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My brother-in-law is living with stage IV pancreatic cancer — what others call dying of cancer. And if the process is equal parts hope and agony, it’s also wholly, profoundly American.

He’s in pain. He’s besieged by tests, scans and appointments, and is in and out of the ICU. His gastrointestinal tract has been poked, prodded and repeatedly coated with x-rayable drink. Even after surgery, his pancreas and neighboring organs remain spotted with tumors. Yet he seeks aggressive treatment, second opinions and hope, just as many of us would — when faced with the choice of three months to live with no chemo, or a year or more with it.

Even under the promising glow of medical technology, we’re faced with a new challenge: how we should die, and how those around us — nurses and physicians among them — can and should help.

— Clareen Wiencek and Dorrie K. Fontaine


Courageously Leading Change

This past year, I’ve traveled around the country and heard many powerful stories of Courageous Care. Stories of nurses courageously leading change to improve patient outcomes.

Read more in my note on page 22.

Karen McQuillan
AACN President

Courage is very important. Like a muscle, it is strengthened by use.

—Ruth Gordon
The American Association of Critical-Care Nurses is the world’s largest specialty nursing organization. AACN is committed to 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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CCRN Certification Turns 40

This year, the AACN community celebrates four decades of certification excellence as we mark the 40th anniversary of CCRN specialty certification for critical care nurses. We spoke with four of our 40-year CCRNs, who shared their longtime experience as critical care nurses and the role certification has played in their nursing journey.

AACN: What led you to become a critical care nurse?

Cindy Bohmont (CB), CVICU staff nurse, Mercy Hospital, Springfield, Missouri: I decided to become a nurse the day we had a bus wreck coming home from 4H camp when I was 14. I decided then and there that I would never again be in a situation where I was helpless and didn’t know how to help an injured person.

Carolyn Langstraat (CL), CVICU staff nurse, educator and preceptor, Baptist Memorial Hospital-Memphis: When I was very young, my Dad contracted polio. I remember helping to care for him and wanted to be a nurse from that time on. The week after high school graduation, I started nursing school, and it has been a passion and devotion for 46 years.

Ellen Prewitt (EP), critical care transport flight nurse practitioner, Cleveland Clinic: It was purely a logical decision. In high school, you had to join the Future Teachers, Future Secretaries or Future Nurses club. I was an awful typist and never wanted to sit behind a desk, and could never see myself talking in front of a group of people, so nursing it was! I have not regretted it at all!

Frances Watson (FW), critical care nurse manager, Memorial Medical Center, Johnstown, Pennsylvania: I had a strong desire to be in a field where I could directly help others. As a teenager, I read nurse-themed books and watched “General Hospital” on TV, but wanted to know what nursing was really about. After a summer as a candy striper, I took the leap of faith applying to nursing schools. With my rotation to ICU, I knew that’s where I was meant to be.

AACN: Why did you pursue CCRN certification all those years ago?

CB: I am a classic over-achiever in everything I do, including nursing. ICU is my place, and if I was to do something, I intended to be among the best — which included becoming certified in my specialty. I not only wanted to know how to do something, but why.

CL: I was a new nurse in the early 1970s, and several friends and I were enthusiastic about becoming the best nurses possible. Together, we studied the few critical care text books we had — no review classes or “Pass CCRN” books in those days! We all made the trek to New Orleans to take the very first certification exam.

EP: When I started in the ICU, I was the youngest nurse there. Most of my colleagues had been working in the ICU for years. I pursued certification to prove to myself I could do it.

FW: In the early 1970s, my mentor and I attended NTI in Boston together, and the talk of an upcoming certification test and the CCRN credential excited us. We were determined to take the very first exam. I failed that exam by just a few points and was disappointed, but even more determined to successfully pass the next exam — which I did!

AACN: What inspired you to maintain your credential?

CB: It helps me stay on the cutting edge of critical care education, and I feel confident knowing I have this background while caring for each of my patients.

CL: I’ve stayed certified because I think it shows devotion to my profession and provides a way to stay at the top of my game. I’m also trying to be a good example to the new nurses I mentor — that I do it, not just suggest it.

EP: It pushed me to keep up with what was going on in critical care and seek out opportunities to challenge myself. It also motivated me and gave me the confidence to go on for my MSN and later, my ACNP.

FW: I am so proud of being a CCRN. It’s been a personal validation of my expertise, something I would always value and maintain as long as I could. It helped me achieve my goal to become the head nurse in the unit where I started as a GN, and I later became nurse manager. As a manager, I also felt that I needed to set an example for my staff.

AACN: How has CCRN certification impacted your practice?

CB: When I started nursing in 1971, we had very little in the way of technology and pharmacological tools. Through certification, it has been a wonderful journey into this future with the progress in patient care and treatment. I pray we will never lose the compassion and the empathy needed by our critically ill patients.

CL: Certification has helped me in many ways; for example, to see new treatments before they were introduced at my hospital. Perhaps the newest example of this is ECMO. Shortly after I learned about it, it was introduced in our hospital. I was able to better educate our staff because of my knowledge.

EP: Being certified has opened doors to new opportunities. I became a staff development instructor and created a critical care orientation program for our institution.

FW: Certification helped shape and define my practice and career. The gold ring of obtaining certification opened up a new world for me, making me a better nurse — as I learned, my con-
CONFIDENCE grew. I could clearly see the reasons why behind what we were doing for patients and what could be done to improve outcomes.

AACN: What do you say to nurses considering certification?

CB: I have championed many nurses, both new and experienced, to become certified. Certification tells the world that you are committed to providing the best possible care and have made the effort to achieve that. You owe it to your patients to be as knowledgeable as possible about their condition and care to keep them safe.

CL: As an ambassador for AACN, I encourage the nurses around me to get certified, join AACN and become involved. Those that do are more confident and prepared to take the best care of our patients.

EP: Just do it … you won’t regret it! It gives you that inner confidence.

FW: Certification is the difference maker in your career. If you are serious about what you do, you need to consider certification. It will expand your knowledge base, and you will soar!

