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In seventh grade, this new kid joined our class. In the interest of confidentiality, her name will be “Ellen.” Ellen was small, shy. She wore these blue cat’s-eye glasses that, at the time, only old ladies wore. When nervous, which was pretty much always, she had a habit of taking a strand of hair into her mouth and chewing on it.

So she came to our school and our neighborhood, and was mostly ignored, occasionally teased (“Your hair taste good?” — that sort of thing). I could see this hurt her. I still remember the way she’d look after such an insult: eyes cast down, a little gut-kicked, as if, having just been reminded of her place in things, she was trying, as much as possible, to disappear. After awhile she’d drift away, hair-strand still in her mouth. …

Sometimes I’d see her hanging around alone in her front yard, as if afraid to leave it.

And then — they moved. That was it. No tragedy, no big final hazing.

One day she was there, next day she wasn’t.

End of story.

Now, why do I regret that? Why, forty-two years later, am I still thinking about it? Relative to most of the other kids, I was actually pretty nice to her. I never said an unkind word to her. In fact, I sometimes even (mildly) defended her.

But still. It bothers me.

So here’s something I know to be true, although it’s a little corny, and I don’t quite know what to do with it:

What I regret most in my life are failures of kindness.

Those moments when another human being was there, in front of me, suffering, and I responded … sensibly. Reservedly. Mildly.

Or, to look at it from the other end of the telescope: Who, in your life, do you remember most fondly, with the most undeniable feelings of warmth?

Those who were kindest to you, I bet.

It’s a little facile, maybe, and certainly hard to implement, but I’d say, as a goal in life, you could do worse than: Try to be kinder.

—George Saunders

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Demystifying the Certification Exam Development Process

It takes as many as 50 volunteer experts collaborating over a two-year period to create a certification exam.

Nurses who attended NTI 2017 had the opportunity to learn more about how AACN Certification Corporation (AACN CertCorp) develops certification exams. With a community of more than 100,000 certified nurses and counting, we figure many more of you could benefit from this information as well.

How does a new or updated certification exam come about? You may think a group of AACN CertCorp staff huddles together in a room or that a nursing expert locks themself away and emerges with a shiny new exam.

In reality, it takes a rigorous process involving 18-24 months of collaboration between many people with different experiences, education and expertise from various hospital units across the country.

The central players in the process are three committees composed of volunteer nurses, most in clinical practice, who work closely with each other, AACN CertCorp and psychometrists (experts in the measurement of knowledge, skills and abilities). These committees have well-defined responsibilities within the process.

Their work is facilitated by AACN CertCorp staff members and overseen by the Certification Corporation Board of Directors (CBOD). The accompanying figure provides a high-level overview of steps in the exam development process.

Committee #1: Practice Analysis Task Force (PATF)

The PATF is made up of six to 10 volunteer subject matter experts (SMEs) who manage the practice analysis and test plan development steps of the process.

The practice analysis (also known as a study of practice) identifies the activities and competencies needed for a particular nursing role. To collect this information, the PATF develops and distributes a survey to a national sample of nurses representing the different clinical settings and levels of experience involved in that particular nursing specialty.

The survey data identify the specific knowledge, skills and abilities needed for a nurse to safely perform that role. Based on the results, the PATF develops a corresponding test plan, also known as an exam blueprint — the specifications for the actual certification exam, precisely setting forth the “what” and “how much” of particular topics.

The CBOD then reviews and approves the new test plan.

Committee #2: Item Writing Committee (IWC)

Enter the IWC, a group of four to eight nurse volunteers in current clinical practice who are responsible for the item writing (test question development) step in the process. Each item is developed based on the test plan and incorporates a patient care problem involving a specific nursing competency.

Each committee member then writes approximately 25 new items for particular test plan topics. As current practitioners, item writers often draw on their own experiences and those of their colleagues to develop test questions that reflect the real-life knowledge and decision making of nurses.

The item writers validate their questions with current evidence-based practice, and a bibliography of their sources is published with the test plan.

Committee #3: Exam Development Committee (EDC)

Typically, four to nine practicing nurses from our community of certificants make up an EDC. Like other committees, the EDC strives for a broad representation of educational preparation, years of experience and type of unit/facility.

The EDC engages in an extensive review of exam items, including the validation, pretesting and evaluation steps of the process.

During the validation phase, EDC members review and approve the new test questions submitted by the IWC to ensure alignment with the new test plan. EDC members must unanimously agree that each item tests the correct knowledge area and relates to specific content on the test plan. Any items not meeting this requirement go back to the IWC.

Approved new items are added to existing versions of the exam (known as exam forms) and pretested with a sampling of certification candidates. Pretesting enables AACN CertCorp and the EDC to gather statistical data on item performance and
evaluate whether each item meets required standards before being presented on exams as scored items.

Finally, the EDC works with AACN CertCorp’s test vendor to finalize the new or updated exam forms.

The Ultimate Goal: Balanced Testing

The desired outcome of the certification exam development process is creating an exam that is both “fair and reasonable to candidates” and a “meaningful tool to validate knowledge.” This goal is achieved by striving for exams that are, among other things:

- **Psychometrically sound**: Psychometric methods and principles (including validity and reliability) are employed to ensure the fairness and accuracy of the exam.
- **Legally defensible**: The exam is developed using methods that can withstand legal scrutiny with respect to fairness and accuracy.

For nurses interested in participating on a certification exam committee, the accompanying article explains how.

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‘Optimizing Care for Acutely Ill Older Adults’ Available at a Special Price

According to statistics, 10,000 Americans turn 65 every day, requiring nurses to be more prepared than ever to treat the unique needs of this specialized population.

AACN’s e-learning course “Optimizing Care for Acutely Ill Older Adults” educates nurses on how to treat these adults who require specialized care. Nurses learn to differentiate between symptoms of usual aging and those arising from illness, ultimately leading to successful care of the patient.

