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When I was twelve, my family moved from the country to the crowded suburbs of New Jersey, and I felt we had done the unforgiveable — we had left behind the place that supported us and gave us everlasting life. There were no more rose bushes or rows of irises and hollyhocks. I could no longer pick apples from our yard or run down the road to get fresh eggs from the neighbor’s farm.

Years later, I realized that the land is always with us. The world as we first knew it remains imprinted on the body and the brain like tiny fossils embedded in a piece of shale. As a child, one has that magical capacity to move among the many eras of the earth; to see the land as an animal does; to experience the sky from the perspective of a flower or a bee; to feel the earth quiver and breathe beneath us; to know a hundred different smells of mud and listen unself-consciously to the soughing of the trees. We are continually articulating the intelligence of the planet, which has grown up through all the species. The whole earth lives within us, and in every moment, we are both its creators and discoverers. We only need to reawaken all these early memories.

—Valerie Andrews


Nurses are experts of the workaround. Granted, we know that some processes are not patient-focused but may be in place to meet regulatory standards. Granted, we accept that hospitals, whether big or small, are complex organizations that strive to do what is right for patients and families — and employees. Yet, if a barrier is placed between a nurse and the care she or he knows the patient needs, it matters that that same nurse will work hard to remove the barrier.

Read more in my note on page 22.

Clareen Wieneck
AACN President

Never let your obstacles be higher than your goals.

—John Wooden
The American Association of Critical-Care Nurses (AACN) is the world’s largest specialty nursing organization. It 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, FCCN, PCCN-K, CCNS, ACCNS-AG, ACCNS-P, ACCNS-N, ACNP, 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 2017: Education, Excellence and Inspiration Made for You

Preview some of this year’s diverse learning opportunities, inspirational gatherings and networking options:

Attend a preconference Sunday, May 21, or sightsee. Deep dive into a topic relevant to your practice when you register for a hands-on, interactive learning preconference. “Navigating NTI 101,” Sunday at 4 p.m. or Monday at 8 a.m., is a must-attend for first-timers and also for experienced NTI attendees who want a refresher. Or arrive early to sightsee.

Feel the magic at Monday’s kickoff SuperSession. AACN President Clareen Wiencek tells us what she’s learned watching us live our theme, “It Matters.” She’s joined by Ving Giang, a businessman and entrepreneur. He’ll open our minds to new possibilities, as he takes us on an unforgettable journey through his stories, remarkable insights into human psychology, business and the wonderful art of magic. His insights set the tone for the first day’s concurrent sessions.

Hear a story of inspiration and healing. Tuesday’s SuperSession features Jennifer Arnold. She stars on TLC’s docudrama “The Little Couple” and has appeared on other television programs, including “Oprah,” “The Today Show,” “Good Morning America” and “The Dr. Oz Show.” During her keynote, Arnold will share how she gained a new appreciation for life after some difficult times and discovered how important it is to be “quality-of-life driven.”

Don’t miss Tuesday’s opening of the Critical Care Exposition, and take in at least one cutting-edge ExpoEd session in the exhibit hall. Advanced practice or certified nurses can party at the Certification Celebration Dinner or API Reception.

Create your masterpiece. At Wednesday’s SuperSession, President-elect Christine Schulman announces our new theme, followed by Erik Wahl. Wahl is a graffiti artist, best-selling author, entrepreneur and philanthropist. He will discuss innovative thinking and how to attain superior performance by using creativity to rethink life, “a blank canvas of limitless opportunity on which to create your masterpiece,” he says.

A night at the museum for Nurses’ Night Off. Explore a fascinating variety of exhibits, with dancing and dessert at the Houston Museum of Natural Science.

Do more in and around Houston. Staying in town Thursday? Attend concurrent sessions through lunchtime. Then explore — Houston has so much to see and do! 🌋

NTI 2017 Early-Bird Registration Ends April 5

AACN’s National Teaching Institute & Critical Care Exposition (NTI), the premier conference for high-acuity and critical care nurses, celebrates 44 years at the forefront of critical care nursing, when it comes to Houston May 22-25 (preconferences May 21).

NTI offers incredible value and a vast choice of educational opportunities through more than 300 sessions and hundreds of exhibitors at the Critical Care Exposition. Register by Wednesday, April 5, to take advantage of early-bird pricing for the main conference.
Putting ‘Caring Practices’ Into Action

Nurses on MD Anderson’s P7 unit embody the Caring Practices component of the Synergy Model, the framework underlying AACN certification programs.

Gallup’s recent annual poll on honesty and ethics reveals that nursing remains the most trusted profession in the U.S. This trust is built not only on clinical competency and expertise, but on nurses’ ability to convey their compassion and concern for patients and families in a palpable way. In Maya Angelou’s words, “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

This is especially true in today’s complex and technology-focused healthcare landscape, where caring, which is at the core of nursing practice, may be overshadowed. However, Caring Practices can play a significant role in achieving optimal patient outcomes and maintaining a competitive edge in patient satisfaction.

Caring Practices is one of seven nurse competencies in the AACN Synergy Model for Patient Care, the framework for AACN certification test plans and renewal programs. Caring Practices is defined as:

Nursing activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing, and preventing unnecessary suffering. These caring behaviors include, but are not limited to, vigilance, engagement and responsiveness of caregivers, including family and healthcare personnel.

What do Caring Practices look like in day-to-day practice? The actions and culture of the P7 Telemetry/Thoracic and Cardiovascular Surgery Unit at The University of Texas MD Anderson Cancer Center, Houston, provide a glimpse into how one group of nurses brings the concept of Caring Practice to life.

Patient and Family Care

“On P7, we create a healing environment for our patients and our staff by cultivating a culture of caring,” says Lyzanne Mason, P7 associate director and CCRN-CSC certificant. “Our staff treats patients and their families as if they were members of their own family.”

As an example, Mason shares that P7 “recently received an Awesome Job award for which a family member stated, ‘Your nurse had such a caring touch for my husband. She explained everything that was to be expected, all his medications, and made me feel so comfortable he would be provided with exceptional care that I actually went home last night to get some sleep.’ Certainly many caregivers can relate to the magnitude of this statement.”

