The AJPH September 2016 issue also features editorials from researchers who used NHS data and information on how the findings influence public policy, research methods and everyday health decisions, including nutritional policies.

Declining VAP Rates Called Into Question

More research is needed on how we survey VAP occurrence and reporting, and how best to prevent this type of pneumonia in vulnerable patients.

Despite reports of declining ventilator-associated pneumonia (VAP) rates in medical and surgical ICUs, an analysis shows rates were substantial and stable over a nine-year period.

"Trend in Ventilator-Associated Pneumonia Rates Between 2005 and 2013," a research letter in JAMA: The Journal of the American Medical Association, states that VAP affected approximately 10 percent of ventilated patients during this time period, bolstering concerns that “most interventions purported to reduce VAP are supported by limited evidence.”

Using data compiled by the Medicare Patient Safety Monitoring System (MPSMS) from 2005 through 2013, the analysis involved 1,856 Medicare patients 65 years and older on a ventilator following certain major surgeries, pneumonia, heart failure or acute myocardial infarction. VAP rates were stable over time, with an observed rate of 10.8 percent during 2005-2006 and 9.7 percent during 2012-2013.

The findings differ significantly from Centers for Disease Control and Prevention (CDC) reports of marked declines in VAP rates. According to the CDC’s National Healthcare Safety Network, incidents of VAP per 1,000 ventilator days decreased 71 percent in medical ICUs and 62 percent in surgical ICUs from 2006 to 2012.

The discordance between these findings and the significant declines reported by the CDC could be due partly to differences in how VAP rates are measured and reported, the analysis notes. However, the findings have limitations, including the fact that “VAP rates were not measured in all hospitalized patients,” only the subset in the MPSMS.

“VAP is still a significant issue and needs more examination into how we survey its occurrence and report it, along with more research into how best to prevent this type of pneumonia in vulnerable patient populations,” lead author Mark Metersky, director of Center for Bronchiectasis Care, University of Connecticut School of Medicine, Farmington, says in a related article on www.HealthManagement.org.


Updated Guidelines for Managing Severe Traumatic Brain Injury

Previously published once every 10 years, the guidelines will now be updated as new scientific research becomes available.

"Guidelines for the Management of Severe Traumatic Brain Injury," 4th edition is a recent update by a panel of experts in neurosurgery, neurointensive care and neurotrauma.

Previously published every 10 years, the guidelines — which provide recommendations on 18 monitoring and treatment topics for patients with severe traumatic brain injury (TBI) — will now be updated as new scientific research becomes available, reports a news article from Oregon Health & Science University (OHSU), Portland. Guideline topics includes surgical procedures, nutrition, monitors that measure intracranial pressure, and the prevention and treatment of brain swelling.

The update was led by the Pacific Northwest Evidence-based Practice Center at OHSU and the Brain Trauma Foundation, Campbell, California. The panel spent “six years evaluating research studies and developing evidence-based recommendations for in-hospital management” of severe TBI, the news article adds.

The update differs from previous editions in many ways: “First, we are moving from a static document to a ‘living guideline’ model that will better meet the needs of the brain trauma community.

“Second, the Brain Trauma Foundation guidelines have been integrated into the Brain Trauma Evidence-based Consortium (B-TEC). In that context, the guidelines will contribute to, and benefit from, the realization of the mission of B-TEC to cause a paradigm shift in the assessment, diagnosis, treatment, and prognosis of brain trauma,” the update explains.

Published in 1996, the original guidelines were the first evidence-based recommendations in any branch of surgery, according to OHSU. Now they are translated and distributed around the world. Updating the guidelines is important, because severe TBIs contribute to 30 percent of all injury-related deaths in the U.S.
Marijuana Use Linked to Heart Condition

Using marijuana may double the risk of later developing stress cardiomyopathy, according to research presented at the American Heart Association’s Scientific Sessions.

During his presentation, co-author Amitoj Singh, chief cardiology fellow at St. Luke’s University Health Network, Bethlehem, Pennsylvania, noted that marijuana users who developed stress cardiomyopathy averaged 44 years old and 36 percent were men, the opposite of who usually tends to develop the condition, according to “Marijuana Use May Weaken Your Heart Muscle,” in Live Science. Typically, the condition develops in postmenopausal women under stress.

Using the Nationwide Inpatient Sample database, the research identified 33,343 admissions for stress cardiomyopathy between 2003 and 2011, and 210 of these patients reported using marijuana or had the drug detected in their urine. The article cites Singh as stating that no patients died from the heart condition, but people “should be aware that certain cardiovascular abnormalities and complications can occur from marijuana use.”