Using real-world patient scenarios, the course has three modules and one final exam. It also:

- Takes nurses beyond the basics of caring for the complex older adult population by providing the latest knowledge, best practices and evidence-based interventions
- Focuses on reducing both the unintended consequences of acute and critical illness and readmissions
- Helps ensure consistent care across nursing teams/units

The course, which offers 4.0 CE contact hours, is being offered at the special price of $55. Individuals and organizations can purchase “Optimizing Care for Acutely Ill Older Adults” by visiting www.aacn.org/olderadultcourse.
NICUs With Nurse Champions Assess Pain More Frequently

NICUs should develop standardized approaches for neonatal pain and identify experienced nurses to lead the effort.

Assessment of prolonged, continuous pain occurred in less than one third of neonatal ICU admissions in 18 European countries.

According to “Assessment of Continuous Pain in Newborns Admitted to NICUs in 18 European Countries,” in *Acta Paediatrica*, characteristics of NICUs that perform recommended pain monitoring more often than others include nurse champions, pain guidelines and more surgical admissions. “All NICUs should develop standardized approaches for neonatal pain and identify experienced nurses to lead this effort,” the study concludes.

The study reviewed the care provided to 6,648 neonates in 243 NICUs across 18 European countries, with 2,113 (31.8 percent) receiving at least one assessment for prolonged, continuous pain, and 689 (10.4 percent) assessed daily. NICUs performing the most assessments were in France (100 percent), Netherlands (80 percent) and Belgium (75 percent); five reviewed countries didn’t perform any assessments.

“A lot of these babies are exposed to prolonged pain caused by surgical operations, repeated invasive procedures, or inflammatory diseases,” lead study author Kanwaljeet Anand, Stanford University School of Medicine, California, says in a related article posted in the Wiley Newsroom. “In the absence of frequent assessments, I’m concerned that many babies may be under-treated or over-treated for painful conditions. We need to develop better ways for monitoring pain in newborn babies.”

Pain assessment rates were reported according to ventilatory status showing 46 percent of those requiring tracheal ventilation, 35 percent with noninvasive ventilation and 20 percent of those with spontaneous ventilation received assessment. Rates also increased for neonates requiring surgery, opioids, sedatives-hypnotics or general anesthetics.

Participating NICUs worked with investigators to ensure thorough data collection, but the study acknowledges the potential for underreporting, because pain assessments and nonpharmacologic interventions may be recorded less frequently than the use of pain medications.


Preterm Babies’ Need for ‘Supportive Touch’

The experience of touch is the beginnings of the development of human communication, which may be interrupted by premature birth.

Preterm babies need to receive as much gentle skin-to-skin contact as possible in the hospital to aid their development.

According to “The Dual Nature of Early-Life Experience on Somatosensory Processing in the Human Infant Brain,” in *Current Biology*, neonates with more pain experiences and medical procedures registered the least response to controlled stimuli. Neonatal ICUs could use the research to increase opportunities for supportive touch, the study notes.

The findings could explain why preterm babies don’t perform as well on cognitive, motor and language assessments as full-term babies after hospital discharge. “Promoting optimal development and function in newborns hospitalized in NICUs may help establish the sensory building blocks of cognition, behavior, and communication,” the study explains.

In a related article in *UPI*, lead study author Nathalie Maitre, a pediatric expert at Nationwide Children’s Hospital, Columbus, Ohio, notes that when parents cannot be in the NICU, “hospitals may want to consider occupational and physical therapists to provide a carefully planned touch experience, sometimes missing from a hospital setting.

“We certainly hoped to see that more positive touch experiences in the hospital would help babies have a more typical perception of touch when they went home. But, we were very surprised to find out that if babies experience more painful procedures early in life, their sense of gentle touch can be affected,” Maitre adds.

The experience of touch is the beginnings of the development of human communication, Maitre says, and that development process may be interrupted by premature birth. The next step, researchers say, is to determine “the long-term effects of such an interruption,” notes the related article.

Extended Sleep Linked to Dementia Risk

People who report long sleep times may warrant assessment and monitoring for problems with thinking and memory.

Prolonged sleep may be a sign of early neurodegeneration, a symptom that could identify people at high risk of developing clinical dementia within 10 years. "Prolonged Sleep Duration as a Marker of Early Neurodegeneration Predicting Incident Dementia," in Neurology, notes that the study, conducted at Boston University Medical Center, involved 2,457 older people who self-reported sleep hours in the Framingham Heart Study (FHS). Over 10 years of follow-up, the study observed 234 cases of all-cause dementia.

"Participants without a high school degree who sleep for more than 9 hours each night had six times the risk of developing dementia in 10 years as compared to participants who slept for less," study co-author Sudha Seshadri, professor of neurology at Boston University School of Medicine (BUSM) and an FHS senior investigator, says in a related article in Building a Better World News. "These results suggest that being highly educated may protect against dementia in the presence of long sleep duration."

According to the article, sleep-pattern changes are an indicator of brain damage, and this study may provide a means to diagnose dementia early and treat it more successfully. Understanding how dementia works could also lead to new treatments.


2017 Alzheimer’s Report

Caregivers are on the front lines in the war against Alzheimer’s.

"2017 Alzheimer’s Disease Facts and Figures," an annual report from the Alzheimer’s Association, notes that "because of the increasing number of people age 65 and older in the United States, particularly the oldest-old, the annual number of new cases of Alzheimer’s and other dementias is projected to double by 2050."

The report also examines future trends in healthcare costs and the impact on caregivers. This year, for example, the annual cost of caring for patients with dementia will be $259 billion, surpassing a quarter trillion dollars for the first time.

Alzheimer’s is like a leaky boat in a hurricane," Huntington Potter, director of Rocky Mountain Alzheimer’s Disease Center, University of Colorado, adds in a related article on CNN. "We have to both bail like mad and fix the leaks. Researchers are working hard to fix the leaks, but it will take time; for now, the main load is carried by the bailing caregivers. They are on the front lines in this war against Alzheimer’s.”

Without additional funding for research and a breakthrough, healthcare costs and deaths from Alzheimer’s, and the emotional and physical effect on caregivers will continue to escalate, the article adds.

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Cooling Caps May Decrease Chemotherapy-Linked Hair Loss

Cooling caps appear to limit hair loss by constricting blood vessels in the scalp, thus reducing the amount of chemotherapy delivered to hair follicles.