Mason also emphasizes the collaboration and teamwork demonstrated on the unit.

“With the spring rains and flooding that hit the Houston area last year, P7 came together to make sure all of our patients were safe and given high-quality care despite staffing challenges. Our Patient Service Coordinators assisted the team by changing patient linens when patients were off the unit, stocking the unit and keeping our team on-task with increased communication about pending tests and procedures. Our Leadership Team helped out to make sure patient care was well coordinated.”

Staff Well-Being

Mason says the P7 team “has a firm belief that one of the best ways to promote great healing and exceptional care is to take care of ourselves.”
She points to the unit’s recently renovated staff tranquility room as an example. “We’ve been able to create a space complete with recliners, a shiatsu massage pillow, aromatherapy, a natural sound and sleep machine, prayer mats and yoga equipment. All of our staff — including our surgeons — is encouraged to use the room for meditation, relaxation and prayer on a regular basis.

“The staff is very proud of this inclusive space that respects the uniqueness of our multicultural team,” Mason adds. “After visiting the tranquility room, they report feeling rejuvenated, refreshed and better able to focus on their patients.”

Nurses on P7 also rally and come to each other’s aid when faced with adverse and stressful situations.

“This past year, one of our most experienced nurses was faced with a personal tragedy,” Mason says. “Her daughter was involved in a motor vehicle accident — a traumatic brain injury involving multiple surgeries and an extended recovery with extensive rehabilitation. The unit raised funds so that this nurse would have enough money to cover meals, parking and coffee, and could remain at her daughter’s bedside.”

The Family Perspective
The P7 team’s efforts are making a difference. The family of a patient with cancer — who wishes to remain anonymous — shares their experience with caring practices demonstrated by P7 staff.

“From the moment we stepped on the unit, we personally experienced this caring attribute from each nurse, staff member and volunteer we came in contact with,” says the patient’s sister, who is an RN herself. “The nurse who greeted us was professional and thorough, yet warm and engaging, and this was representative of the culture of the unit. She provided a comprehensive introduction to the room, unit and hospital processes, and reviewed the plan of care with us. We were viewed as a welcome addition to the healthcare team.”

The patient’s mother says, “I was extremely impressed with the quality of the nurses and the level of care provided. We were right there the whole time and were treated with dignity, respect, care and compassion. I was never made to feel like I was interrupting when I wanted information. As a mother, that was greatly reassuring.”

The patient’s sister was reassured, as well. “I had planned to spend the night in the room, but after observing the nurses’ vigilance and attention to detail, I knew my sister was in good hands. I felt comfortable walking out the door, which made my sister feel safe, since she knows how particular I am. It allowed her to relax and not worry, which is so important for healing.”

Some examples of Caring Practices include therapeutic touch, comfort measures, therapeutic communication, stress management and dealing with grief/loss. Caring Practices can be found in AACN specialty and advanced practice certification test plans. Several certification renewal programs require minimums in categories A, B and C. Caring Practices can be found in Category B, which also includes Response to Diversity, Advocacy/Moral Agency and Facilitation of Learning.

To learn more about nurse competencies in the AACN Synergy Model for Patient Care and AACN certification programs, visit www.aacn.org > Nursing Excellence > AACN Standards > Synergy Model.
Mortality Rates of Four Major Cancers Decline

The decline in cancer mortality over the last two decades is the result of steady reductions in smoking and advances in early detection and treatment.

Cancer death rates in the U.S. declined 25 percent from 1991 to 2014, resulting in about 2.1 million fewer deaths than expected if rates had remained at their peak, states the American Cancer Society (ACS) in a new report.

“Cancer Statistics, 2017,” in CA: A Cancer Journal for Clinicians, also finds that racial disparities in cancer deaths are declining, and five-year survival rates have increased 20 percent among whites and 24 percent among blacks.

“The decline in cancer mortality over the past two decades is the result of steady reductions in smoking and advances in early detection and treatment, reflected in considerable decreases for the four major cancers (lung, breast, prostate, and colorectum),” the report states.

In 2017, nearly 1.7 million new cancer diagnoses will occur nationwide and about 600,000 deaths, according to the report, which lists national and state estimates based on data through 2014.

Despite the declines, the report notes that “death rates are increasing rapidly for cancers of the liver (one of the most fatal cancers) and uterine corpus, both of which are strongly associated with obesity.” Also, a significant gender gap remains, as men have higher rates of cancer (20 percent) and mortality (40 percent) than women.

Over the past decade, however, cancer incidence remained stable in women but declined about 2 percent annually in men, while the death rate declined about 1.5 percent annually in both men and women, the report shows.

“The continuing drops in the cancer death rate are a powerful sign of the potential we have to reduce cancer’s deadly toll,” Otis Brawley, ACS chief medical officer, says in a related article in The Washington Post. “Continuing that success will require more clinical and basic research to improve early detection and treatment, as well as creative new strategies to increase healthy behaviors nationwide.”


PSA Level Could Signal Patients Most at Risk

For men with prostate cancer, a PSA value above 0.5 ng/mL after radiation (RT) and androgen deprivation therapy (ADT) indicates a high risk of death requiring immediate treatment.

“Surrogate End Points for All-Cause Mortality in Men With Localized Unfavorable-Risk Prostate Cancer Treated With Radiation Therapy vs. Radiation Therapy Plus Androgen Deprivation Therapy: A Secondary Analysis of a Randomized Clinical Trial,” in JAMA Oncology, compares the effect of RT alone vs. RT plus six months of ADT in 157 men, median age 72.4, with localized prostate cancer.

If a patient’s PSA value remains above 0.5 ng/mL, the treatment has likely failed and the cancer could become fatal, reports a related article in NBC News. “By identifying and enrolling these men in clinical trials immediately, the hope is to take a prostate cancer that appears to be incurable and make it curable,” lead study author Trevor J. Royce, a radiation oncologist at Harvard Medical School, adds in the article.

Good Work Environments for Nurses Can Improve Outcomes

Good nurse work environments appear to provide a strong signal for better quality, lower cost and higher value.

Hospitals with good work environments for nurses and above-average staffing levels produce better patient outcomes for similar costs, especially for higher-risk patients.