The research did not establish marijuana as a potential cause of stress cardiomyopathy. There was no information on how long patients used marijuana, how much they used or how it was ingested. Although Singh notes studies on some positive effects, he adds, “We don’t know everything about marijuana.”

As some states move toward legalizing marijuana, Melissa Walton-Shirley, clinical cardiologist at St. Thomas Heart, Nashville, Tennessee, writes in a commentary on Medscape that more people, including young and middle-aged Americans, may develop cardiovascular complications.

“Seeing this uptick in apical ballooning in the young (and males to boot) is proof that manipulating the sympathetic and parasympathetic nervous systems is probably not a good thing for any age or gender unless those systems are producing pathology,” Walton-Shirley writes, pointing to other studies that also have shown the harmful effects marijuana can have on cardiovascular health.

Statin Use Rises, Inequities Remain

Statin use among adults ages 40 and over increased 79.8 percent from 2002 to 2013.

Using statins to help prevent cardiovascular events has increased dramatically, but questions remain about equity of distribution, use by high-risk groups and cost-effectiveness.

According to “National Trends in Statin Use and Expenditures in the US Adult Population From 2002 to 2013,” in JAMA Cardiology, statin use among adults ages 40 and over increased 79.8 percent in the 11-year period, from 21.8 million people (with 134 million prescriptions) to 39.2 million people (221 million prescriptions). The cohort study estimated national data from a review of 157,000 participants in the Medical Expenditure Panel Survey.

Among patients with atherosclerotic cardiovascular disease, usage increased from 49.8 percent in 2002 to 58.1 percent in 2013. Less than one-third of these patients received high-intensity doses.

Trends among subgroups also show areas for improved equity in prescriptions, reflecting “unacceptable health care disparities in our society,” according to a related editorial in JAMA Cardiology. Women were 81 percent as likely to take statins as men, members of minority groups were 65 percent as likely and uninsured patients 33 percent as likely.

The study finds that out-of-pocket expenses decreased from a mean of $348 annually to $94, reflecting increased access to generic medicine. The total GDP-adjusted cost of statins decreased from $17.2 billion in 2002 to $16.9 billion in 2013, with brand names accounting for 55 percent of total costs in 2013.

The editorial identifies ongoing challenges in defining adherence to prescribed use as well as finding alternatives for patients who experience muscle pain as an adverse effect of statins. Early indications on the effectiveness of PCSK9 inhibitors, the newest drugs, suggest promise as an alternative therapy, the editorial notes.

Renaissance Man
An Interview With Billy Rosa

Billy Rosa is a nurse, in much the same manner that Michael Jordan played basketball. He doesn’t work at it as much as he lives it, breathes it, has it for breakfast, agonizes over it and then lives it some more. He’s been lauded with a ton of nursing awards — including AACN’s 2015 Circle of Excellence — and then writes about it. A lot. In fact, it’s kind of difficult to believe Rosa came to nursing as a second career, but it’s true.

How did you decide to become a nurse?
I am a second-career nurse. I hold a Bachelor of Fine Arts in Drama from NYU’s Tisch School of the Arts. I was a dancer, singer and actor for years, and, until I was 23, performed in several regional theater performances and well-known shows like the Radio City Christmas Spectacular. During a particularly grueling contract, I sustained a repetitive motion fracture to my left hip and wasn’t walking for months.

I went to massage therapy school, taking time for myself to heal and be quiet. When I would work in the clinics as a massage therapist, I was amazed by how patients would respond to clinical massage. One woman struggled with chronic asthma since her childhood and shared that she rarely knew a day without having to use her rescue inhalers. She wrote a letter to the clinic some weeks later saying she had never experienced such ease of breathing as she did the week after her massage. Better yet, she hadn’t used her rescue inhalers one time over the following seven days.

Over time, I learned that my ability to impact the outcomes of clinic patients went beyond physical techniques and, many times, it was my presence, willingness to listen and kindness that made the biggest difference. I wanted to find a job where I could fuse this art and science of caring that I had learned as a massage therapist and maximize my contributions to the public. A friend suggested I look into nursing … and there you have it.

What other events or experiences led you to where you are today?
When I heard about the Human Resources for Health Program in Rwanda, the goals of the initiative resonated deeply with me: Increase the quantity of doctors and nurses in Rwanda, improve the quality of available education, increase autonomy of the healthcare workforce and Ministry of Health, and decrease overall dependence on foreign aid over a seven-year period. This was about empowering a people to be independent and take ownership of their nation’s health.

So this was much more than the typical short-term service project? It was about being an advocate for human-centered healthcare in true partnership with Rwandans who were passionate about improving the quality of their providers, systems and the lives of their 12 million fellow citizens. The role also required me to live abroad for a one-year minimum contract, offering me the opportunity to engage in the Rwandan context with my whole self, learning firsthand about the culture and being exposed to the socioeconomic, political and historical factors that contribute to the various indicators of health in a post-conflict country.