Scalp cooling caps may help prevent hair loss in some patients with breast cancer undergoing chemotherapy.

“Association Between Use of a Scalp Cooling Device and Alopecia After Chemotherapy for Breast Cancer: The SCALP Randomized Clinical Trial” and “Association Between Use of a Scalp Cooling Device and Alopecia After Chemotherapy for Breast Cancer,” both in JAMA: The Journal of the American Medical Association, find that among women undergoing chemotherapy for early-stage breast cancer, scalp cooling was associated with significantly less hair loss four weeks after the last dose of chemotherapy.

Cooling caps appear to limit hair loss by constricting blood vessels in the scalp, thus reducing the amount of chemotherapy delivered to hair follicles, Julie Nangia — lead author of the first study and an assistant professor at Baylor College of Medicine, Houston — explains in a related article in Chicago Tribune. “The cooling caps also might decrease the biochemical damage done to follicles by whatever chemo does get through.”

Nangia adds that more than half of the women wearing cooling caps kept their hair; the control group had no retention. “The second study also found that the cooling caps could reduce hair loss, with two-thirds of patients losing half or less of their hair during chemotherapy,” the article adds. Patients put on the cooling caps 30 minutes before chemotherapy and kept them on for 90 to 120 minutes in the second study.

Although neither study finds any short-term adverse effects, there is a concern that cancer could return years after treatment. Both studies plan to follow the participants for at least five years.

The quality-of-life data from both studies should be interpreted with caution, because the overall effects of breast cancer diagnosis, surgery and chemotherapy may have had a substantial influence on patient-reported outcomes in both groups, notes an editorial in JAMA.


Novel Technology: Needle-Free Blood-Draw Device

The device helps clinicians provide more compassionate, standardized, patient-centered blood draws.

San Francisco-based startup Velano Vascular has received marketing clearance from the Food and Drug Administration (FDA) for its blood-draw device.

“Velano Vascular Gains FDA Clearance for Needle-Free Blood-Draw Technology,” in FDA News, says the device “seeks to improve the blood draw experience for patients while reducing risks to patients and practitioners. PIVO is a single-use, disposable device that enables blood sampling from indwelling peripheral IV lines, allowing hospitals to reduce reliance on repeated needle sticks and central line access for blood collection.”

A related news release adds that the company also “aims to equip hospitals to better serve the increasing population” of patients who have difficult venous access. The device also provides a safer environment for healthcare staff and a more compassionate experience for patients.

“Feedback from hundreds of practitioners already using our technology reinforced PIVO’s ability to enhance the blood draw experience for patients and clinical staff, and helped us to develop a next generation product better suited for widespread adoption,” adds Eric Stone, the company’s chief executive.
Top 10 Patient Safety Issues for 2017

This year’s top safety concern is information management in electronic health records.

The ECRI Institute, a Pennsylvania-based nonprofit, has released a new list of patient safety issues.

“ECRI Institute Names Top 10 Patient Safety Concerns for 2017,” a company news release, notes that the annual report, “Top 10 Patient Safety Concerns for Healthcare Organizations,” strives to identify causes of serious patient safety events and help healthcare organizations create action plans. ECRI based its list on data from patient safety organizations, concerns from healthcare providers and judgment from experts.

Topping the list for the second year is health information technology, notes a related article in Medscape News, which adds the issue is being brought to the forefront with the advent of electronic health records. Having easy electronic access to patient information has become an important tool to help make the best clinical decisions, and the information needs to be accurate and easily accessible, the article notes.

Unrecognized patient deterioration is the second biggest concern. The report notes that “conditions such as sepsis, some maternal conditions, and serious postsurgical complications” need prompt recognition and attention to have good outcomes, the article adds; however, better clinical protocols and education have led to improvements.

“People have seen how well these campaigns have worked for stroke and STEMI and how much they’ve improved outcomes,” Patricia Neumann, ECRI senior patient safety analyst, explains in the release. “What if those same principles could be applied to other conditions that require fast recognition and management? We could have a big impact on improving outcomes.”

Following is a brief list of the 10 concerns:

- Information management in electronic health records
- Unrecognized patient deterioration
- Use of clinical decision support
- Test result reporting and follow-up
- Antimicrobial stewardship
- Patient identification
- Opioid administration and acute care monitoring
- Behavioral health issues in nonbehavioral health settings
- Managing new oral anticoagulants
- Inadequate systems or processes to improve safety and quality

The report “emphasizes the importance of proactive strategies to examine processes, identify what can go wrong, and improve the process to make it less vulnerable to error,” the article adds.

Two Healthcare Organizations Merge, Plan to Reboot Patient Safety

The National Patient Safety Foundation and Institute for Healthcare Improvement (IHI), two Boston-based healthcare organizations, officially merged May 1 under the IHI name.

IHI president and CEO Derek Feeley says the patient safety movement needs reinvention, notes an article in H&HN: Hospitals & Health Networks. The combined organization is moving from piecemeal, project-based methods to a more systems-based approach.

Company leaders say that a combined effort will be a more effective way to engage the healthcare community, influence key leaders and policymakers, and better serve patients and families. However, both organizations will continue hosting their existing schedule of patient safety conferences.

In addition, there is a call to action in response to preventable adverse events in healthcare. IHI pledges to make significant new investments in safety programs.
Facing Moral Distress and Ethical Dilemmas — as a Team
An Interview With Stephanie Trowbridge

There may have been a time when the mere mention of “ethics” would send most nurses, including Stephanie Trowbridge, hurrying away. But she is now a champion ethics advocate, leading a five-member team of nurse ethics liaisons in the Pediatric Intensive Care Unit (PICU) at Children’s Hospital Colorado. She also has her own photography business and is an avid runner who completed a marathon.

How did you get started in nursing?
My aunt was a nurse when I was little, and I wanted to be just like her. I did not study science until college, so until a nursing professor challenged me to apply for nursing school I believed that a major in P.E. was the only option for me. My first day in nursing school, I cried. I realized I had arrived at my calling.