“Comparison of the Value of Nursing Work Environments in Hospitals Across Different Levels of Patient Risk,” in Journal of the American Medical Association Surgery, finds that 25,752 patients in 35 hospitals with nationally recognized good work environments for nurses and nurse-to-bed ratios of one or higher (local hospitals) had lower 30-day mortality rates than a group of 25,076 patients exactly matched for 130 surgical procedures in 293 control hospitals.

Examining data from older Medicare general surgery patients at the local hospitals in three states from 2004 to 2006, the analysis estimates these hospitals had a lower average overall cost per patient (-$163) with mortality rates of 4.8 percent, compared to 5.8 percent in control hospitals.

Patients in the focal hospitals had lower 30-day failure to rescue rates (7.5 percent vs. 8.9 percent), shorter lengths of stay (8.4 days vs. 8.6 days) and were less often in the ICU (32.9 percent vs. 42.9 percent). Since intensive care use was dramatically lower at the local hospitals, the analysis adds, “this finding could be consistent with better nursing care on the floor, acting as a substitute for ICU care or other resource utilization for some patients, possibly leading to lower overall resource utilization and contributing to the business case for improving nursing environments.”

Because value-based healthcare analysis has grown in importance in U.S. policymaking, the analysis suggests that further research might explore whether hospitals that improve nurse work environments also achieve increases in value. “While better outcomes and value may be owing to other features of hospitals with good nursing, excellent nursing environments appear to provide a strong signal to patients and referring physicians for better quality, lower cost, and higher value.”


Resources for Healthy Work Environments

AACN Standards for a Healthy Work Environment – www.aacn.org/hwe

AACN Healthy Work Environment Assessment Tool (free) – www.aacn.org/hwe

(Note: CE expires June 1, 2017.)
Rural America Hit Hard by Leading Causes of Death

Rural America is most in need of healthcare services, yet it has the fewest options.

Mortality rates for the nation’s top five causes of death are higher in nonmetropolitan (rural) areas.


About 46 million Americans (15 percent) live in nonmetropolitan areas, where rates of smoking, hypertension, obesity and physical inactivity during leisure time are higher than urban areas, and residents have less access to healthcare services and are less likely to have health insurance. They also tend to be older and not use seat belts.

For each leading cause of death, the study identified three states with the lowest death rates from 2008-2010 and averaged those rates. Deaths were considered “potentially excess” if the number of deaths among people younger than 80 exceeded benchmark rates.

“Previous CDC research has identified that a substantial proportion of deaths in each of the five categories could have been avoided. But the data from the latest report showing more premature deaths in rural areas represents a new finding,” notes a related article in The Washington Post.

Alan Morgan, chief executive of the National Rural Health Association, adds that rural America is most in need of healthcare services, yet it has the fewest options. “When the federal government tries to address health disparities, it usually focuses on large population areas where they can get the most bang for the federal dollar,” Morgan says. “And that leaves vast areas of America without a federal or state partnership on ensuring access to care.”

The article adds that measures to address rural disparities could include “more comprehensive screening for high blood pressure and cancer, plus increased efforts to get residents to quit smoking and wear seat belts.”


Portable Biosensors Offer Useful Insights

New wearable biosensors take frequent measurements of health-related physiology.

“Digital Health: Tracking Physiomes and Activity Using Wearable Biosensors Reveals Useful Health-Related Information,” in PLOS Biology, notes that a team at Stanford University School of Medicine, California, recruited volunteers who were given one to seven off-the-shelf health and activity monitors to wear. Heart rate, blood oxygen, skin temperature, calories expended and even exposure to gamma and X-rays were used to establish a baseline.

A custom algorithm helped find patterns in 250,000 daily measurements for up to 43 individuals. Nearly 2 billion readings were collected, plus periodic data from laboratory tests of blood chemistry and gene expression.

“Wearable devices were useful in identification of early signs of Lyme disease and inflammatory responses.” In addition, “wearables distinguish physiological differences between insulin-sensitive and -resistant individuals,” the study adds.

“Overall, these results indicated that portable biosensors provide useful information for monitoring personal activities and physiology and are likely to play an important role in managing health and enabling affordable health care access to groups traditionally limited by socioeconomic class or remote geography.”

Diabetes Tops U.S. Healthcare Spending List

Pain conditions, including lower back and neck, are the largest treatment category for working-age adults and one of the fastest-growing spending areas. Spending to diagnose and treat patients with diabetes tops the list of U.S. healthcare expenditures — $101.4 billion of the $2.1 trillion total in 2013 — and is growing 6 percent per year.

According to “US Spending on Personal Health Care and Public Health, 1996-2013,” in JAMA: The Journal of the American Medical Association, diabetes ($101 billion), ischemic heart disease ($88.1 billion), low back and neck pain ($87.6 billion), high blood pressure ($83.9 billion) and fall injuries ($76.3 billion) add up to 18 percent of total spending. Although the study categorizes 155 health conditions, the care for only 29 combined cancers is about $115 billion.

Also listed are depression ($71.1 billion), dental care ($66.4 billion), vision and hearing ($59 billion), skin-related issues ($55.7 billion), and pregnancy and postpartum care ($55.6 billion). “There are things on that list that, when we think of health care, they’re not necessarily the things the average American would think of,” lead study author Joseph Dieleman says in a related article in U.S. News & World Report.

From 1996 to 2013, total spending climbed an average of 3.5 percent per year, but diabetes spending grew 36 times faster than expenses for heart disease. Over 57 percent of diabetes costs were for pharmaceuticals, and 23.5 percent were for outpatient care.

A variety of pain conditions, including low back and neck, are the largest treatment category for working-age adults and one of the fastest-growing spending areas. “Low back and neck pain is certainly one of those places where we’re spending a lot, and it encourages us to look closer and evaluate what we are getting out of that spending,” Dieleman adds in the article.

The largest age group for spending by far is women 85 and older, with men’s spending peaking between ages 65 and 74. Overall, women account for about 25 percent more total spending, even excluding pregnancy and maternity costs.


MRI-Safe Infusion Pump Receives FDA Clearance

The Food and Drug Administration (FDA) has cleared a non-magnetic MRI-compatible infusion pump.