Talk about your experience in Rwanda.
I lived and worked in Rwanda from August 2015 through August 2016. I served as a critical care unit clinical educator, Rwanda Military Hospital and as visiting faculty, School of Nursing and Midwifery, University of Rwanda, in the country’s first-ever Master of Science in Nursing (MScN) program. Every aspect of this experience can be summed up in two words: humbling gratitude. Being in Rwanda really taught me, on a fundamental level, beyond the mere concept of a shared humanity, just how interconnected we all are. One of my favorite thought leaders says it best: “I am not my brother’s keeper, I am my brother.”
I desperately wanted to find a way for the emerging MScN students to be connected to a global community of nurses through professional association membership. I am eternally grateful to AACN and several other nursing associations who heard my plea and came to the rescue. AACN offered 16 critical care MScN students three-year virtual gratis memberships, granting them access to all that we as members share. Can you imagine? What these nurses will be able to accomplish, with the help and support of AACN, is a testament to the fact that our professional associations believe in empowering the global community of nurses, not just those in resource-rich environments.

In the six weeks before we came home, my husband, Michael, and I traveled across South Africa, Namibia, Botswana, Zambia and Zimbabwe, deliberately facing our fears and breaking through all of our own self-imposed nonsense. We cage-dived with great white sharks, went skydiving (amazing), bungee jumping (never again), walked with lions, went white-water rafting and had daily adventures that this native New Yorker had never imagined.

**What’s next? What’s on your professional bucket list, so to speak?**

I am currently about halfway through a Palliative Care Nurse Practitioner Fellowship and will start full-time PhD studies in the fall of 2017. Governments responsible for allocating healthcare dollars in low- and middle-income countries primarily fund programs to decrease the prevalence of communicable diseases, such as malaria, tuberculosis and HIV/AIDS. However, we must help policymakers in these settings understand the need to redirect monies toward those suffering from a host of intractable pain and associated symptoms in order to improve the dignity of life and living.

**And you’re writing.**

My second book, “A New Era in Global Development Agenda,” is scheduled to be released in May. I am currently compiling my third text with a team of incredible co-editors, an expansive and inclusive volume that will invite nearly 40 years of research, education, practice and theory development related to caring science scholarship.

Ultimately, I want to be able to take what I know to be true from a nursing lens and communicate that across sectors and disciplines to create a truly unified healthcare system. In this way, I want to make nursing’s contributions evident and also create new models of interprofessional collaboration that strengthen systems and stratify care.

**What do you do outside of work to keep your work/life balance?**

On my free time, I love to write. Remember, I was a professional dancer and performer for years. I used to be able to spend hours and hours in a studio dancing. I now feel that way about writing. Writing provides me with an outlet to feel fully self-expressed. It is so incredibly important for my own well-being.

Spending time with friends and family is undeniably life affirming. It truly does reboot me and remind me how grateful I am for my health, relationships and the inspiring amount of love in my life. It refills me so that I can continue to do this deeply sacred work of healing that we call nursing.

**If humanity is to survive, we must understand the gravity of planetary health and the environmental, humanitarian and sociopolitical global action items that we, as nurses, play a key role in helping to implement.**

**Anything you’d like to add?**

I want to say two things to my fellow critical care nurses.

First: Write! Publish! Share what you know! I believe it is an ethical obligation to write. Critical care nurses engage with patients and families during the most vulnerable moments of their lives. Translate your experiences into the literature in a way that helps others learn, grow and mature. Believe that what you have to say is important enough for others to hear. Be amenable to editorial feedback that calls you to grow as a communicator and helps you hone your message, so that diverse audiences can readily and graciously receive it.

Second: Educate yourself on the transnational agendas impacting global health access and delivery, and the worldwide nursing and midwifery collective. Familiarize yourself with documents such as the World Health Organization’s “Global Strategic Directions for Strengthening Nursing and Midwifery 2016-2020,” the “United Nation’s 2030 Sustainable Development Agenda” and the work being done by the Global Advisory Panel on the Future of Nursing. Sigma Theta Tau Intl. If humanity is to survive, we must understand the gravity of planetary health and the environmental, humanitarian and sociopolitical global action items that we, as nurses, play a key role in helping to implement. Being a ‘global nurse’ is a shift in consciousness that allows us to understand the more global implications of what we say and do, what we choose not to say and do, and identify a plan to procure safety, peace, health and well-being for all life on the planet for generations to come.