How did you come to be involved in critical care?
I first worked at a small regional center that had a 12-bed pediatric unit. We, the pediatric nurses, would respond to any pediatric traumas in the Emergency Department. After my first two traumas, I couldn’t shake two things: First, I loved it. Second, I wanted to know more. I began working my way to an amazing Pediatric Intensive Care Unit at Children’s Hospital Colorado.

Why pediatrics?
I was chronically ill as a child and into my adulthood. There were not many answers for me based on many factors, but being a child with chronic pain led me to specifically working with children even prior to nursing. I told my nursing mentor I would only be a nurse for children. If I have the opportunity to relieve even a small amount of suffering for a child it means the world to me.

You’re a nurse ethics liaison. Talk about what a nurse ethics liaison is and does.
We are not part of the ethics consult team. In the PICU, our team supports our unit during and after ethical challenges. We have learned that this is most effective by mentoring and supporting our peers in moral truth. We are in the trenches together. We all face moral distress and ethical dilemmas. We listen and are objective, because we are courageously encouraging these conversations to happen. We desire to help during these difficult situations when they occur, not if they will occur. Because of this understanding, we are ready at all times to listen, mentor through and advocate for the concerns of our peers.
How did you get started in nurse ethics?
We have a unique team within Children’s Hospital Colorado that started a year or two before I joined. We have a traditional ethics team that consults and is made up of various providers and nurses in the institution. To assist ethics education and staff support surrounding ethics a Nurse Ethics Liaison Team was formed. My team represents the PICU.

You mentioned there are five of you on your PICU liaison team. How does it function?
Currently, I lead the team/committee of PICU nurse ethics liaisons. During our monthly meetings we support our team members first, encouraging self-care and community. We discuss any ethics challenges that might have arisen in the previous weeks and if we need to review any components of the challenges. We all have individual projects, although we all work together to collaborate and promote each. Projects include self-care sessions, rounding at the bedside and educational newsletters about ethics consults. These projects are incorporated into our clinical ladder requirements and allow for greater exposure to the particular needs occurring on the unit. We share the responsibility of being on-call for our peers if any challenges arise. We attend a monthly house-wide ethics liaison committee meeting that incorporates ethics education, case studies and strategies for enhancing the ethics climate within the institution. Now we average eight ethics consults each year.

Any particular experiences you’d like to share?
I was the primary nurse ethics liaison for one of the most ethically challenging situations I have ever experienced. For two-plus weeks, twice a day, I checked in on the bedside nurse via a phone call, a note left at the cubby, a text message or an in-person conversation. My phone number was in the nurses’ cubby for any time of the shift that I could offer support. One of the primary nurses had been hesitant to participate in discussions related to ethical challenges in the past. Through the experience I gained a friend. I was there when she needed someone the most. We still talk about that patient. We respect each other, and she knows I will be there again. That experience taught me that even the most difficult situations can promote change and resiliency.

Yesterday, I sat with two PICU attendings to find out how the ethics climate seems to them in the unit. I am currently surveying all our attendings. Seven years ago I would have been anxious to bring up the topic, and today I reflect on their openness and collaboration with me.

Can you talk about the how this idea began?
I love to have deep meaningful conversations, thrive on it sometimes. Peer relations and creating a positive work environment especially for new nurses is incredibly important to me. When we started seven years ago we tried to have ethics education in the form of rounds, and very few people came. The hesitance around ethics consults continued with every different attempt at education. As the team expanded so did the ability to be available. I remember being asked to be involved with a difficult ethical situation. I sat down with the RN who needed help communicating her distress during a consult. I spoke for her during the ethics consult. I followed up with her, the other primary nurses who were providing care for the patient and spoke with the providers. It fit. It made an impact. It brought clarity and structure to the process. I built upon the model as the team grew. The model is still growing with each challenge, but it seems to be effective. One of us on the team will take the primary role of the nurse ethics liaison to carry a case through. Once a setting hesitant to ethical consultation, now the PICU averages eight ethics consults each year.

Work/life balance is very important. How do you help yourself in this regard?
"Nursing is precious. It’s the heartbeat of healthcare, I believe.” Part of our current efforts is to encourage the ethics of self-care. If we encourage our peers to have good mental and emotional well-being, we believe that excellent care continues to the bedside.

After my first trauma, a 3-year-old found down after being abused several days before, I had PTSD. I started looking for bruises on any child I saw. I could not sleep. I did not want to go to work. I quickly realized it and started developing healthy habits to help me when I encountered difficult situations. Photography had always been my other love, and so when I started in the intensive care unit I especially needed something extra to help me deal with the pressures and memories. I picked up my camera and started shooting. Taking pictures of happy, healthy children and families gives balance to the intensity of my nursing profession. My hobby grew into a business, and now I balance both loves along with being a wife and mother.

I meet with a counselor monthly. I also volunteer at a teen moms’ organization where I photograph, network and mentor. I give back to my church community and lead other nurses in a Bible study. I run/exercise and find special moments of stillness with a cup of coffee with a friend or with a journal in hand. Life is full and work is hard, but I wouldn’t have it any other way. I do whatever I can to show up and to make a difference.

Finally, what is it to you that makes nursing so special?
Nursing is precious. It’s the heartbeat of healthcare, I believe. It’s the first impression of a whole experience. A nurse is the first and the last person you see when you wake up and fall asleep in a hospital bed. It’s the person you call when you need something. In my personal story, it’s the person who cared enough to stay past her shift to advocate for my doctor to be at my bedside to save my life. A nurse learns to be intuitive and uses it for the good of the patient. If I can be just a small part of this influence, I’m all in.

Interview by Paul Taylor, paul.taylor@aacn.org
America’s Best Hospitals for 2017

Hospitals that achieve America’s Best Hospitals distinction have sustained high-quality outcomes for their patients for many years.

Healthgrades, an online healthcare-provider rating service, has released its list of the “Top Hospitals for 2017.”

Representing the top 1 percent, the Top 50 hospitals were in 22 states, the same as last year. California had the most Top 50 hospitals, with 10, and Illinois followed with seven, reports “Healthgrades Names 100 Best Hospitals for 2017,” in HealthLeaders Media.