Forty Years Later, Certification Continues to Reflect a Commitment to Excellence and Patient Safety

When AACN Certification Corporation launched the CCRN credential in 1976, it allowed critical care nurses to demonstrate that their knowledge, skills and abilities met rigorous national standards of excellence and reflected a deep commitment to patient safety.

Today, 16 of those original CCRN-certified nurses still hold their credential. We couldn’t be prouder of them — and their commitment to the nursing profession and exceptional patient care.

Over the last 40 years, the number of active CCRNs has grown to more than 76,000, with an average of 8,500 nurses obtaining CCRN certification each year.

AACN Certification Corporation currently offers 19 specialty, subspecialty and advanced practice certification programs for acute, progressive and critical care nurses, with more than 96,000 active certificants.

Learn more about our certification programs at www.aacn.org/certification, or call 800-899-2226.

“...the ‘thinking out loud’ technique used in these cases has helped me to reflect how I might improve my own diagnostic reasoning and that of my students!”

—Nancy Munro, RN, MN, CCRN, ACNP-BC, FAANP  
Senior Acute Care Nurse Practitioner  
National Institutes of Health, Bethesda MD

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More Scholarships for AACN Members

AACN is here to support you, applaud you and inspire you along your professional journey.

AACN scholarships are awarded to members in support of lifelong learning, career enrichment and knowledge acquisition through a variety of programs and conferences.

A portion of the scholarship fund is also designated for members pursuing their academic education, because AACN understands the demands of nursing and is here to support you, applaud you and inspire you along your professional journey.

Aligning with landmark studies, such as the 2010 Institute of Medicine (IOM) report, “The Future of Nursing: Leading Change, Advancing Health,” the follow-up report, “Assessing Progress on the IOM Report: The Future of Nursing,” and other studies and recommendations, AACN has designated additional scholarships for members who qualify and are pursuing a Bachelor of Science in Nursing, or higher degrees such as a Master of Science in Nursing or a doctorate.

For more information on the requirements and an application, visit www.aacn.org/scholarships, and please email scholarships@aacn.org with your questions.

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Possible Link Between Proton Pump Inhibitors and Dementia

Avoiding PPI medication may prevent the development of dementia, but more study is needed.

The use of proton pump inhibitors (PPIs), for treating patients with gastrointestinal disorders, is associated with a higher incidence of dementia or Alzheimer’s disease. In “Association of Proton Pump Inhibitors With Risk of Dementia,” in JAMA Neurology, analyses of diagnoses and prescription data for 73,679 patients ages 75 and above who were free of signs of dementia at baseline show a higher risk of developing dementia (33 percent higher) or Alzheimer’s (44 percent) if the patient regularly takes a PPI (omeprazole, pantoprazole, lansoprazole, esomeprazole or rabeprazole).

Gathered from Germany’s largest health insurer database and spanning 2004 to 2011, the data demonstrated that PPI users were significantly more likely to be in the group who received a dementia diagnosis. “The avoidance of PPI medication may prevent the development of dementia,” the study concludes. It notes that prospective randomized trials are needed to determine if an actual cause and effect relationship exists between the use of PPIs and the occurrence of dementia.

A related article in Medscape Medical News, “Proton Pump Inhibitors Linked to Dementia,” says PPIs are frequently overprescribed and increasingly being given to older patients. In searching for medical explanations for a possible link, the article notes evidence of PPIs crossing the blood-brain barrier and previous studies showing vitamin B12 deficiencies in PPI users.

If the association proves medically accurate, a related editorial in JAMA Neurology observes, the United States could expect approximately 10,000 new dementia cases linked to PPI use annually for patients ages 75-84. “An important issue raised by this study and similar studies of drugs that may increase risk of dementia,” the editorial notes, “is whether a careful evaluation of cognitive changes and/or neuropathology should be a component of the evaluation of drugs that are widely used among the elderly.”

REFERENCES:

Are We Ready for Robotic Physicians?

The infrastructure for a more automated future is already being laid out.

Robotics and artificial intelligence for patient care — using technology that’s been vetted in other industries — is in the future. It’s just a matter of sufficient testing, notes “Robots in Health Care Could Lead to a Doctorless Hospital,” in The Conversation. Although, for safety reasons, hospitals have been slow to incorporate automated processes, robotic physicians don’t have to be 100 percent reliable, the article claims. Robots need to be more reliable than human physicians, while also helping to control the increasing cost of patient care.

“Hospitals will be very different places in 20 years. Beds will be able to move autonomously, transporting patients from the emergency room to the operating theatre, via X-ray if needed,” the article adds. The infrastructure for a more automated future is already being laid out. Robots perform surgery remotely or assist physicians directly in the operating room, although the surgeon is always in full control. Computerized medical devices also provide diagnostic assistance and help monitor vital signs.

“Insurance costs and litigation will hopefully reduce as machines perform procedures more precisely and with fewer complications. But who do you sue if your medical treatment goes tragically wrong and no human has touched you? ... So too is the question of whether people will really trust a machine to make a diagnosis, give out tablets or do an operation,” the article adds.
Collaboration Helps Reduce Infection Rates

Cleaning patients’ rooms to remove *C. diff* included doubling the time to 90 minutes and scrubbing hard for long periods of time with bleach wipes.

*Hospitals and nursing homes in Rochester, New York, collaborated to improve cleanliness practices and antibiotic prescription strategies to reduce *Clostridium difficile* (*C. diff*) infection rates.*

“Rochester Hospitals Unite to Defeat a Common Foe: *C. Difficile*,” in *The Wall Street Journal*, explains how the city’s four hospitals started a *C. diff* prevention collaborative; six nursing homes that share patients with these hospitals formed a separate alliance. These efforts helped cut the hospitals’ *C. diff* infection rate in the 12 months ending September 2015 by 36 percent from 2011 levels. Infection rates in the third quarter of 2015 dropped to six per 10,000 patient days, from a peak of 13 in the fourth quarter of 2011.

Shared strategies for cleaning patients’ rooms to remove all traces of *C. diff* included doubling the time to 90 minutes and scrubbing hard for long periods of time with bleach wipes. An innovative tool that can check for trace amounts of contaminants allowed inspectors to ensure *C. diff* was no longer present.