*Interview by Paul Taylor, paul.taylor@aacn.org*
Nurse Practitioner-Staffed ICUs Give Safe, Effective Care

Advanced practice providers can render safe and effective ICU care and mitigate shortages in the critical care workforce.

A comparison of two medical ICUs (MICUs), one staffed by nurse practitioners (NPs) and the other by resident physicians, finds no difference in mortality rates.

“A Comparison of Usage and Outcomes Between Nurse Practitioner and Resident-Staffed Medical ICUs,” in Critical Care Medicine, concludes the results add “further evidence that advanced practice providers can render safe and effective ICU care.”

Conducted at Jefferson University Hospital in Philadelphia, from March 2012 to February 2013, the study involved 221 admissions to an eight-bed NP-staffed unit and 936 admissions to a 17-bed unit staffed by residents. Primary outcomes include MICU and in-hospital mortality, as well as lengths of stay in the MICU and in the hospital after MICU discharge.

Patients in the NP-staffed unit were older, more likely to be transferred from an inpatient unit and had a higher severity of illness. The only outcomes that differed were MICU length of stay and post-hospital discharge to a non-home location; both were higher in the NP-staffed unit.

The “main finding showed similar rates of patient mortality for the nurse practitioner-staffed MICU (14.5 percent) and the resident physician-staffed ICU (13.1 percent), both within national estimates of MICU mortality (12-16 percent),” explains a news release, which adds that “48-hour readmissions to the MICU were similar among the two groups of patients.”

“As healthcare evolves, our staffing models need to keep pace,” lead author Rachel Scherzer, an acute care NP at Jefferson, notes in the release. “These data back up what practicing doctors and nurses have known for some time — advanced practice providers can render safe and effective ICU care, and are part of the answer to shortages in the critical care workforce.”

REFERENCE: Scherzer R, Dennis MP, Swan BA, Kavuru MS, Oxman DA. A comparison of usage and outcomes between nurse practitioner and resident-staffed medical ICUs [published online September 14, 2016]. Crit Care Med.

Patients’ Data Vital to Successful Care

To provide the best possible experience for patients, every detail matters, and their satisfaction extends well beyond addressing physical ailments.

Good hospitals understand that many factors along the patient’s journey, including empathy, knowledge, cleanliness, wait time and staff approachability, contribute to overall wellbeing, according to “How to Improve Healthcare With Patient Journey Data,” on Customer Think. “The emotional state of the patient plays a major role in healing and patient wellbeing.”

“For providers, the best chance to get each of those details right exists in the patient data itself,” explains Sven-Olof Husmark, chief marketing officer at Qmatic Group, Sweden. Data gleaned from arrival information, wait times, total visit durations and post-care feedback can illustrate how well a provider manages elements such as patient flow, care levels and staffing. When quality data is generated and deciphered, actionable insights emerge, Husmark adds.

The article lists many benefits to engaging in and understanding patients’ data, including the following:

- Avoid unnecessary expenses, improve patient satisfaction and improve patient outcome scores by being aware of potential operational issues, training gaps or other causes of preventable medical errors.
- Lower the risks and costs by reducing readmissions. About 30 percent of annual healthcare costs and 20 percent of admissions occur within 30 days of a previous discharge, indicating that a diagnosis or treatment protocol may have been missed.
- Avoid emergencies by knowing where education and follow-up care are needed.
- Reduce operational costs by avoiding unnecessary procedures and fixing patient-process inefficiencies. This step could save an estimated $600 billion for the healthcare industry.
Rural Telehospice Awarded Innovations in Care Grant

The grants will leverage a federally funded telepalliative care model that provides remote, in-home hospice services in western North Carolina.

A telehospice serving rural western North Carolina is among the 2016 recipients of the Hillman Innovations in Care Program.

The initiative funds “nurse-driven programs that address the healthcare needs of vulnerable populations,” explains “Hillman Foundation Announces 2016 Innovations in Care Winners,” on www.rahf.org. Recipients receive a $600,000 three-year grant from The Rita & Alex Hillman Foundation, New York, which sponsors the program.

One of the grants will leverage a federally funded telepalliative care model at Four Seasons Compassion for Life, Flat Rock, North Carolina. The goal is to develop a program that provides remote, in-home hospice services in western North Carolina.

The grant will help implement a care management portal for the telehospice program. Specially trained nurses will provide hospice care by remotely handling “symptom and pain management, medication adherence, advance care planning, and spiritual and psychosocial needs.” Visits will be conducted via TapCloud (a HIPAA-compliant app) and a videoconferencing service.

Patients or caregivers will enter information on symptoms and medications with patient portal software. Nurses and the hospice team will use this information, including online vital sign measurement, to “monitor progress, adjust treatments and determine when in-person visits” are necessary.