Healthgrades designates the Top 50 hospitals as those that have been in the top 1 percent nationally for clinical excellence at least six consecutive years.

The Top 100 hospitals have been in the top 2 percent for clinical excellence at least three consecutive years. The rating service says that patients treated in the “Top 100 hospitals have, on average, a 27.1% lower risk of dying than if they were treated in hospitals that did not receive this award,” the article adds.

Healthgrades “evaluates hospital quality for conditions and procedures based solely on clinical outcomes for the most common in-hospital procedures and conditions and adjusts for risk factors, such as age, gender and medical condition. The analysis is based on 45 million Medicare claims records for the most recent three-year time period available from nearly 4,500 hospitals nationwide,” according to its website.

Brad Bowman, Healthgrades chief medical officer, adds, “Hospitals that have achieved America’s Best Hospitals distinction have sustained high quality outcomes for their patients over many years and often offer programs that engage consumers and their overall communities in their care.”

Hospital Floors May Transmit Pathogens

Floors in the rooms of hospital patients are often contaminated with pathogens from high-touch objects placed there.

“Are Hospital Floors an Underappreciated Reservoir for Transmission of Health Care-Associated Pathogens?” in American Journal of Infection Control, surveyed 318 floor sites in 159 patient rooms (two sites per room) in five hospitals. The study assessed the frequency of contamination with *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant enterococci and their potential transfer to hands.

“High-touch objects such as blood pressure cuffs and call buttons were often in contact with the floor. Contact with objects on floors frequently resulted in transfer of pathogens to hands.” Other high-touch items include cellphone chargers, pulse oximeters, heating pads, urinals, washbasins, heel protectors, pillows, sheets and towels. Contamination was common in CDI (*Clostridium difficile* infection) and non-CDI rooms; CDI was the most frequently recovered pathogen.

The findings have several implications for infection control, the study reveals. First, healthcare personnel and patients should avoid placing high-touch objects on floors when possible.

Second, further studies need to examine the effectiveness of cleaning and disinfecting strategies in removing potential pathogens. In particular, because CDI spores were frequently recovered from floors in CDI and non-CDI rooms, approaches that reduce these spores need to be identified. Ultraviolet devices can help; however, they were used in only one of the study hospitals and only in CDI rooms.

Also, “we only studied *C difficile* spores and 2 gram-positive pathogens. Additional studies are needed to investigate contamination of floors with gram-negative pathogens and viruses. None of the hospitals used sporicial agents on floors and therefore the frequency of *C difficile* spore contamination is likely to be higher than in facilities that use sporicial agents,” the study explains.

Robotic Sleeve Shows Early Promise

A robotic sleeve, tested in pigs, has been developed to function like a cardiac ventricular assist device. Although existing mechanical devices can help restore heart function, they require implantation in the heart, which can cause adverse reactions, including blood clots. The new robotic sleeve is implanted outside the heart and has material properties similar to the tissue it’s meant to snug around.

According to “Soft Robotic Sleeve Supports Heart Function,” in *Science Translational Medicine*, the biologically inspired design mimics the contractions of the human cardiac muscle. Compressed air powers artificial silicone muscles that can twist, compress or perform both actions at once on one or both sides of the heart.

“The soft robotic sleeve can be customized to patient-specific needs and may have the potential to act as a bridge to transplant for patients with heart failure,” the study adds. “The sleeve does not contact blood, obviating the need for anticoagulation therapy or blood thinners, and reduces complications with current ventricular assist devices, such as clotting and infection.”

So far, scientists from Harvard, Boston Children’s Hospital and Leeds, England, have used the device in six pigs, notes a related article in *BBC News*. When these pigs experienced a drug-induced cardiac arrest, the device increased cardiac ejection volume in vitro. More longer-term animal studies, then human studies, are needed before it can be used in patients.


Easing Patient Anxiety With Virtual Reality

Virtual reality can distract patients from the pain and anxiety of surgery.

Some surgeries that usually necessitate analgesics and sedatives may now require only a local anesthetic when using a new technique highlighted in *The Atlantic*.

Jose Luis Mosso Vazquez, a researcher and surgeon at Panamerican University in Mexico City, has successfully used virtual reality (VR) to distract patients from the anxiety of surgery, explains “Virtual Reality Can Make the Pain of Surgery Easier to Bear,” in *The Atlantic*. He says VR technology also can lower the risk of complications, improve recovery time and reduce costs.

The article recounts the case of a 61-year-old woman who had surgery to remove a lipoma from her thigh. Sedation would be the standard procedure, but she agreed to try a VR headset to explore an immersive three-dimensional simulation of Machu Picchu in Peru. She was given a local anesthetic, although sedation was on hand if she needed it.

After the 20-minute operation, which Mosso supervised, the patient said she was so relaxed during surgery she barely felt the scalpel cutting her skin. In fact, her already-high blood pressure actually decreased during surgery.

Patients reportedly experienced 24 percent less pain and anxiety than control groups, says Mosso, who has used VR for more than 350 surgeries, from childbirth recovery to heart surgery. He says some of the most successful results are for minor procedures such as removing lipomas and cysts.

“Mosso has collected data on all of the surgeries he carried out, and hopes that his experiences will encourage the use of VR to help patients in other under-resourced communities around the world,” the article adds.
Check your biases at the door” was a phrase I heard often during my nursing education. As a group of eager and optimistic students, we often considered our own personal beliefs and how they might influence our care.

But from the removed distance of the classroom, it was easy to spot our biases and readily assume they could be overcome. Early on as a nurse, I committed to seeing all patients as valuable, deserving people simply because they are humans.

Throughout the years, this philosophy had never been challenged to the extent that it was recently. There has been the occasional difficult personality or demanding patient, but never a time I found myself truly not wanting to care for a patient because of who they appeared to be. Though my maxim of all humans deserving sincere care was put to the test, my recent experience proved it profoundly true, though at times incredibly challenging to follow. Nursing care comes from an outflow of the heart, and when my heart is insincere, my nursing care is compromised.