Because commonly prescribed antibiotics also kill good bacteria in patients’ guts and make patients with *C. diff* more difficult to treat, the collaborating hospitals decided to promote the use of doxycycline for less severe forms of pneumonia instead. One hospital used the collective policy as a springboard to change an electronic form, so orders for the undesirable antibiotic would require special approval.

The collaborating hospitals also worked with the nursing homes, which share a common patient pool, to provide guidelines for diagnosing and treating urinary tract infections to help reduce overprescribing of antibiotics. “It’s fairly clear that you have to work with the nursing homes and you have to work across the community to make progress,” Mark Shelly, chief of infection disease at Highland Hospital, Rochester, adds in the article.

Cleaning patients’ rooms to remove *C. diff* included doubling the time to 90 minutes and scrubbing hard for long periods of time with bleach wipes.

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Updated Guide for CLABSI Prevention

The guide offers preventive measures, tools and resources for infection prevention.

**A** n updated guide on central line-associated bloodstream infections (CLABSIs) outlines essential steps for prevention and supplements existing practices.

“APIC Updates Guidance for CLABSI Prevention,” in *Healio Infectious Disease News*, notes that “Guide to Preventing Central Line-Associated Bloodstream Infections” offers preventive measures, tools and resources for clinicians, regardless of practice setting. “APIC Issues Free Resource to Prevent CLABSI,” a news release from Association for Professionals in Infection Control and Epidemiology (APIC), Washington, includes a link to the free guide (registration required for download).

While research indicates most CLABSIs are preventable, the Centers for Disease Control and Prevention, Atlanta, estimates that more than 30,000 CLABSIs are reported annually in the U.S., and 25 percent of patients die, the article notes. While prevention remains a challenge, the release adds that the guide provides the “opportunity to objectively evaluate current practice within the framework of continuous improvement.”

Among the topics covered are epidemiology and pathogenesis, surveillance, adherence to the central line bundle, preventing infections during catheter maintenance and preventing infection during long-term device use. “Topic-specific information is presented in an easy-to-understand and use format that includes numerous examples and tools,” the release adds.

Lead editor Linda Goss, University of Louisville (Kentucky) Global Health Center, notes in the release that CLABSIs are associated with the highest number of preventable deaths compared to other healthcare-associated infections.

“Therefore, it is imperative for healthcare facilities to adopt best practices to prevent these infections, making this practical, hands-on implementation guide the perfect tool.”

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AT THE BEDSIDE

Procedure Would Allow Kidney Transplants From Any Live Donor

Although the main use of desensitization would be for kidney transplants, it might be suitable for living-donor transplants of livers and lungs.

A new procedure, known as desensitization, would allow kidney transplants from any live donor and, in the process, potentially save lives.

As described in “Survival Benefit With Kidney Transplants From HLA-Incompatible Live Donors,” in *The New England Journal of Medicine*, physicians successfully altered patients’ immune systems, so they could accept kidneys from incompatible donors. Many more of those patients were alive after eight years, compared to patients who remained on waiting lists or received a kidney from a deceased donor; however, the generalizability of that finding is not clear.

Funded by the National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, Maryland, the “multi-center study validated single-center evidence that patients who received kidney transplants from HLA-incompatible live donors had a substantial survival benefit compared with patients who did not undergo transplantation and those who waited for transplants from deceased donors.”

The method “has the potential to save many lives,” Jeffery Berns, a kidney specialist at University of Pennsylvania’s Perelman School of Medicine, Philadelphia, adds in a related article in *The New York Times*.

Desensitization involves first filtering antibodies from the patient’s blood. The patient then receives an infusion of other antibodies “to provide some protection while the immune system regenerates its own antibodies,” the article adds. For an unknown reason, the regenerated antibodies are less likely to attack the new organ.

If the regenerated natural antibodies are still a concern, the patient is treated with drugs that destroy any white blood cells that might create antibodies that would attack the new kidney, Dorry Segev, lead study author and a transplant surgeon at Johns Hopkins University School of Medicine, Baltimore, says in the *Times*.

Although the main use of desensitization by far would be for kidney transplants, “the process might be suitable for living-donor transplants of livers and lungs.”


Proposed Ban on Most Powdered Gloves

The FDA announced plans to ban these products from the marketplace, because they pose a substantial health risk to patients and staff.

Although the use of powdered gloves is on the decline, the Food and Drug Administration (FDA) issued a proposal to ban the products because of potential health concerns.

“FDA Proposes Ban on Most Powdered Medical Gloves” notes that the ban would apply to “powdered surgeon’s gloves, powdered patient examination gloves and absorbable powder for lubricating a surgeon’s glove.”

The FDA discovered that powder used on natural (not synthetic) rubber latex gloves “can carry proteins that may cause respiratory allergic reactions.” Powdered synthetic gloves are associated with other adverse effects, such as severe airway inflammation, wound inflammation and postsurgical adhesions.

Because these risks cannot be corrected through product labeling, the FDA announced a proposal to ban these products from the marketplace, since they pose a substantial health risk to patients and staff. The proposed rule is available online for public comment until June 20, 11:59 p.m. ET.

The news release notes that the FDA conducted an economic analysis, which indicates the ban would not have a significant economic impact or lead to a shortage of gloves. Non-powdered surgeon’s gloves and non-powdered patient exam gloves would not be part of the ban.
Eating Chocolate May Improve Brain Function

The beneficial ingredients in chocolate are naturally occurring cocoa flavanol compounds, which improve blood flow to the brain.

Chocolate is associated with several documented health benefits, which now may include improved cognitive function. “Chocolate Intake Is Associated With Better Cognitive Function: The Maine-Syracuse Longitudinal Study,” in Appetite, finds that long-term weekly consumption of chocolate may be associated with increased performance across a range of cognitive domains. Regardless of other dietary habits, improvements were observed in visual-spatial memory, working memory, scanning and tracking, abstract reasoning and the Mini-Mental State Examination. The beneficial ingredients in chocolate are naturally occurring cocoa flavanol compounds, which improve blood flow to the brain — “and possibly protect against normal age-related cognitive decline.”