Another grant will help “expand, evaluate, and sustain the Advanced Illness Care Program, a faith-based nursing-driven intervention” developed with Alameda County Care Alliance and the Public Health Institute.

“Each person-centered, community-focused program is uniquely positioned to make a national impact on the care of underserved populations with advanced illnesses,” Ahrin Mishan, executive director of the foundation, adds in the article. ☉
Strategies for Retaining Millennial Staff

Strong internal career development and advancement are part of the solution.

To slow nurse turnover, hospitals should supplement employee engagement efforts with a retention strategy focused on staff members younger than 35.

According to “Stop Turnover in the First Three Years,” on the Advisory Board website, the national healthcare turnover rate is trending steadily upward. “Our benchmarks pegged median hospital turnover at 13.4% in 2015 — indicating half of organizations have turnover above that rate. Leaders are concerned for good reason: staff turnover is disruptive and costly, and creates more work for HR, managers, and remaining staff.”

The study says the factors that engage staff are similar between millennials and other age cohorts with one important difference: Millennials, about one-third of the nursing workforce, tend to be more engaged than loyal early in their careers. “If you can retain them past the three-year mark, the gap between their levels of loyalty and engagement starts to close.”

The study identifies three characteristics that influence loyalty among millennials:

- They’re young, which means they have fewer past work experiences to compare.
- They’re likely thinking about the next year or two of their careers rather than long-term.
- They have more opportunities than ever in this labor market.

The study recommends key steps to retain millennial staff that include strong mentoring to help them manage their workload. It’s also important to have short-term growth opportunities and early-tenure career ladders in entry-level roles.

In addition, identify and redirect millennials’ thinking about leaving their jobs. Strategies include rewarding top performers, giving managers tools to identify nurses at risk of leaving and attempting to reverse resignations or at least learn from them.

“Career restlessness is a new norm in the workplace, so strong internal career development and advancement will have to be part of the solution,” states a related article on Emerging RN Leader, adding that nurse leaders play a key role in retention. “If you currently don’t do resignation recovery conversations with staff, now is the time to begin.”

Nurses as Leaders in Disaster Preparedness and Response

Opportunities exist to strengthen disaster readiness, enhance national surge capacity and build community resilience to disasters.

“Nurses as Leaders in Disaster Preparedness and Response – A Call to Action” presents a vision for the future of disaster nursing.

Published in Journal of Nursing Scholarship, the article details a project that represents an important step toward enhancing nurses’ roles as leaders, educators, responders, policymakers and researchers in disaster preparedness and response.

“At a time when disasters and public health emergencies are occurring with increasing frequency, it is essential that the breadth and untapped potential of the nursing profession be fully understood and deployed,” the article notes. “Despite considerable funding for hospital and public health preparedness since the attacks of September 11, 2001, efforts to prepare and mobilize nurses for disaster preparedness and response have been episodic and difficult to sustain.”

To generate the recommendations, a series of conference calls were held with 14 subject matter experts from September through December 2014.

The group identified current barriers and opportunities to advance nursing’s response to disasters. A broad array of recommendations for nursing practice, education, policy and research were developed, and implementation challenges were discussed.

The article states that “nurses comprise the largest healthcare workforce, and opportunities exist to strengthen disaster readiness, enhance national surge capacity, and build community resiliency to disasters.

“Further exploration of these ideas and a commitment to expand the national dialogue within the nursing profession and beyond is needed to truly achieve national nurse readiness.”
An ICU Communication Facilitator May Improve Quality of Care

Adding a full-time communication facilitator in the ICU may improve quality of care, while reducing healthcare costs, notes an article in *Annals of the American Thoracic Society.*

The results described in “Economic Feasibility of Staffing the Intensive Care Unit With a Communication Facilitator” are based on an analysis conducted by Nita Khandelwal from the University of Washington in Seattle and colleagues, explains a related article in *Physician’s Briefing.*

Data from a randomized trial of an ICU communication facilitator were analyzed using a simulation model that varied the full-time equivalent (FTE) of the facilitator and ICU mortality risk. The analysis linked to hospital financial records for 135 patients admitted to one hospital ICU. “Adjusted regression analyses assessed differences in ICU total and direct-variable costs between intervention and control patients,” the analysis adds.

Total and average daily ICU costs were much lower with the facilitator. With one FTE facilitator and a predicted ICU mortality of 15 percent, the model projected a total weekly ICU cost savings of $58,400 and weekly direct-variable savings of $5,700, including facilitator costs.

The analysis also indicates “the intervention is likely to be more cost-effective in a lower mortality population.”