“Iradimed’s MRI Compatible MRidium 3860+ IV Infusion Pump FDA Cleared,” in MedGadget, notes the device — made by IRadimed Corp., Winter Springs, Florida — is designed with a non-magnetic motor and non-ferrous components, and the infuser is not affected by magnetic fields.

It’s safe to use near magnetic resonance imaging (MRI) machines up to 3.0 Tesla, which would be almost any hospital scanner. This feature is important for patients who must remain on medication or children who are sedated to remain still during a scan.

In the past, clinicians have set up long lines of extension tubing to non-MRI-safe pumps. That process could increase infection risk and deliver inaccurate doses, because non-MRI-safe infusers could be adversely affected by the strong magnetic field.

The infuser also operates independently of power sources by using an internal lithium battery that can pump doses from 0.1 mL to 1,400 mL/hour for both pediatric and adult patients. It can deliver 125 mL/hour for up to 12 hours on a single charge. The device also offers adjustable KVO rate, occlusion detection, air-in-line detection and delivery via syringe, bag or bottle.
On June 12, 2016, a lone gunman killed 49 people and wounded 53 others at Pulse, a nightclub in Orlando, Florida, the deadliest mass shooting by a single shooter in U.S. history. Thirty-five patients were admitted to Orlando Regional Medical Center — all of whom survived. Trauma nurse Marisa Kreuzer was one of those on hand providing direct care.

How did you choose nursing?
Well, my sister is a nurse. I’ve got an aunt that is a nurse. I like helping people. I’m compassionate and just felt like it was the right thing for me to do.

What was it about trauma nursing that attracted you?
It was the adrenaline rush. It was the fast pace, the critical care thinking and the variety of injuries that you saw with trauma. It was kind of a wide variety of things to learn with terms like multisystems.

Were you already working, or were you called in, on the day of the shooting?
I was actually off. I had woken up at about 9 that Sunday morning, and it was all over the news, and as soon as I saw that, I had called my unit — the trauma ICU — to see if they needed help. They said that I would be able to come in and help out, that was basically all hands on deck at that point, so I had gone in. This is roughly probably around 10.

What was it like when you got there?
The amount of media surrounding the area was very overwhelming. I’ve never seen anything like that before, and then just all the police vehicles — the club is very close to the hospital, and I had to take a detour. Seeing all of the police vehicles was very overwhelming. Upon walking into the unit then it was still somewhat chaotic, but it seemed there was some level of control.

In regard to the media and police, is it easy to ignore all that and get to work?
No, it wasn’t. Normally I would be driving past the Pulse nightclub to and from work every day. However, with the media they had that area blocked off, so I had to take a detour for I don’t recall exactly how long it was after that, but there was a detour, and you could still see, though, where all the media people were outside the hospital.

What did you experience at the hospital?
Upon getting into the trauma ICU at that time there was a patient coming back from the operating room. There were multiple physicians helping bring the patient into the room, so I went and jumped in and was helping take care of that patient, and at that point that particular patient was probably a four-to-one, as in four nurses to one patient, and there were multiple physicians in the room constantly as well. This is the patient that sticks out to me the most from that whole experience.

And this was the first one you saw?
This is the first patient that I helped to take care of, yes. This patient had sustained multiple abdominal and multi-organ injuries and was taken to the operating room several times within a 24-hour period. This patient also received more blood products than any other patient I’ve ever seen and was essentially on our massive transfusion protocol for 24 hours or so.

What was the outcome?
Well, all the patients that were admitted survived.

Did you have any idea what to expect when you walked into the hospital?
No, I did not know what to expect. In terms of preparation, we do practice mass casualty drills.

But I can’t imagine that anything really prepares you for the real thing.
No, and I’m not prepared for the types of things that I saw either that day in terms of wounds and the patients and patients’ families.

How do you get beyond that to concentrate on the care itself?
It was difficult. Throughout that first day if I had like one second to stop and think I wanted to break down and start crying, but I had to remember that this is a patient I’m taking care of. There is a job to be done. We need to help these people. I need to stay strong right now and help take care of these people.

How long were you there that day?
I was there until probably about 7:30 or 8 that evening, because our shifts are 7 to 7.
There had to be a time where you processed what you just went through or saw. Do you remember how you dealt with that?
Yes. I would say it was probably when I got into my car after that first shift and had a moment of quiet to kind of start processing everything.

What was that like?
It just is a flood of emotions. First and foremost, I was sad that somebody could actually do something like this to all those innocent people, and then at the same time I was also proud of the team that I work with to see how we all came together. I think we have a very strong team with the trauma team, including the emergency room, the trauma ICU nurses or trauma step-down nurses, the physicians. Our whole trauma team in general is a very strong, knowledgeable group, and I am so proud to be a part of that. From that experience it really showed how well we all can work together.

Did your experience caring for these patients reinforce your desire to be in trauma nursing — or did you have doubts about it?
I never had any doubts about it. If anything, it confirmed my desire to work in trauma.

You mentioned the first victim that you treated. Was there anything else — an incident or experience — during the course of that day that still stands out to you?
Yes. We take care of gunshot victims all the time, but this was different. I’ve never seen bullet wounds like those that I saw that day, and the patients. The bullet wounds themselves were larger than any I’d ever seen.

The extent of the injuries really stood out?
Yes, and also there were some patients that were able to talk later in the day, and there were patients that did remember everything from in the club. That was heartbreaking to have to hear.

I would imagine after the initial trauma care you probably talked to patients, helping them talk through it. That’s hard to say. I guess the thing I can kind of build on is what other things — after all of this there was a meeting just to see how well the patients — to see their progression and to see them get better. This particular patient that I’ve been mentioning, I did go see him on our step-down unit, and at that point he was doing better and able to talk to me. And I just remember going into the room and immediately grabbing the patient’s hand, and I just started crying, and I apologized, and I said that I just was overwhelmed with joy to see how well he was doing, because you see someone coming in that is almost dying to now this person’s able to talk to me, and I was able to help be a part of that progression.

“Throughout that first day if I had like one second to stop and think I wanted to break down and start crying, but I had to remember that this is a patient I’m taking care of. There is a job to be done. We need to help these people. I need to stay strong right now and help take care of these people.”