Although past health studies have focused on dark chocolate, which contains a richer amount of flavanols, consumption of white, dark and milk chocolate was included in the study, indicating that all types of chocolate may offer some benefit.

The cohort study included a cross-sectional analysis of 968 community-dwelling participants ages 23 to 98 years old. Data was drawn from a study of adult residents of Syracuse, New York, that measured cardiovascular disease and cognitive function. Cardiovascular lifestyle and other dietary factors were also considered.

Limitations include the fact that “chocolate intake was self-reported, and therefore subject to inherent reporting error,” and respondents were not asked what type of chocolate they ate. The study concludes, “Further intervention trials and longitudinal studies are needed to explore relations between chocolate, cocoa flavanols and cognition, and the underlying causal mechanisms.”


Communication Across Teams Makes Everyone Responsible

In an era of team-based interdisciplinary care, the concept of a “captain in charge” does not contribute to optimal outcomes.

Teamwork, rather than a “captain in charge,” makes for a seamless and effective work environment, recommends a Viewpoint article in JAMA Surgery.

“Contemporary Multidisciplinary Care – Who Is the Captain of the Ship, and Does It Matter?” discusses the history of the one-person-in-charge mentality and how the growth of medical specialties has changed the way communication should be approached, in order to improve management of patients.

The basis of the captain approach rests with how medicine was once practiced. One physician cared for a patient throughout his or her hospital stay and after discharge. Now, this care is shared among specialists, nurses and other healthcare professionals who may change on a daily basis, if not more frequently.

Hospitals are already working in a multidisciplinary fashion, the article adds, but the leadership model has not yet evolved.

Recommendations to incorporate a cohesive model include the administration rewarding teamwork and communication, providing staff training, not communicating in a top-down manner and addressing barriers — physical and administrative — that may prevent communication between departments.

The article stresses, however, that these recommendations do not mean there is no personal responsibility for patients, because when communication breaks down, people do want to know who is in charge. But if the system is working well, with good communication, the care is seamless and everyone involved is responsible for their part.

A Tale of Two Nurses
An Interview With Kim Hicks and Angela Gillies

Part of the same nursing school graduating class, hired by the same facility, at the same time, to work in the same department, one might have the impression Kim Hicks and Angela Gillies were bound to do great things together in healthcare. And they have. But their story of success, about how two young nurses helped lead the University of California, Irvine, Medical Center’s surgical ICU to the Promised Land of nursing practice — a gold-level Beacon Award — is so unlikely it would probably be rejected by Hollywood.

Why did you become a nurse?
Kim Hicks: I decided to become a nurse because I was always interested in healthcare and knew I wanted to work in the healthcare setting somewhere. My dad is a doctor and my mom is a social worker, and both of them told me that I should go into nursing. My dad said that nursing was the best spot in healthcare, that they have independence and can choose their own way. He was exactly right. So I applied to nursing school at UC Irvine and was fortunate enough to get accepted.

Angela Gillies: I did not grow up knowing I wanted to become a nurse, but now that I am one, I cannot imagine doing anything else. I knew I wanted to work in healthcare, so my career could help make a difference in the lives of others. The University of California, Irvine, started the Nursing Science Program the same year I began studying there, and I was fortunate enough to be accepted into the program.

What about your job makes you happy?
KH: I really enjoy working with my night shift crew. We have a really strong team of nurses at night, and I love coming in and seeing the amazing work everyone is doing. I am most happy at work when I have a very critical patient. I enjoy the fast-paced, adrenaline-filled environment that we often have in the SICU.

AG: I love what I do, because I have the potential to make a positive impact on the lives of others every time I go to work.
It is an honor to care for others when they are most vulnerable and to help them feel safe and empowered. It also helps having such an incredible group of co-workers.

What has been your best patient experience, and what did it teach you?

KH: The best patient experience I ever had was a lady who was three days post-op for a double mastectomy and tram-flap after finding out she had breast cancer. For these patients at our institution, it is very important that they stay in a flexed position so it gives the incisions time to heal. Unfortunately, it means that the patient has to stay in bed for the first couple of days, and my patient was starting to feel pretty grimy and gross. So that morning, I did what I like to call “bed, bath and beyond.” I set up a way so that we could wash her hair, get it combed out and really give her a good scrubbing. She was so thankful; she told me, “I feel like I can deal with the pain and the stiffness, but I just really, really wanted to wash my hair.” It taught me that sometimes as a critical care nurse, we can get caught up in the numbers and the criticalness of our patients’ conditions but never forget that there is a human in that bed who has other needs beyond just the numbers.

AG: One that has stuck with me was when I cared for a critically ill patient who was on cardiopulmonary support (CPS), continuous renal replacement therapy (CRRT) and multiple drips. It seemed there was not even room to move in the ICU room that usually seemed so spacious. It happens to be my favorite kind of environment to work in, since every decision is a critical one, and the adrenaline makes the shift fly by in the blink of an eye. As I steadfastly worked through the shift, I remember wondering if the lifeless body in the bed before me would ever recover. I was determined to at least give him the best chance possible. When I went back to work the next week, I learned he had been weaned off all the machines and had progressed to eating meals out of bed! Every time I think of that story, I am reminded that no matter how sick a patient may seem, we can’t ever, ever lose hope. Beneath all the lines, tubes and drains is a human being who most likely means the world to somebody.

Let’s talk about Beacon. Can you give me the details of this incredible story?

AG: Our Beacon journey originated at NTI in Boston in 2013. We were sitting on the shuttle on our way back to the hotel and decided to look into what it entailed to receive the Beacon Award, since we had just seen units honored for it.

KH: When Kim and I approached her about it, she was so excited to get the process started. We then introduced the idea to our Practice Council, and the members were more than willing to help gather information. Once we had the bulk of information we would need, Kim and I began typing and organizing it into one cohesive document.

AG: So when Kim and I approached her about it, she was excited to get the process started. We then introduced the idea to our Practice Council, and the members were more than willing to help gather information. Once we had the bulk of information we would need, Kim and I began typing and organizing it into one cohesive document.