**REFERENCE:** Nita Khandelwal N, Benkeser D, Coe NB, Engelberg RA, Curtis JR. Economic feasibility of staffing the intensive care unit with a communication facilitator [published online September 27, 2016]. *Ann Am Thorac Soc.*

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**Scholarship Opportunities for AACN Members**

**Would you like to attend a class or event to further your knowledge or enhance your career goals? Do you want to earn a Bachelor of Science in Nursing or a higher degree?**

AACN members can apply for Continuing Professional Development Scholarships anytime throughout the year.

Many opportunities are available, including:

- **VitalSmarts’ Effective Communications and Influencer Training**
- **Safe medication practices — webinars, lectures, educational programming and fellowships**
- **Various events and programs in your community and across the U.S.**

There are so many possibilities to suit your specific learning goals. Be sure to take advantage of this very special member benefit, and please allow several months for AACN to process your online application. Email scholarships@aacn.org with your questions.

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**AACNJ** — *American Association of Critical-Care Nurses.*
In Our Journals

Hot topics from this month’s AACN journal

Contrast-induced acute kidney injury (CI-AKI) is both prevalent and preventable among patients undergoing cardiac catheterization. In a multi-institution project, interprofessional teams implemented evidence-based interventions and successfully reduced the rate of CI-AKI. The interventions included patient education on oral rehydration, standardization of intravenous fluid orders, reducing nothing by mouth time, limiting the amount of contrast dye and type of dye used. The authors note that collaboration and transparency among the teams were essential to successfully implementing changes in practice.

(Brown, CCN, February 2017)

www.ccnonline.org

Embolism is the leading cause of ischemic stroke, and the most common source is cardiac emboli. Effective management of patients with cardioembolic stroke includes rapid neurological assessment and intervention, evaluation for cardiac risk factors and ongoing management of the complications that stroke-related disability creates. A case study describes the evidence-based medical and nursing management of patients with cardioembolic stroke and its impact on patient outcome.

By describing a single patient’s complicated hospitalization from admission to the emergency department through discharge to a skilled nursing facility, the authors convey the essential elements of managing cardioembolic stroke in an accessible narrative format.

(Babkair, CCN, February 2017)

www.ccnonline.org

Pain, anxiety and insomnia are frequent and distressing symptoms among progressive care unit patients. Researchers report that clinical massage and guided imagery are effective low-cost tools for managing patients with these symptoms. In a study of 288 patients, 243 reported significant immediate improvement in pain and anxiety following clinical massage. The other 45 patients in the study reported that listening to a guided imagery recording was effective in alleviating pain, anxiety and insomnia. The authors note that staff support and patient acceptance are key factors in integrating alternative therapies into the management of progressive care patients.

(Patricolo, CCN, February 2017)

www.ccnonline.org

Transitions

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

Martha A.Q. Curley. Ellen and Robert Kapito Professor in Nursing Science at University of Pennsylvania School of Nursing — a past recipient of AACN’s Distinguished Research Lectureship, who helped develop the AACN Synergy Model for Patient Care — is elected to membership in the National Academy of Medicine.

Betty Ferrell, director of nurse research and education at City of Hope, Duarte, California and a pioneer in the fields of palliative care and pain management, is named a Health Hero by WebMD. Robin Roberts, of “Good Morning America,” who presented the award at a gala, later tweeted, “Tremendously grateful to Betty and all nurses for their work and for bringing comfort to patients and their families.”

Kimberly Jackson, critical care nurse in the Cardiovascular Short Stay Unit at CaroMont Regional Medical Center, Gastonia — an AACN member since 1998 who has more than 31 years of nursing experience — is named one of the Great 100 North Carolina Nurses.

Richard Lawson, previously manager, becomes director of critical care and neuro progressive at Washington Regional Medical Center, Fayetteville, Arkansas. He earned a master’s degree in nursing from Western Governors University, Salt Lake City.

Brian Miser, family practitioner, who also serves in the U.S. Air National Guard, joins the staff of Primary Care and Hope Clinic in Murfreesboro, Tennessee. He previously worked in the Surgical ICU at the VA Medical Center in Nashville.

Cindy Munro, professor and associate dean of research and innovation at University of South Florida College of Nursing, Tampa, and co-editor-in-chief of American Journal of Critical Care, leads a research team at USF that received $1.9 million to study a potential method to prevent delirium in the ICU.

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.

To see the table of contents for the February issue of CCN, visit www.ccnonline.org.
Things to Do in Houston During NTI 2017

Sample the town’s vital food scene, dynamic music and arts, vibrant street culture and colorful attractions.

On a recent episode of “Parts Unknown,” host Anthony Bourdain confessed that he wasn’t prepared for Houston to be such an interesting place.