I began my shift the same as I always do — throw my stethoscope around my neck, load my pockets with pens and saline flushes, and silently ask for grace as I take care of people I’ve never met. After getting the report I walked into my patient’s room to introduce myself, completely unprepared for what I was about to encounter.

The hospital where I work has several semiprivate rooms, and although we do our best to maintain confidentiality, the truth of the matter is that anything above a whisper is not going to be blocked by a thin curtain separating the beds. While I was in the room checking my patient’s vitals, a doctor came into the room to see the other patient. Speaking in a loud voice, the doctor began discussing tests and plans for his patient.

Once the gentleman I was caring for heard the doctor say the word cirrhosis, his eyes got wide as he sat up indignantly and said, “Dirty alcoholic, I’m not sharing a room with one of those people!”

Hoping his neighbor had not overheard, I calmly requested he please afford others the same respect he would want for himself. Ideally, he would suddenly return to reality and refrain from further inappropriate comments. Instead, he became enraged and expressed his disgust through clenched teeth as he aggressively waved a pointed finger centimeters from my face. At this point I felt upset for the patient in the next bed and was also uncomfortable with this man’s behavior toward me. I told the patient I would return after a few minutes and left the room, both to compose myself and allow him to cool off, since reason was evidently ineffective.

I went to my sanctuary (the supply closet) to steal a moment of peace to process the rapidly escalating events that had just transpired. Questions raced through my mind as I recalled the conversation: What just happened? How dare this man pass that judgment on his neighbor? He knows nothing about his neighbor’s diagnosis or life! Who is he to determine who is deserving of care in the hospital? Why should I have to put up with this?

I felt angry that someone could be so judgmental and unkind. I was upset that I had to take care of this grumpy man for the remainder of the day. Since it was only 7:45 a.m., there was still a long day ahead of us.

I mechanically pushed through the next few hours of the shift. Technically speaking I was doing my job. I was checking the boxes, doing assessments, giving medicine, but I didn’t want to be this man’s nurse. Unfortunately, there was no recognition of wrongdoing on his part, but this patient generally behaved himself and the rest of the morning was without further incident. However, my opinion of him had already been formed, and it would seem there would be no changing it.

When I finally made it to my lunch break, I had a moment to sit and seriously consider the matter. There was a voice inside me that told me that I was just as guilty of being judgmental. I was judging him for his lack of respect toward his neighbor and
myself. Though I hadn’t fully realized it in the moment, I had concluded this man did not deserve to be treated with kindness and respect since he could not do so for others. He could have the medical care he needed, but no more than that.

I attempted to push the stream of thoughts aside, assuring myself that my standard of behavior was right. But I saw how I was applying terms and conditions for sincere care, and it cut to the heart of the matter quickly. This person does not deserve my sincerity because … he is an alcoholic or because he is judgmental and devalued his neighbor. Was I doing the exact same thing? Surely not. Hadn’t I committed to providing unbiased care based on the fact that being human meant you deserved care?

This was different, I argued. That small voice pressed in further, you’re not really seeing this man. You’re only doing what’s required, but he needs more. These were uncomfortable realizations I wanted to deny, but knew I couldn’t.

I will not pretend that the remainder of the shift was easy or that caring for this man was a joy. But I returned from lunch with new eyes, and I sought to see this man apart from his comments and behavior. I put aside how offended I was and how wrong his comments were, and that left room for an astounding observation. I saw a man with an advanced disease process who was incredibly afraid. Everything in his life was out of control, and he was grasping at anything nearby to give him a sense of safety and security. This by no means justifies his behavior, but it reminded me that even rude patients experience hardship and need my compassion.

I saw this man again only one week later while helping his nurse reposition him in the bed. The change in him was profound. His thinking had become confused and slow due to his disease process. He was fragile, his organs were shutting down, his body was failing him and there was nothing to be done. Instead of harsh words and aggression, he was subdued though still

“Nursing care comes from an outflow of the heart, and when my heart is insincere, my nursing care is compromised.”

Kind and compassionate care for all who come through our units. Judgments aside.

Monica earned a bachelor of science in clinical nutrition from the University of California, Davis, and a BSN from Duke University School of Nursing. She has spent her nursing career working in the adult acute care setting with cardiac medicine and cardiothoracic surgical patients. Currently, she is a volunteer aboard the Africa Mercy hospital ship, docked in Benin, West Africa, where she cares for surgical patients.

Do you have a first-person account of your bedside nursing practice you’d like us to consider for AACN Bold Voices? Send it to aacnboldvoices@aacn.org.

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Red Hot Benefits of Chili Peppers

TRP channels, the primary receptors for pungent agents such as capsaicin (the main component in chili peppers), may be partly responsible for the benefit.

Consuming hot red chili peppers is associated with a 13 percent lower risk of death. “The Association of Hot Red Chili Pepper Consumption and Mortality: A Large Population-Based Cohort Study,” in *PLoS ONE*, analyzed data from more than 16,000 Americans in the National Health and Nutritional Examination Survey III. Survey participants were followed for a median of 18.9 years.

The study finds that people who eat hot red chili peppers tend to be “younger, male, white, Mexican-American, married, and to smoke cigarettes, drink alcohol, and consume more vegetables and meats and had lower HDL cholesterol, lower income and less education,” compared to participants who did not eat hot red chili peppers, reports a related article in CBS News.

Although the mechanism in peppers that could delay death is uncertain, transient receptor potential (TRP) channels, the primary receptors for pungent agents such as capsaicin (the main component in chili peppers), may be partly responsible for the observed connection. Capsaicin, which has antimicrobial properties, may prevent obesity and regulate coronary blood flow.

“These results add to the literature by corroborating the main results of an earlier study. They are distinct in that they are drawn from a different population and thus support the generalizability of the protective effects of hot red chili peppers,” the study notes. A study conducted in China in 2015 looked at the connection between chili pepper consumption and reduced mortality. 


**NSAIDs May Increase Risk of Out-of-Hospital Cardiac Arrest**

The findings from a Danish study are a reminder that NSAIDs are not harmless.