KH: We divided up the categories, split up into five groups and started gathering the information for all the categories. Then, Angela and I took all that information and made it into a succinct, streamlined document with the goal of finding out the results by NTI San Diego in 2015, so that as many of our co-workers that wanted to come down and celebrate would be able to make the short trip south. We applied in August 2014, and in January 2015 we got the amazing news that we had been awarded Beacon gold!

What was it like when you first got the news?

KH: Angela was working that night, so Susanne called me first. I was so pumped, I think I got some weird looks from my husband. But then she called Angela, and I’ve heard stories about how that went. I think things got a little crazy.

AG: Yeah, I might have broken into a little dance or something. We were so excited!

What has been the result of your journey? What have you found out about yourself personally or professionally?

KH: I learned a lot about my unit and how we relate to the other ICUs in the hospital. Working night shift, sometimes you can feel disconnected from the rest of the hospital and feel out of the loop. Writing the Beacon application reaffirmed for me that I picked the best place to work, somewhere that really focuses on patient outcomes and moves forward with applying the best evidence-based practice to benefit our patients.

AG: Working on the Beacon application was a reminder you can do anything you set your mind to. It seemed like quite a daunting task in the beginning, since there was so much information to gather and organize, but the more I thought about the SICU and all the incredible things we accomplish, the more eager I became to complete the application. As a result of our journey, I feel we are a united unit that is proud of the work we do!

Interview by Paul Taylor (paul.taylor@aacn.org)
For Visitor Hand Hygiene, Location Matters

Visitors were 5.28 times more likely to use sanitizers located in the central area of a hospital lobby with limited landmarks or barriers.

To improve visitors’ hand hygiene (HH), hospitals should consider placing alcohol-based hand sanitizers (AHS) in the middle of the lobby instead of near an information desk.

“Visitor Characteristics and Alcohol-based Hand Sanitizer Dispenser Locations at the Hospital Entrance: Effect on Visitor Use Rates,” in American Journal of Infection Control, finds that HH rates are generally low among hospital visitors; overall AHS use across all main entrance locations is 3.71 percent. However, visitors are 5.28 times more likely to use AHS located in a central area of the lobby with limited landmarks or barriers, the study explains. Visitor HH is an important aspect in preventing healthcare-associated infections.

The three-week observational study, which involved more than 6,660 visitors to Greenville Memorial Hospital in South Carolina, also notes that hospital visitors are 1.39 times more likely to use AHS when they arrive as part of a group of two or more individuals than if they enter the hospital alone, adds a related article in FierceHealthcare.

The study lists several limitations and suggests opportunities for further research to determine how visitor characteristics, location, time of day and group dynamics affect HH in the lobby of a large hospital. It “also suggests future research for visitor HH to be expanded throughout the entire hospital (not just the entrance) and to evaluate how the rates of AHS differ in areas of the hospital that have higher rates of HH (e.g., NICUs).”


Ransomware Poses Major Threat to Hospitals

Teaching employees to be cyber vigilant at home as well as at work is one of the best ways to establish secure habits.

Earlier this year, hackers remotely locked out the medical records and IT systems at Hollywood Presbyterian in Los Angeles and netted a $17,000 ransom.

“Healthcare Information Technology – What Hospitals Can Learn From Hollywood Presbyterian’s Ransomware Run-In,” in Becker’s Health IT and CIO Review, notes the hospital has since established stronger security policies, but the breach was likely due to employee error. The cause offers a sobering cyber-security lesson for all hospitals.

Overall, healthcare IT systems tend to be more secure to maintain privacy compliance. But the weakest link to any fortified network is human error, which is why hackers often target employees with virus-laden email, links to malicious websites and phone calls that fish for access clues.

For example, criminals could visit a hospital and leave a USB drive marked radiology in hopes that it would be picked up by an employee and plugged into a computer to check it. That would be sufficient to give hackers access to the hospital’s network.

Improving personnel training is key. Teaching employees how to be cyber vigilant at home as well as at work is one of the best ways to establish secure habits.

“Demands are going to get higher, not lower,” adds Mike Overly, a lawyer with Foley & Lardner, in Los Angeles, who specializes in information security. “Hollywood Presbyterian is not the first nor will it be the last.”

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Preterm ESA Therapy Benefits Seen in Preschool Years

Clinicians may wish to seriously consider such prophylactic therapy for extremely low birth weight preterm infants.

Preterm infants treated with erythropoiesis-stimulating agents (ESAs) shortly after birth have better cognitive outcomes and less developmental impairment in preschool years than those given a placebo.

“Preschool Assessment of Preterm Infants Treated With Darbepoetin and Erythropoietin,” in Pediatrics, notes that previous research shows cognitive benefits for ESA-treated preterm infants assessed at two years. This study sought to determine whether those benefits remained evident into the preschool years, reports a related article in 2 Minute Medicine.

The study involved 53 former preterm infants from two centers in New Mexico and Utah — 39 of whom previously received the ESAs erythropoietin or darbepoetin, and 14 who received a placebo. For comparison, healthy children delivered at full term also were recruited.

“Although not performing as well as term controls, preterm infants who had received an ESA scored higher on full-scale IQ and verbal IQ tests than those who had not received an ESA,” adds the article in 2 Minute Medicine. Infants receiving ESAs also performed better at executive function tasks than those in the placebo group and at a level consistent with that of full-term children.

While none of the 39 children in the ESA group had been diagnosed with cerebral palsy, three of the 14 in the placebo group (21 percent) had mild forms of this condition. Also of note, General Language Composite scores for the placebo and ESA-treated infants were comparable to each other but significantly lower than those of term controls.

Study limitations include significant differences in maternal education between the ESA and placebo groups as well as participation involving infants from different centers. Still, considering mounting evidence in favor of ESAs, the article notes that “clinicians may wish to seriously consider such prophylactic therapy for extremely low birth weight preterm infants.”


High-Dose IV Sedation for ICU Patients With Alcohol Withdrawal

Treatment of alcohol withdrawal syndrome with high-dose, continuously infused sedating medications was not associated with excess morbidity or mortality.

A single, small study has shown that continuously infused sedating medications administered to critically ill patients with alcohol withdrawal syndrome were not associated with excess morbidity and mortality.