You said after you were done you went to your car and began processing what you’d just been through. After that initial processing did you find it easy to move on and get back to work?
No. Even after the road by the club wasn’t blocked off anymore, it took me a long time just to be able to drive past the club without getting tears in my eyes. And then also I don’t know how much this was shown on the news or anything, but on the entrance to the hospital somebody had made these 49 white crosses. On these 49 white crosses then families had put pictures of the victims, and these are the 49 people that did not make it out of the shooting, that did not survive. Having to drive past that in and out of work every day too was very difficult. At one point I thought, “OK, I feel a little bit better.” I was getting back into a routine, and then those crosses were put up, and then the pictures were put up, and then you see all these people are by the crosses grieving. That was very difficult, and that made it harder to move on as well.

Is there anything we haven’t talked about that you’d like to add?
I guess through this whole thing, the whole tragedy, one thing that it has shown me that even after such a terrible tragedy that even the community as a whole, how everyone was able to find strength and compassion and come together and rise above.

Interview by Paul Taylor, paul.taylor@aacn.org
Patients on Same Ward May Share Negative Outcomes

One explanation could be that units divert resources to a critically ill patient and become less attentive to other patients during a crisis.

A patient with cardiac arrest or transferring to intensive care increases the likelihood of other patients on the same ward having their own setbacks.

"Association Between In-Hospital Critical Illness Events and Outcomes in Patients on the Same Ward," a research letter in JAMA: The Journal of the American Medical Association, finds that one patient with cardiac arrest or transferring to the ICU in a six-hour period raised the risk of a setback in another patient about 18 percent. Multiple events in the preceding six hours increased the risk about 53 percent.

The observational cohort study, which reviewed 83,723 admissions from 13 medical-surgical wards (with about 20 beds per ward and an average 4:1 patient/nurse ratio) at University of Chicago Medical Center from 2009 to 2013, identified 179 cardiac arrests and 4,107 ICU transfers. "Although the absolute increased risk was small, these events were associated with high morbidity and mortality."

The letter suggests that one explanation for this domino effect could be that units divert resources to a critically ill patient and become less attentive to other patients during a crisis. "Following these high-intensity events, our to-do list should include a thorough assessment of the other patients on the unit, to make sure none of them are at risk of slipping through the cracks," study co-author Matthew Churpek, assistant professor of medicine at the University of Chicago, adds in a news release.

Patients experiencing the primary events averaged 60 years old (vs. 57 for those without an event), were more likely to be male (53 percent vs. 50 percent) and had longer median lengths of stay (12.8 days vs. 3.0 days).

The letter adds that more study is needed, and limitations include "the retrospective design, single center, unavailability of patient-specific clinical information or reason for admission, and possible residual confounding."


Relationship Between Safety Culture and Patient Experience

Teamwork, adequate staffing and organizational learning help create a positive patient experience.

Modifiable aspects of hospital culture can improve Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) top box percentages. "The Relationship Between Nurse-Reported Safety Culture and the Patient Experience," in JONA: The Journal of Nursing Administration, explains the study was designed to shed light on the “relationship between nurse-reported safety culture and the patient experience in a multistate sample of nurses and patients, matched by hospital unit/service line and time-frame of care delivery.”

Multivariate, mixed-effects regression models were specified using multistate data from hospital units that administered both the Agency for Healthcare Research and Quality (AHRQ) staff safety culture survey and the HCAHPS patient satisfaction survey during a 12-month period.

After key variables were correlated, the findings highlighted the relationship between teamwork, adequate staffing and organizational learning on achieving a positive patient experience. The study presents the following examples of interventions that could have positive effects:

- Empower nurse managers to make staffing changes to accommodate fluctuating workload
- Improve consistency of staff assignments to increase communication, teamwork and learning from opportunities
- Strive to reduce nursing staff turnover

A notable strength of the study is that data from two sources (nurses and patients) are linked by time and hospital service unit, as well as the surveys from AHRQ and HCAHPS.

Correctly Prioritizing ICU Admissions

Using SCCM guidelines to prioritize ICU patient admissions could improve care and efficiency and save costs.

More than half of ICU admissions at a large academic medical center did not have the correct priority status.

“Priority Levels in Medical Intensive Care at an Academic Public Hospital,” a research letter in *JAMA Internal Medicine*, evaluates the priority ranks that could have been applied to 808 medical ICU admissions from July 2015 to June 2016 at a hospital in Los Angeles, using Society of Critical Care Medicine (SCCM) guidelines.

SCCM priority ranks and the ICU’s admission percentages:

- Priority 1 (critically ill and best suited to ICU admission) = 46.9 percent of admissions
- Priority 2 (not critically ill but requiring close monitoring) = 23.4 percent
- Priority 3 (critically ill with low likelihood of recovery) = 20.9 percent
- Priority 4 (equivalent outcomes outside ICU) = 8.8 percent

“Over 50% of patients admitted to the ICU had priority ranks suggesting that they were potentially either too well (priority 2) or too sick (priority 3) to benefit from ICU care or could have received equivalent care in non-ICU settings (priority 4),” the letter adds.

About 26 percent of patients in priority 3 had advanced malignant neoplasms, and 27 percent had advanced dementia, “suggesting that many patients in this priority group were at risk for receiving inappropriate ICU care,” adds a related article in *MedPage Today*.

“Our findings suggest that ICU care is inefficient, devoting substantial resources to patients less likely to benefit,” the research letter notes. However, the authors note, determining appropriate ICU care is complex; as such, this study “cannot fully differentiate between appropriate and inappropriate care.” Acknowledging the limitations of a single-site review, the letter suggests that institutions themselves can identify opportunities for greater efficiency.


ICU Patients Receive Journals, Pens to Encourage Better Communication

Communication between clinical staff and patients/families is as important as communication between staff.

TriStar Skyline Medical Center, Nashville, Tennessee, is providing patients in its ICU with pens and journals to encourage them to ask questions and interact with staff.

“ICU Rooms Get Pen, Paper to Spur Family to Ask Questions,” in *The Tennessean*, notes that the nurses always encourage families, or patients when possible, to write down any questions or notes for the next time the physician rounds, or as a follow-up for nurses. “But they didn’t have anything to write with,” says Christine Lunger, a nurse and director of the critical care unit. As a result, nurses would often look for writing materials at the nurses’ station.