But with over 90 languages spoken, Houston is among the most ethnically diverse cities in the country. That diversity has helped create a vital food scene, dynamic music and arts, vibrant street culture and colorful attractions. It’s also helped reshape the town into what Forbes insists will be one of the next great global cities and what Business Insider calls “the best city in America.”

So, let’s find some fun things to do in this diverse and interesting place.

**Space out.** NASA is still Houston’s pride and joy, and even though the city no longer factors into America’s missions into the great beyond, Space Center Houston remains ground zero for viewing artifacts of our extraterrestrial past. That doesn’t mean Space Center Houston is a musty, old museum relic — it features an ambitious schedule of exhibits (frequently “Star Wars” related) and numerous interactive adventures packed with bells and whistles for kids. www.spacecenter.org

**Visit a museum or two.** With 19 different museums, Houston’s Museum District is one of the city’s great attractions. Some of the highlights include the Museum of Fine Arts, Museum of Natural Science, Children’s Museum, Rothko Chapel, Menil Collection, Holocaust Museum and Contemporary Arts Museum. Most of the museums are within easy walking distance of one another, and many are free of charge. www.houmuse.org

**Park it.** Discovery Green — the sprawling park in the middle of town — has been referred to as “Houston’s version of Central Park.” The park offers hundreds of events throughout the year, from free movie screenings to concerts and festivals. And even when there isn’t something going on, you’ll still find plenty to do. If you’re seeking peace and quiet, you’ll probably love Houston Arboretum & Nature Center. Located just a few miles from downtown, the 155-acre nonprofit nature sanctuary offers the perfect respite from the hustle and bustle of city life as well as the opportunity to experience native plants and animals. www.discoverygreen.com; www.houstonarboretum.org

**Shop vintage stores, and then head to the mall.** For all things vintage and retro — clothing, décor, collectibles — funky 19th Street in The Heights is the place to go. You’ll find a variety of fun and quirky shops featuring unique and delightful items. When you’re finished window shopping on 19th, you can head to the ultra-high-end Galleria mall, the antique stores, boutiques and thrift shops along Westheimer Road or the high-density hodgepodge of old and new retail stores lining Rice Village. Whatever your taste and budget, you’ll delight in Houston’s fantastic variety of shopping options. www.visithoustontexas.com/things-to-do/shopping

**Satisfy your Texas-sized appetite.** With more than 10,000 restaurants, the red-hot Houston culinary scene offers a plate for every palate — everything from puffy fried tacos to Korean braised goat and dumplings to lemongrass-infused Viet-Cajun crawfish to authentic Jewish deli pastrami on rye. Oh, and you can get queso-coated everything. And there are food trucks galore. If you can name or describe it, Houston’s probably got it. Don’t forget to pick up a few bags of the city’s famous chocolate-covered corn chips, pretzel sticks and chopped pecan brittle. You’re welcome. www.visithoustontexas.com/restaurants

Wherever your explorations take you in this one-of-a-kind town, we’re sure you’ll agree that Houston is a big city with loads of Southern charm.
As a community of exceptional nurses, we work together to achieve our vision of a healthcare system driven by the needs of patients and their families. Your participation in advancing AACN’s mission is essential. Because of the significant contributions you and your fellow members made last year, our AACN community was able to accomplish exceptional things. Here’s just a partial list.

- Over 8,000 nurses returned to their patients from NTI 2016 in New Orleans inspired and ready to share newly acquired knowledge with their colleagues.
- Nurses far and wide now benefit from a state-of-the-art new website, based on your input, with enhanced access to clinical and professional resources, others within the community and sources of inspiration.
- Leading experts from the AACN community provided seven new, no-cost AACN critical care webinars featuring the latest evidence-based learning and clinical practices for thousands of participants.
- Through AACN CSI Academy, teams of nurses throughout the country led projects focused on improving patient outcomes such as preventing delirium, infections and pressure ulcers, and advancing beneficial new programs to ensure progressive mobility, better communication and more-effective rapid response.
- The AACN community now has the collective and individual influence of more than 107,000 members focused on fulfilling their promise to patients and families.
- Over 1,500 volunteers contributed their knowledge and expertise to a multitude of projects that advanced the mission of AACN.
- More than 220 AACN chapters continued to advance nursing excellence in their communities, offering opportunities for leadership, education and service.
Incorporating a decade’s worth of research and evidence, AACN released the second edition of the landmark “AACN Standards for Establishing and Sustaining Healthy Work Environments.” The standards are the blueprint for what must be present to remove the significant barriers that thousands of AACN members reported are getting in the way of delivering the exceptional care they aspire to provide in this increasingly complex healthcare system.

The vital work of nurse researchers aimed at driving change in high-acuity and critical care nursing practice was advanced through the provision of $160,000 in grants.