“Outcomes of Patients With Alcohol Withdrawal Syndrome Treated With High-Dose Sedatives and Deferred Intubation,” in Annals of the American Thoracic Society, describes an observational cohort study that looked at 188 patients in the ICU (mean age 50.8 years) who had been hospitalized with alcohol withdrawal syndrome from 2008 through 2012 at one medical center. Thirty of the 188 patients (16 percent) developed pneumonia, and 38 (20.2 percent) needed intubation.

All patients received a median total dose of 42.5 mg of lorazepam, and 170 received a median total dose of 527 mg of midazolam; all but two by continuous intravenous infusion. Nineteen intubated patients received a median total dose of 6,000 mg of propofol, and 19 were given a median total dose of 1,075 mg of dexmedetomidine. Patients who were intubated received more benzodiazepine than those who did not require intubation.

Patients who were intubated had a higher risk for pneumonia, higher-acuity illness and more days in the hospital (median of 15 days), compared with six days for those who were not intubated. One patient died while in the hospital.

The article notes that although this study suggests hypotheses and implies general safety, “well-constructed, prospective, randomized controlled clinical studies are required to examine the relative effectiveness of various regimens.”

Helping Healthcare Personnel Stay Home When Sick

The study recommends that healthcare facilities have backup staffing measures for physicians and advanced practice clinicians.

Attending physicians and advanced practice clinicians frequently work while sick, despite recognizing that their choice may put patients at risk.

“Changing the ‘Working While Sick’ Culture: Promoting Fitness for Duty in Health Care,” in JAMA Pediatrics, notes that the “decision to work sick is shaped by systems-level and sociocultural factors. Multimodal interventions are needed to reduce the frequency of this behavior.”

An anonymous survey, conducted from January through March 2014 at a large children’s hospital in Philadelphia, included 459 attending physicians and 470 advanced practice clinicians. Responses were received from 280 physicians (61.0 percent) and 256 clinicians (54.5 percent).

Most of the respondents (504 or 95.3 percent) believe that working while sick puts their patients at risk. Despite this belief, 446 respondents (83.1 percent) report working sick at least once in the past year, and 50 (9.3 percent) report working while sick at least five times.

“Institutional culture also contributed to presenteeism, including not wanting to disappoint colleagues, fear of ostracism from colleagues, unsupportive leadership, and coming to work while ill because their colleagues do the same.”

Hospitals could use organization-wide triage policies for ill healthcare workers, reports a related article in FierceHealthcare. For example, University of Chicago personnel with upper respiratory symptoms or fever were tested for influenza virus during a recent flu season. If the tests were positive, the personnel were required to stay home for at least seven days, which reduced the rate of flu cases transmitted from clinicians to patients.

The study recommends that healthcare facilities have backup staffing measures in place for attending physicians and advanced practice clinicians, so that sick workers can stay home and avoid the risk of compromising patient care.


Developing Millennial Nurse Leaders

It’s becoming a lost art to understand what someone is going through and then communicate that understanding back to them.

One of the main challenges faced by veteran nurses is teaching a new generation of nurses to become the leaders, mentors and coaches who will eventually succeed them.

“The Best Strategies to Engage Millennial Nurse Leaders,” in Becker’s Infection Control & Clinical Quality, offers a leadership guide based on fostering trust and teamwork, providing emotional and material support to co-workers and patients, and developing those overlooked soft skills that are essential for knowing what a patient needs.

A well-developed sense of empathy is a skill that can be taught. Empathy can help nurses understand what patients are experiencing, so they can lead with compassion. The article recommends including empathy development, with role-playing exercises, in annual training sessions.

“Empathy is a cognitive attribute; it’s not emotional. You have to be able to understand what someone is going through and then communicate the understanding back to them. It’s really becoming a lost art,” Press Ganey CNO Christy Dempsey adds in the article.

Generational management and the best ways to work with millennial nurses are also discussed. For example, millennials tend to value a healthy work-life balance, which should be considered for staffing and scheduling. They are far more effective when not managed in a traditional sense, the article adds. Nursing leaders are advised to reframe their roles as supervisors to become collaborative mentors who can help groom future millennial leaders.

Most importantly, veteran nurses should coach millennials, who have a strong tech orientation, on how to make more meaningful personal bedside connections with patients who may not understand social media. The article suggests that nurses use hourly purposeful rounding with patients to establish connections beyond a clinical relationship. The effort can have a strong influence on patients’ well-being.
Female Nurses Concerned About Equal Pay

Pay issues aside, 68 percent of survey respondents say male and female nurses are treated equally in the workplace.

A survey of 6,000 recent nursing school graduates finds that 79 percent of female nurses are concerned that their male counterparts are paid more for the same work, Kaplan Test Prep reports in a news release.

While 61 percent of male nurses sympathize with their female colleagues, results show that 39 percent of men say that salary equality is an issue that doesn’t bother them, although few male nurses were included.

The e-survey from April to July 2015 gathered data from 5,945 recent nursing school graduates (5,312 women and 633 men) who took an NCLEX-RN prep course with Kaplan Test Prep, reports a related article in Advance for Nurses.

Additional survey findings include the following:
- Pay issues aside, 68 percent say male and female nurses are treated equally in the workplace.
- Forty-one percent of nurses often talk about salary with one another.

“Nurses aren’t in their profession for the money, but it’s entirely understandable that female nurses in particular are concerned about their salary and being paid equally to their male counterparts. Nurses perform the same job duties regardless of their gender,” Susan Sanders, vice president of nursing for Kaplan Test Prep, and a former hospital chief nursing officer, says in the company release. “Because pay is often discussed among nurses, it’s an issue that’s not going to go away quietly. Employers need to pay attention to it.”

Another study, released in 2015, involving 290,000 RNs, reveals that male nurses earn about $5,000 more per year than females in similar roles, reports a health and wellness blog in The New York Times. That study, the first to measure gender disparities in pay over time, does not address reasons for the pay gap, which didn’t decrease from 1988 to 2013, the blog notes.

Start the Workday With a Huddle

Huddles encourage face-to-face communication and a collaborative environment.

Starting the workday with a leadership huddle helps Midland Memorial Hospital, Texas, improve patient safety and hospital operations.