An employee suggested the idea for improvement, and the pilot program could well become a fixture in the ICU. Having easy access to writing tools underscores the importance of communication between clinical staff and the patient and family, which is as important as communication between staff.

“Clinicians want caregivers to speak up about how the patient is looking and acting and ask more questions. People who are a primary figure during a patient’s stay are essential resources of information about the patient. And, they are a vital link to ensuring treatment and recovering continue once the patient is discharged,” the article adds.
FDA Issues Guidance on Medical Device Cybersecurity

Hospital networks experience constant attempts at intrusion, which can threaten patient safety.

The Food and Drug Administration (FDA) has issued guidance for postmarket management of medical device cybersecurity.

“Guidance for Industry and Food and Drug Administration Staff,” on www.FDA.gov, provides manufacturers with guidelines to fix security bugs in equipment such as pacemakers, insulin pumps and imaging systems. The 30-page document establishes a risk-based framework for assessing when changes in medical devices because of cybersecurity vulnerabilities require FDA reporting. It also outlines circumstances in which the FDA does not plan to require reporting.

“Cybersecurity threats are real, ever-present, and continuously changing,” Suzanne Schwartz, a senior FDA official who worked on the new guidance, says in a related article on Fox Health News. “In fact, hospital networks experience constant attempts of intrusion and attack, which can pose a threat to patient safety. And as hackers become more sophisticated, these cybersecurity risks will evolve.”

2016: A Year of ‘Amazing and Pleasantly Unexpected’ Medical Technologies

In 2016, medical technology advancements were “amazing and pleasantly unexpected,” pointing to potential new treatments for heart disease, spinal cord injuries, diabetes and other conditions, notes “Medgadget’s Best Medical Technologies of 2016.” Here’s a peek at some of the publication’s choices:

- **Ultrasound**: Wireless ultrasound transducers use tablets or smartphones as interfaces instead of screens. Small and portable, they can be used almost anywhere.
- **Virtual Reality (VR)**: For the first time, live cancer surgery is broadcast via VR to anyone with a smartphone and Google Cardboard. VR research is also helping patients with spinal cord injuries move their legs without implants or other surgical interventions.
- **Prosthetics**: A brain implant gathers signals for finger movement, which allows patients to move the fingers on a robotic arm, potentially leading to new prosthetics with deft finger control.
- **Drones**: A drone created by a company in Michigan delivers blood and stool samples from remote Madagascar villages to a regional hospital. The drone can fly 40 miles with 4.5 pounds of samples and medical supplies.
- **Brain Assessment**: Devices that analyze the brain for injury are gaining FDA consent. One uses a disposable EEG electrode patch that connects to a smartphone to detect brainwave abnormalities. Another, using a VR headset with built-in eye trackers, can screen athletes for concussion.
- **Surgery**: A new mechanism, which is easier to use than traditional laparoscopic instruments, is so intuitive that a promotional video shows a 12-year-old using it.
- **Diabetes**: The first “Hybrid Closed Loop” insulin-delivery system calculates insulin delivery time and dosage; the insulin pump and glucometer communicate to keep sugar levels at a healthy range.
New Guidelines for Optimizing Family Support in ICU

Use these new guidelines, which include communicating with families, to ensure your unit’s practice is in line with the latest evidence.

Optimizing family support of critically ill patients in the ICU through evidence-based strategies is the goal of new guidelines.

“Guidelines for Family-Centered Care in the Neonatal, Pediatric, and Adult ICU,” in Critical Care Medicine, notes that the guidelines were established by a 29-member multidisciplinary team of experts in guideline development, evidence analysis and family-centered care.

The American Association of Critical-Care Nurses (AACN) contributed to the review and endorses these guidelines. “Family-centered care in the ICU is ideal but can be challenging,” AACN adds. “You can use these new guidelines, which include family support and communication strategies, to ensure your unit’s practice is in line with the latest evidence.”

The original “Clinical Practice Guidelines,” released in 2007, were developed using what is now considered outdated analysis. The new ones are not an update but “instead are the result of a completely new and more rigorous analysis,” the article explains.

Following are some of the suggestions:

- **Family Presence in the ICU**: Offer family members flexible bedside presence, the option to participate in team rounds and to be present during resuscitation efforts.
- **Family Support**: Seven recommendations address family support considerations to improve parental confidence and family satisfaction, and reduce family member stress and depression.
- **Communication With Family Members**: Hold routine interdisciplinary family conferences to improve family satisfaction and trust. Provide family-centered education for ICU clinicians.
- **Specific Consultations**: Hold palliative care consultations for certain critically ill patients. Include psychologists, family navigators, spiritual support, ethics consultation and social workers to improve family satisfaction, reduce length of stay (LOS) and improve outcomes.
- **Operational Issues**: Implement protocols to ensure adequate sedation and analgesia during life-support withdrawal. Address environmental issues to reduce noise and improve family sleep. Involve nurses in decisions on care goals, and educate them to provide family support as part of a program to improve communication and decrease LOS.

“All recommendations were weak, highlighting the relative nascency of this field of research and the importance of future research to identify the most effective interventions to improve this important aspect of ICU care,” the article adds.


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Artificial Blood Could Soon Be Used in Emergency Situations, but More Study Is Needed

Artificial blood could help keep donated organs alive and supplement a hospital’s regular blood supplies.

Within 10 years, artificial blood may buy trauma patients more time to reach the hospital and give them a much better chance of survival. Although the findings are preliminary and have not been published in a peer-reviewed journal, “Another Step Closer to Artificial Blood,” in HealthDay News, notes the research team was able to replace 70 percent of a mouse’s blood volume with the blood substitute. The test mice were indistinguishable from the animals that received a transfusion from another mouse.

One key advantage of the artificial blood is that it can be freeze-dried and stored as powder in plastic IV bags, which could be helpful in emergencies and combat situations. All that’s required for reconstitution is mixing it with sterile water. Because the packs do not require refrigeration, it’s an ideal way to stock ambulances and medical kits, since the IV packs could have a shelf life of a year or more.