Through the efforts of a wide array of clinical experts and nurse educators, the revised Essentials of Critical Care Orientation (ECCO) 3.0 was launched, providing a standardized approach to preparing nurses new to critical or progressive care at the bedside.

We recognized 171 hospital units for their demonstration of nursing excellence with the Beacon Award for Excellence.

We achieved a new milestone — over 100,000 nurses have now validated their clinical knowledge and commitment to patient safety by becoming certified through AACN Certification Corporation.

Through generous contributions from the community to the AACN Scholarship Endowment, AACN supported members on their professional development journeys with over $100,000 in scholarships.

Our AACN community advances and advocates for the nursing profession through our increasing work in coalition with other organizations to positively influence healthcare and the environments in which our nurses practice. Among the 39 groups we worked with this year:

- The Nursing Community, Nursing Organizations Alliance and ANA Organizational Affiliates
- Critical Care Societies Collaborative (AACN, American Thoracic Society, American College of Chest Physicians and Society of Critical Care Medicine)
- Institute for Healthcare Improvement
- Institute for Patient- and Family-Centered Care
- Centers for Disease Control and Prevention
- Association for the Advancement of Medical Instrumentation
- World Federation of Critical Care Nurses
- Licensure, Accreditation, Certification, Education (LACE) work group

"As nurses we know that when we show up and speak up about things that impact the quality of care that we deliver and the environment in which we work — It Matters."

—Clareen Wiencek, AACN President

**It Matters**

Thank you for your unique role in advancing AACN’s vital mission. Whether by guiding your practice with evidence-based resources, becoming certified or supporting AACN’s free resources with your membership dollars — It Matters ... and You Matter!
Which organ in the body matters most? ICU teams have bantered about this for a long time, so I conducted a small review of three journals to answer the question. Is it the heart — that hardworking pump? Or is it the lungs and pulmonary system — that portal to the most vital substance, oxygen? Or perhaps the brain and its 100 billion neurons that control the other organs and our very humanness? I reviewed major articles in American Journal of Critical Care, Critical Care Nurse and Critical Care Medicine. Using less than robust methods, I chose cardiovascular titles as the winner, with sepsis a close second and pulmonary topics in third place.

This review supported my belief that the heart matters and aligns with February as National Heart Month and a time when we celebrate love. Love and caring are associated with the public image of the kindhearted nurse. But can this image — this caring narrative — that suggests nurses are valued most for their personal virtues such as compassion and niceness actually create a barrier to the public truly understanding what nurses do?

I recently heard Suzanne Gordon speak. She’s an American journalist and author of multiple books on nursing’s public image, including “From Silence to Voice: What Nurses Know and Must Communicate to the Public.” Gordon implores nurses to change the way we talk about caring and to boldly inform the public that nurses’ brainwork is the foundation of our care work.

To answer Gordon’s challenge, you can take a different view of the tasks you complete during your shift. These tasks matter, and yet perhaps there is a different way to talk to patients and families about them:

- “I will be checking on you often tonight so you will not fall and enable you to get home sooner.”
- “I do a regular assessment of your husband to look for signs of confusion or agitation, so that he will be less likely to experience negative long-term effects that some patients can have after their ICU stay.”
- “It takes courage for me to tell a physician that they didn’t wash their hands, but I do that so patients are less likely to get infections.”
- “My nursing tasks ensure that our team follows high-quality clinical standards to prevent infections, falls, low blood pressure, pain and other complications that can happen in the course of being a patient in the ICU.”

Nurses know that holistic care is both the whole and the interdependence of its parts. Just as we know that our patients cannot survive with just their heart, we know that even the most skillfully applied compassion without critical thinking, professional judgment, knowledge of physiology, pharmacology and evidence-based practice does not fully define what we do.

We know that what we do matters, but the public does not always know. The day after I heard Suzanne Gordon speak, an old friend asked me, “What do nurses do?” His daughter is a new nurse on a neuro stepdown unit. He was sincere and earnest in his question. I thought about using Gordon’s elevator speech that nurses save lives, relieve pain and suffering, and save money. But instead I used my version: Acute and critical care nurses save the lives of the sickest patients, relieve pain and suffering in the most vulnerable, and create most of the value that hospitals provide.

Construct your own version that explains why what you do matters, and share it with me at itmatters@aacn.org. Because you are more than your caring heart, lungs or brain — you are a nurse, and It Matters.

At AACN’s premier educational conference for high-acuity and critical care nurses, 7,000 colleagues come together to share, learn and celebrate. Create your educational plan with more than 300 clinical and professional practice topics, while earning up to 37.5 CEs on-site. Add more CEs when you view and share sessions at home.

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*patent pending