“How to Improve Hospital Operations and Patient Safety in 14 Minutes a Day,” in Hospitals & Health Networks (He?HN), states that during the morning huddle at Midland — no longer than 14 minutes — 30 to 40 hospital leaders pledge to focus on the positive and “turn every complaint into either a blessing or constructive suggestion,” rather than the negative, which can contribute to a culture of blame and complaints.

The daily leadership huddle — based on a change in organizational culture, which saw the leaders take responsibility and ownership — occurs in the main lobby. The location was chosen so that anyone passing by, including patients and their family members, could see the huddle and hear the pledge.

All leaders participate, not only those in provision of care. “Because it is in the main lobby, physicians may join if they are walking by and front-line workers may listen if they are on a break — it takes down some of those barriers among disciplines because everyone is included,” the article explains.

The huddle is also a time for leaders to bring up any patient safety issues. Someone is then assigned to address the matter and report the next day on how it was resolved.

Midland is not the first healthcare facility to use the huddle approach. An article in FierceHealthcare describes how a similar approach at Advocate Health Care in Illinois helped increase safety event reporting 40 percent.

Huddles encourage face-to-face communication and help participants get to know one another, fostering an environment where they work together. “We develop relationships, realize we are all on the same team and working toward the same goal,” adds the article in He?HN.

Do you have huddles at your facility? Tell us at aacnbolvoices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.
Lack of Professional Respect an Ongoing Issue

Despite patient safety consequences and detrimental effects on the work environment, incivility and lack of professional respect continue to be significant problems.


In the 2010 follow-up survey, more than 20 percent of respondents indicated patient harm was a result of disrespect and abusive behavior, yet only a tiny percentage of nurses said they engaged a disrespectful colleague about the issue. Other surveys reveal that physicians receive most of the blame from both nurses and other physicians, but nurses also cite frequent verbal abuse among nurses.

Organizations that improved civility made efforts to define disrespectful behaviors specifically and encourage employee communication and collaboration. The article cites one hospital that developed a program to teach staff the skills for having difficult conversations.

One challenge is that physicians are often outside employees whose work supports the hospital financially, so the facility has less authority and incentive to condemn their behavior. Nurses, meanwhile, are more likely to be disciplined, because they are usually hospital staff.

Providing Spiritual Care for Patients and Families

Spiritual care, an important part of whole-person care, improves patient satisfaction.

Quality spiritual care, an essential part of healthcare, can be demonstrated by evidence-based indicators, explains a statement developed by a panel of experts and issued by HealthCare Chaplaincy Network (HCCN), New York.

“What Is Quality Spiritual Care in Health Care and How Do You Measure It?” states that spiritual care improves patient satisfaction and reduces spiritual distress. Evidence-based indicators can help measure it. The 18 indicators include:

- Having certified or credentialed spiritual guide professionals
- Setting aside a dedicated sacred space
- Providing information about the spiritual care services available
- Providing end-of-life and bereavement care
- Educating the facility’s staff about the role of spiritual care for patients and families
- Having a variety of religious services available

“We believe these evidence-based quality indicators are a game-changer,” Eric J. Hall, HCCN’s president and CEO, says in a company news release. “They speak to health care’s emphasis on value over volume of services. Being able to identify value in specific situations will help elevate the importance of spiritual care as part of whole-person care, casting aside perceptions and anecdotes about its impact in favor of indicators that can solidly demonstrate quality of care and outcomes.”

AACN Resources on Communication

Healthy Work Environment (HWE) Initiative – www.aacn.org/hwe

HWE Assessment Tool – www.aacn.org/hwe

“Silence Kills: Can Technology Drive Meaningful Cultural Change in Healthcare?” – Article in Forbes

“New Research Shows Communication Breakdowns in Hospitals Undercut the Effectiveness of Safety Tools and Negatively Impact Patient Outcomes” – AACN news release on “The Silent Treatment”

Although workplace incivility ranks as a problem across many industries, the consequences for patients are very high, with more than 25 percent of respondents in a 2008 study identifying a link between patient death and disrespectful behavior. “The responsibility falls on everyone — those who dish it out, those who take it, and those who oversee the dishers and the takers — to keep disrespect out of healthcare.”

What procedures are in place at your hospital to promote a healthy and respectful work environment? Tell us at aacnboldvoices@aacn.org, click on the blue auto-reply button in the digital edition or post a wall comment at facebook.com/aacnface.
The practice of prolonged supine positioning for patients after angiography has been based on tradition but not necessarily on evidence. A study of 80 patients undergoing elective coronary angiography compared bleeding complications and back pain in those who had gradual head-of-bed elevation starting at hour one versus those who remained supine for three hours. No bleeding complications occurred in either group, and patient satisfaction with pain control was similar, but the supine group reported higher rates of back pain after one hour. (Olson, CCN, June 2016) www.ccnonline.org

Support for family presence during resuscitation is strong, but shifting to family inclusion is challenging in some ICUs. Nurses in one pediatric ICU identified a gap in practice regarding family presence during resuscitation and administered a tool to assess the staff’s commitment to family- and patient-centered care. Nurse leaders then developed a curriculum to prepare nurses to serve on the Parent Advocacy Group for Events of Resuscitation. Nurses who joined this group respond to resuscitation events by providing care to parents, simultaneously effecting and role modeling an evidence-based change in practice. (Pasek, CCN, June 2016) www.ccnonline.org

In Our Journals

Hot topics from this month’s AACN journal

Death due to hemorrhage occurs soon after trauma, usually within the first six hours of hospital admission. This article compares the use of fresh whole blood (FWB) transfusion with the predominant practice of blood component therapy in trauma resuscitation. FWB administration is simple, with the potential to reduce death from hemorrhage. The military’s use of walking blood banks — donors ready to provide FWB in response to a mass casualty event — may be a strategy that civilian disaster preparedness leaders can employ. (Goforth, CCN, June 2016) www.ccnonline.org

CCN, June 2016 www.ccnonline.org

To see the table of contents for the June issue of CCN, visit www.ccnonline.org.