The artificial blood is made from purified human hemoglobin proteins coated with a polymer. The synthetic coating is “immune silent,” the article adds, so it can be used in anyone, regardless of blood type. The coating also keeps the hemoglobin from reacting with nitric oxide, which could cause blood vessels to constrict.

In addition to aiding in emergencies, artificial blood could help keep donated organs alive and supplement a hospital’s regular blood supplies. However, the artificial cells last only a third to a half day, whereas real blood cells can circulate for about 120 days. The artificial blood is designed to deliver oxygen and not perform the other functions of real blood.

Tips to Prevent Medication Errors

RNAs have a critical role in patient safety, including the safe administration of medications.

Furosemide, enoxaparin, insulin and vancomycin are the most common drugs associated with medical errors (MEs) made by RNs that harmed patients.

“Association of Medication Errors With Drug Classifications, Clinical Units, and Consequence of Errors: Are They Related?” in Applied Nursing Research, describes a review of 1,276 MEs made by RNs at Southwest hospitals. Cardiovascular drug errors are the most common category of preventable errors and accounted for 24.7 percent of all MEs. In that class, anticoagulants accounted for the most MEs (11.3 percent). Antimicrobials were the second most common drug class associated with MEs (19.1 percent).

Thirty-five percent of ME cases were in medical/surgical units followed by 14.7 percent in ICUs. Ten percent of MEs resulted in harm to patients, and 11 percent occurred even with increased monitoring.

Even for experienced staff, patients with complex medication needs, short-staffed workplaces and heavy workloads add to the challenges of managing medication.

The review recommends the following:

- A supportive work environment that includes simulation-based education for nurses
- Continuing education in pharmacology during licensure
- Education on the administration of anticoagulation drugs
- Nurses who teach clinicians how to use computerized provider order entry systems
- More effective use of ME incident reports

Review limitations include different reporting forms, possible under-reporting of MEs and omitting patient information on MEs. “Future research may a) examine the rate of MEs with drug classes and individual drugs, b) examine the association of MEs in different hospitals across the nation, and c) examine the factors associated with MEs involving high risk drugs,” the review adds.

**Challenges for New Nurse Managers**

Many managers have almost no orientation to their new leadership role.

During the transition from staff member to leader, many nurses ask themselves: “What did I get myself into? I manage multiple units, and it is so difficult to meet everyone’s needs.”

These and other insights are shared in *Emerging Nurse Leader’s “Challenges for New Nurse Managers,”* by Rose O. Sherman, professor of nursing and director of the Nursing Leadership Institute, Christine E. Lynn College of Nursing, Boca Raton, Florida.

Sherman recently co-taught the New Nurse Manager Program sponsored by the American Nurses Association. In the inaugural class, 37 participants from across the country discussed the challenges they face as nurse managers.

“What we learned from working with these new managers was the sense of relief they felt when they realized that others were sharing their challenges. Unfortunately, many had almost no orientation to their new leadership role and some even paid to attend the class themselves,” Sherman adds in the article.

Challenges cited by the participants include the following:

- I feel sandwiched between upper management and the staff.
- I multitask and have challenges with workload.
- Work-life balance is an issue, because I work very long hours.
- Staffing is a continual problem.
- I struggle between clinical and leadership responsibilities.

“In today’s environment, we worry about the transition of new graduates but very little is being written about the struggles of novice nurse managers at a time when their numbers are growing,” Sherman adds. “We owe it to our new nurse managers to provide supportive transitions because … their challenges are many.”

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**Are You Emotionally Intelligent?**

Ninety percent of top performers have high emotional intelligence.

Emotional intelligence (EQ) is an intangible quality that everyone has, but for people with a high EQ, it can make all the difference in performance.

“18 Signs You Have High Emotional Intelligence,” in *Success*, refers to “Are You Emotionally Intelligent? Here’s How to Know for Sure,” published in *LinkedIn Pulse*. “The connection is so strong that we know 90 percent of top performers have high emotional intelligence,” the new article notes.

Travis Bradberry, co-author of “Emotional Intelligence 2.0,” analyzed data from over 1 million people to identify behaviors indicating high EQ. The article presents 18 traits of high EQ, which affects how people “manage behavior, navigate social complexities and make personal decisions to achieve positive results.”

According to the article, people with a high EQ:

- Have a strong emotional vocabulary; they can identify emotions as they occur
- Are curious about other people and empathetic
- Adapt to change; fear of change can threaten success
- Know their own strengths and weaknesses
- Are good judges of character
- Are not easily offended; self-confidence and open-mindedness create a thick skin
- Know how to say no, which includes self-control
- Let go of their mistakes; dwelling on them creates anxiety
- Give without expecting anything in return
- Don’t hold onto grudges to avoid stress
- Neutralize difficult people by keeping their feelings in check
- Don’t seek perfection, because they know it doesn’t exist
- Are grateful for what they have
- Can disconnect to help control stress
- Limit caffeine to avoid fight-or-flight responses that bypass rational thinking
- Get sufficient sleep to wake up alert and clearheaded
- Avoid negative self-talk, because most negative thoughts are not facts
- Don’t let anyone limit their joy
In Our Journals

Hot topics from this month’s AACN journal

Central venous catheter complications are often discussed but peripheral venous access devices (PVADs), though less risky, are more commonly used. This article describes the types of injury and infection that can occur with both types of PVADs, peripherally inserted central catheters (PICCs) and short peripheral catheters (SPCs). Signs, symptoms and risk factors for complication as well as strategies for preventing, detecting and managing injury and infection are discussed. Key points include routine evaluation of staff competency in PVAD insertion, assessment, stabilization and removal, and increased awareness of complication risk.

(Mattox, CCN, April 2017)

While enteral nutrition was once considered a supportive intervention for critically ill patients, recent research shows it is an essential component in promoting recovery and preventing complications. One strategy for putting this evidence into practice is the use of enteral nutrition protocols. This article reviews the benefits of enteral nutrition and how protocols can increase its use. The authors note that protocols that allow for individualized care and encourage team communication are more likely to succeed.