Nonsteroidal anti-inflammatory drugs (NSAIDs) may increase the risk of out-of-hospital cardiac arrest (OHCA), particularly for users of ibuprofen and diclofenac.

“Non-Steroidal Anti-Inflammatory Drug Use Is Associated With Increased Risk of Out-of-Hospital Cardiac Arrest: A Nationwide Case-Time-Control Study,” in *European Heart Journal – Cardiovascular Pharmacotherapy*, examined data from a Danish national health registry to evaluate the possible link between OHCA and NSAIDs. Using an NSAID within 30 days was associated with a 31 percent increased risk of OHCA, with ibuprofen at 31 percent and diclofenac at 50 percent.

“The findings are a stark reminder that NSAIDs are not harmless,” study author Gunnar Gislason, professor of cardiology at Copenhagen University Hospital Gentofte, Denmark, says in a related news release.

Of the 28,947 patients with OHCA from 2001 to 2010, 3,376 took an NSAID within 30 days of the event, with 51 percent taking ibuprofen and 21.8 percent taking diclofenac. Patients who took naproxen, celecoxib and rofecoxib did not have a higher risk factor, but their use was much less frequent.

The study adds that the main limitation is “inherent in the observational nature of the analyses. The treatment allocation is not randomized and the study reports only associations and therefore any conclusion on causality should be made with caution.”

Genomics, Personalized Medicine to Shape Healthcare Evolution

Providers will be able to prescribe therapeutics, pharmacogenetics and treatment regimens that are specific to each patient.

As part of Elsevier’s 100th anniversary celebration of Medical Clinics, the company asked health IT leaders to predict the future of healthcare.

“Experts: Personalized Medicine, Data Accessibility Will Shape the Next Century in Healthcare,” in FierceHealthcare, notes that the “rise of genomics and personalized medicine will pave the way for healthcare’s transition to a more patient-centered approach to care over the next 100 years.” The article predicts that advances in genetic testing will give clinicians a more complete picture of each patient’s risk of acquiring complex diseases.

Geeta Nayyar, chief healthcare and innovation officer, Femwell Group Health, Miami, says, “Precision medicine will become more ingrained in patient care” and that, although genetic testing and precision medicine is still in its infancy, researchers are making it a priority this year.

“We are going to see precision medicine actually executed,” Nayyar notes in the article. “We are going to know the DNA composition of patients — their genetic makeup and their families’ genetic makeup.” Nayyar adds that medical providers will be able to prescribe therapeutics, pharmacogenetics and treatment regimens that are specific to each patient.

Other health IT leaders predict patients will be more actively involved in their care, partly because information will be more easily accessible. Victoria Tiase, director of informatics strategy at NewYork-Presbyterian Hospital, hopes technology will help patients “understand their state of wellness at all times.”

As further evidence of this trend, the article reports that hospital leaders at the World Economic Forum in Switzerland emphasized the importance of patient data in the evolution of healthcare. Several health systems have already started integrating new data points for more customized care.

New Technology Could Speed Up Bacteria Identification

The system’s algorithm identified the correct bacteria 99.8 percent of the time, compared to an error rate of 23 percent for traditional methods.

A new diagnostic tool that identifies bacteria strains by analyzing their high-resolution melt curves offers the potential to assist clinicians in identifying specific pathogens that cause sepsis.

“Nested Machine Learning Facilitates Increased Sequence Content for Large-Scale Automated High Resolution Melt Genotyping,” in Scientific Reports, describes an innovation that uses lab-on-chip technology (microfluidics) as well as DNA analysis through the unique identifiers of individual bacteria strains. The system, which identified the high-resolution melt curves of 37 bacteria, could theoretically provide matching abilities for clinicians seeking to target therapy rapidly.

Lead study author Stephanie Fraley, assistant professor of bioengineering, says in a related article in New Atlas that she hopes the system, developed at the University of California, San Diego, could reach physicians within five years. The challenge will be building a comprehensive database so that a bacteria not yet represented would not be misclassified as the nearest match but would be identified by its unique properties.

According to the study, the system’s algorithm identified the correct bacteria 99.8 percent of the time, compared to an error rate of 23 percent for traditional methods. The system, which has not yet been tested with patient samples, was developed to understand its capabilities.

The system “could be particularly useful for identifying DNA that is difficult to sequence due to repetitive nucleotides that hamper alignment of short read lengths, a limitation of many sequencing technologies.” The technology also could be used to further explore DNA melting behavior and possibly identify additional clinical tools.

Increasing the Number of Nurses on Hospital Boards

Nurses’ experience and skills help hospital boards make more effective operational, financial and strategic decisions.

Although nurses provide more diversity and an invaluable operational point of view, only 5 percent of U.S. hospitals have a nurse on their boards.

“Getting Nurses on Board,” in Trustee, explains that the issue could be due, in part, to the perception of the role of nurses. The article cites a 2010 Gallup Poll that finds nurses are not perceived as influencers. Although the field consists largely of women, they are underrepresented on hospital boards. Even in other industries, women hold a small fraction of board seats.

At least one recent study finds a quantifiable benefit to having nurses as trustees. An analysis by the University HealthSystem Consortium finds a correlation between the number of nurse trustees and improved quality and safety in hospitals. Workplaces with nurses on their boards also have higher retention rates for staff nurses.

The article offers some suggestions to help hospitals find qualified trustees. “Nurse leaders can be found, of course, within your hospital or health care system — but they might have to be asked.” Other sources include deans at local community colleges with a nursing school or organizations such as the Red Cross and the American Heart Association.

Resources

Several organizations, noted in the accompanying article, are working to increase nurses on boards, including the following:

- Nurses on Boards Coalition, a campaign to help ensure 10,000 nurses are on boards by 2020, encourages nurses to register their involvement on its website.
- American Nurses Foundation is developing a database that matches nursing leaders with boards. Companies can submit a request.
- Future of Nursing: Campaign for Action has action coalitions in every state and the District of Columbia that offer recommendations.
In Our Journals

Hot topics from this month’s AACN journal

A review of current evidence indicates that the harm of administering acid-suppressive therapy (AST) to prevent gastrointestinal bleeding outweighs the benefit in most hospitalized patients. Stress ulcers are common in critical illness, but gastrointestinal bleeding is a rare complication. Research shows that raising gastric pH increases the risk for infection, specifically pneumonia and enteric infections such as Clostridium difficile. The authors advise evaluating patient risk for gastrointestinal bleeding before administering AST, removing proton pump inhibitors and histamine 2 blockers from order sets, and considering discontinuing AST when patients are transferred from the ICU.