(O’Leary-Kelley, CCN, April 2017)

Fluid resuscitation can improve organ perfusion in patients with shock but also carries risks, such as fluid overload and pulmonary edema. A systematic review including 15 recent studies demonstrates that passive leg raise (PLR) accurately predicts response to fluid bolus in most patients. The PLR maneuver is noninvasive and causes an autotransfusion that mimics a fluid bolus. The studies reviewed include spontaneously breathing and mechanically ventilated patients and both invasive and noninvasive methods for measuring the impact of PLR on stroke volume.

(Pickett, CCN, April 2017)

Transitions

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

Previously administrative director of critical patient services at Indiana University Health Ball Memorial Hospital, Lynne Bunch becomes vice president of patient services at Planned Parenthood of Indiana and Kentucky.

The Nu Mu Chapter of Sigma Theta Tau International, Honor Society of Nursing at California State University inducts Raulin Feria, clinical nurse for pediatric intensive care at Huntington Hospital, Pasadena, California, as a nurse leader. The inductees are nurses from diverse backgrounds who exemplify clinical, leadership and academic excellence in nursing.

Tiffany Greiman, a certified nurse practitioner with more than nine years of critical care experience, joins the Palliative Care Team at Quincy Medical Group, Illinois.

Ruth Kleinpell, professor at Rush University College of Nursing and director of the Center for Clinical Research and Scholarship at Rush University Medical Center, Chicago, begins a one-year term as president of the Society of Critical Care Medicine, the third nurse to serve as president in its 46-year history. A past recipient of AACN’s Flame of Excellence Award and past board member of the American Academy of Nursing, she has served in many volunteer roles for both organizations.

Robin McGuinness becomes regional chief clinical officer for the Florida Hospital West Florida Region. An AACN member since 1999, she continues her role as vice president of patient care services and chief nursing officer at Florida Hospital Carrollwood.

Jennifer Schleier, stroke manager at Level 1 Comprehensive Stroke Center, Upstate University Hospital, Syracuse, become chair-elect of the Central and Western New York Stroke Coordinators Consortium.

Eileen Westley-Hetrick, clinical nurse educator, PennState Health Milton S. Hershey Medical Center, Hershey, Pennsylvania, is chosen to serve on the education board of the American Health Council, Hauppauge, New York.

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.
Advanced Critical Care Book Offers Latest Evidence-Based Knowledge, Procedures

The second edition of the popular advanced practice resource book “Advanced Critical Care Nursing,” by Vicki Good and Peggy Kirkwood, has been released. Endorsed by AACN and considered an authoritative reference, the book provides the latest evidence-based knowledge and procedures to effectively address life-threatening and potentially life-threatening patient conditions. The comprehensive, nursing-focused text centers on the clinical reasoning process, as it helps nurses comprehend, analyze, synthesize and apply advanced critical care knowledge and concepts.

“Experienced critical care nurses will find the ‘Advanced Critical Care Nursing’ textbook an excellent resource to propel their practice forward in caring for the highly complex patients found in the critical care environment,” Good says. “The textbook addresses many common disorders but also provides valuable information on conditions not routinely seen in critical care such as obstetrics, oncology and psychiatry.”

In addition, the new edition features:

- Updated information throughout that reflects the latest evidence-based knowledge as well as national and international treatment guidelines.
- Streamlined content. The book places a greater focus on need-to-know information for today’s high-acuity, progressive and critical care settings.
- Expanded coverage of emerging and infectious diseases and multidrug-resistant infections. It helps keep readers up-to-date on topical diseases, such as the Zika virus.
- Additional content on alternative settings for critical care, including the tele-ICU and remote monitoring.
- A full-color design that clarifies important concepts and improves the book’s usability.

Please visit www.aacn.org/store to learn more and purchase this book.

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Nurses are experts of the workaround. Granted, we know that some processes are not patient-focused but may be in place to meet regulatory standards. Granted, we accept that hospitals, whether big or small, are complex organizations that strive to do what is right for patients and families — and employees. Yet, if a barrier is placed between a nurse and the care she or he knows the patient needs, it matters that that same nurse will work hard to remove the barrier.

Last year, we invited our AACN community to identify the obstacles between nurses and their delivery of the best possible care. Our community was bold and courageous in identifying the five most common barriers: staff shortages and higher workloads, regulatory burdens, behaviors of patients and families, workplace hostility and less than authentic leadership.

This discovery coincided with the launch of the second edition of AACN’s Healthy Work Environment (HWE) Standards last March. The themes were remarkably similar — whether you practice in a small town in New York, a large city in Washington or in the bayous of the Gulf states. You confirmed that a significant gap exists between the ideal work setting and the realities of many nurses’ practice environments.

Our AACN community is acting collectively to help close that gap. This spring, AACN leaders participated with other thought leaders to address the important topic of appropriate staffing. This ongoing work, together with bold statements and new evidence on staffing in the second edition of the HWE standards, was a follow-up to the staffing summit at last year’s National Teaching Institute (NTI).

AACN is also adding its bold voice to various collaboratives and panels focused on barriers to practice. As a member of the Critical Care Societies Collaborative, we published a call to action with our physician colleagues on burnout syndrome. To ensure our workforce is healthy and resilient, AACN is participating in the National Academy of Medicine’s Action Collaborative on Clinician Resilience and Well-Being. And, next month there will be numerous sessions related to HWE, staffing and other practice barriers at NTI. Set a goal now to attend these sessions in Houston and, more importantly, take back what you learn to your team and unit.

Creating change as a community is important, but we as individuals can also set goals to overcome barriers to practice and stay positive. We can take that high road even if others go low, by embracing healthy practices, such as sharing success stories. Louise Saladino, board director and director of nursing at Ochsner Medical Center in New Orleans, asks her nurses to share “passions to practice” instead of barriers to practice. Nurses at the University of Rochester have implemented transport teams so nurses can safely cover multiple assignments. And, UCLA Ronald Reagan Medical Center in Los Angeles utilizes “break nurses” so each nurse can get away for what might be the most important part of their day — fueling their body and mind so they can provide excellent care — because nothing less is acceptable.

So how can you turn workarounds into goals that remove barriers to practice? By owning your practice — relentlessly and with pride. Because it matters that nurses are experts at removing barriers so patients and families get the care they need. And, it matters that we, as nurses, figure out ways to make our teams and units healthier, so we can all thrive.

Share your goals to overcome obstacles and create success at ItMatters@aacn.org.
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