(Faust, CCN, June 2017)

A nurse-led protocol significantly reduced rates of catheter-associated urinary tract infections. After assembling a team and getting input from the staff, the nurses implemented a three-pronged strategy that included evidence-based, educational and supportive interventions. Staff concerns that removing catheters would increase rates of skin breakdown were discussed and addressed with barrier protection. The authors attribute their success to the bundling of interventions, to their non-punitive approach to staff and to a change in culture that increased nurse and physician collaboration.

(Richards, CCN, June 2017)

A quality improvement project on a progressive care unit showed that addressing patient hand hygiene affects hospital-acquired infection rates. Patients were given written and verbal education about hand-washing, and alcohol-based hand sanitizer was kept within reach. Over the 19-month study period, the unit saw a 63 percent decline in methicillin-resistant Staphylococcus aureus infection, a 70 percent decline in vancomycin-resistant enterococci infection and a 31 percent increase in Clostridium difficile infection, which may be because C difficile requires soap and water hand-washing. These findings support further projects that use patient hand hygiene as an intervention to control hospital-acquired infections.

(Haverstick, CCN, June 2017)

Transitions

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

April Archibald, nurse practitioner, joins the staff at Essentia Health St. Mary’s Heart and Vascular Center, Duluth, Minnesota. She has worked at Essentia Health for 17 years.

The Honor Society of Nursing, Sigma Theta Tau International, Indianapolis, inducts nurse researchers “who have achieved significant and sustained national or international recognition” into the International Researcher Hall of Fame, including the following for 2017:

- **Diane Carroll**, nurse scientist, Yvonne L. Munn Center for Nursing Research, Massachusetts General, Boston, and an AACN member since 1989
- **Nancy Redeker**, professor, Yale School of Nursing, New Haven, Connecticut, and editor of *Heart & Lung*
- **Mary Lou Sole**, dean and professor, University of Central Florida, Orlando, past editor of *AACN Clinical Issues*, past recipient of an AACN Distinguished Research Lectureship and a member since 1975
- **Terri Weaver**, professor and dean, University of Illinois at Chicago

Washington State University College of Nursing, Spokane, honors Debbie Brinker, clinical assistant professor and assistant dean for faculty affairs & community engagement — AACN past president, a member since 1988 and past president of the Spokane Chapter — with its Distinguished Teaching Award. She says, “I believe in living AACN’s vision every day, now through teaching and leadership. I truly value our association and enjoy paying it forward with student memberships each semester.”

Maria R. Shirey, professor and chair, Acute, Chronic and Continuing Care Department, University of Alabama at Birmingham School of Nursing — and past chair of AACN Certification Corporation — receives the inaugural Suzanne Smith Memorial Award for Scholarly Writing Excellence, which was presented by the Council on Graduate Education for Administration in Nursing.

Mary Zellinger, past AACN board member, was inducted as a fellow of the American College of Critical Care Medicine during the Society of Critical Care Medicine’s annual congress.

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.
A year ago in New Orleans, I announced this year’s theme, It Matters, by quoting the inspiring words of Martin Luther King Jr., whose quote frames this column. I believe this moving declaration lies at the heart of some of the most important work that nurses do. When we use our voice to advocate for patients and families, it matters. When we speak up to create healthy work environments and drive change needed in our units and systems, it matters. And when we speak on the national level in a united voice that drives change in healthcare and enlarges our role as nurses, it matters.

Our voices are powerful. In fact, according to Jason Leitch, clinical director of Scotland’s National Health Service, our voices might be the most important vital sign of all. In his TED talk, “What Matters to Me — A New Vital Sign,” Leitch talks about the importance of identifying what matters to patients. I found it transformative to think about this question. As a palliative care nurse practitioner, I now consider it as vital when I talk with patients, as all those other vital signs we take so frequently.

I asked this same question often when I met with nurses this year: What matters to you? What brings you joy? And I can boil down the most common responses to two words: love and family. But I was also happy to hear many nurses say that the experience of being a nurse — the human centeredness, the values unique to our profession, enjoying the people they work with often referred to as family — also filled their lives with joy.

Last year at NTI, I told a story about myself as a new graduate nurse working the night shift. My patient had gone into full cardiac arrest, and the other night-shift nurse — a veteran of 30 years — and I tried valiantly but unsuccessfully to resuscitate him. The next day I heard through the rumor mill that the other nurse believed that my inexperience as a new graduate contributed to the unsuccessful resuscitation.

Let me tell you — that devastated me. But even more devastating was that I did not talk to my co-workers or anyone else to gain insight into what I might have done wrong — or right. I did not use my voice. I remained silent about something that mattered.

I now stand before you as the veteran nurse. I proudly wear my experience on my face, in my joints and in my heart. And today I am encouraged and inspired. Why?

Because you used your bold voices to let me know this year what matters to you. You spoke to me in emails, social media, chapter meetings, tours of your units and conferences to let me know. You inspired me with the different ways you demonstrate every day that nurses matter. As I visited you from Atlanta to Pennsylvania to Denver to New York to Seattle, you told me what matters most to you. So thank you.

As my term comes to a close, I am more humble than when it began. I especially want to thank you for showing me that during a year of significant change in our country, the rich and vital work of nursing matters even more. Of course, a recent Gallup poll named nursing the most trusted profession for the 15th consecutive year. Of course!

So never doubt that you matter. And that your voice matters. It matters because it enables all of us to provide human-centered care that transforms our patients’ lives and preserves families’ memories. It matters because it allows us to relentlessly drive change that is vital for our patients, for the units and systems where we work and for this honored profession we call nursing.
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