Transitions

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

Gloria Bindelglass, a nurse at Yale New Haven Health System, Connecticut, and an AACN member since 2003, launched an app called CARMA for Life, to help guide practitioners through resuscitation at the bedside and ensure accurate documentation.

Kathleen Dracup — past co-editor of Heart & Lung, founding co-editor of American Journal of Critical Care, past recipient of the Marguerite Rodgers Kinney Award for a Distinguished Career, and emeritus dean of University of California School of Nursing San Francisco — receives the UCSF Medal, the university’s highest honor, for her outstanding contributions to nursing and her leadership at UCSF.

Dorrie Fontaine, dean of University of Virginia School of Nursing, Charlottesville, AACN past president and a member since 1983, was interviewed for “Implementing the Healthy Workplace” in Voice of Nursing Leadership.

Margo Halm, director of nursing research, professional practices and Magnet, Salem Health, Oregon, a prolific author and an AACN member since 1986, is co-guest editor of a series on “Holistic and Integrative Care” in American Journal of Nursing.

Sonya Hardin, past chair of AACN Certification Corporation, and co-editor with Roberta Kaplow of “Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care,” becomes associate dean for graduate programs at East Carolina University College of Nursing, Greenville, North Carolina.

Mary McKinley, a nurse at Ohio Valley Medical Center, Wheeling, West Virginia, and East Ohio Regional Hospital, Martins Ferry, Ohio, is recognized on the center’s website for 30 years of continuous certification as a CCRN. She is past president of AACN and a member since 1982.

Karen Myers becomes vice president and chief nursing officer of Memorial Hermann-Texas Medical Center, Houston. Among her duties, she will oversee the nursing department and patient care services.

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.
AACN’s Facebook Community Weighs In

Responding to a Monday Poll question at facebook.com/aacnface, AACN’s community speaks boldly about what they would like to change about their job. Post your own comments on AACN’s wall, or send them to aacnboldvoices@aacn.org.

AACN American Association of Critical-Care Nurses Monday Poll: If I could change anything about my job, it would be ________________________________.

Julie Salazar Tarbell Eliminating Press-Ganey surveys and patient satisfaction scores! Just let us practice and heal the sick like we did 10 years ago!

Rachel Jean Cicci That schools of nursing would chill in turning out nurses who think that if you “don’t” strive to have an advanced practice degree, you just aren’t working to your potential. I love the bedside. Wish people would quit making it sound like if you don’t go “farther” in school, you’re not at full potential.

Sandra Hardin To have my back so I could be a bedside nurse again.

Monica Rizer The level of disrespect, unprofessionalism and backstabbing in the profession. I can deal with heavy loads and bad ratios, but my colleagues have hit an all-time low when it comes to the crabs in a bucket syndrome ... the nurse that’s been there 30 years and runs all the new staff away (might I add that management does nothing about any of this & the ratios would be better if we had better retention rates).

Duncan MacDonald (Some) Google-educated families trying to dictate care irrespective of competent medical and nursing care. Complete disrespect.

Marisa Schlatter For management to see how valuable we are instead of acting like we are replaceable and constantly taking away instead of making us feel wanted.

Cecile Frye The surveys that are unrealistic in healthcare! 99% of people do not put “always” on any survey! Making healthcare motivated by greed not great care!

Leah Brown Not spending so much time at the computer

Diane Pemberton Concentrating on patients not charting!!!!

Kelly Minty Lenz Taking care of all the drug overdoses that go out and do it again and again.

Lynda Bruce Basing my job on how happy they are when what they want is toxic to them. They can be happy and dead 10 minutes from the event. “Wow — look at all the dilaudid they gave me because I threw a fit!”

Rebecca Ann Hazlegrove Staffing ratios that ensure patient safety no matter the cost!

Maggie Theriault People would actually listen when they ask for your thoughts, ideas and opinions.

Paris Niesterowicz Exhaustion

Victoria Sullivan Rude, nasty Drs

Allison Davis My compensation

Kathy Olson-Meyer Higher-ups adding more and more documentation and job duties to “keep our patients safe” but actually take us away from the bedside.

Amanda Petersen Allowing patients and families to mistreat nurses in the name of “customer service.”

Lori Shields A safe environment for nurses and patients. Reimbursement based on satisfaction is unsafe. It’s a hospital, not a luxury hotel. I’m sorry you don’t like the food, the timing of the labs or the frequency that your blood pressure is taken — but it’s all for a reason.

Margaret Rhoda Respect and the ability to do my job without answering to ridiculous policies. Caring for patients without families, MDs, administrators telling me how to do my job. User-friendly technology that actually saves time instead of wasting it. Need I go on?

Patricia Meehan Put into law staffing regulations.

Rubí More Go back to paper charting!

David Roberts Lots of valid stuff here. Most of it true and I’m sure applicable in 95% of ICUs. Feeling “valued” I’m sure would solve some of this, communication from admin and requesting info from staff before implementing policies and new requirements, etc ... it’s really not that hard but for some reason when folks leave the bedside to fulfill an admin position, they forget what team they’re on.
Michelle Rapp  Budget cuts or patient satisfaction surveys. I just want to go do my job well, no worries. When I don’t give a pain medication two seconds after someone asks for it, I don’t feel like the patient should be allowed to dictate a poor hospital stay.

Suzi Lee  Eliminate Press-Ganey/patient satisfaction scores. The surveys are designed to make us fail. And the whole “customer is always right” mindset does not ring true when we’re talking about someone’s health and well-being.

Liz Thackaberry  To ensure safe staffing all the time so my team members can feel that they were able to do a good job and make a difference in the lives of the people they touched.

Anne M. Bennett  ... all of the barriers that bar us from working to the full extent of our Scope of Practice.

Michelle Shiao  Patient and family abuse of nurses

Lavonna Boley  Insurance companies making treatment decisions rather than doctors and nurses.

Liz Molenda  Doctors would treat us like we have brains.


Kathryn Fiyak  Yes to most of these, especially STAFFING!

Elizabeth Lyons LeClair  Having more ICU beds available for actual ICU level patients; when pt’s are downgraded to medical level of care, MOVE THEM to that level of care, puh-lease. Oh, and I agree with most all of the other comments too!

Jo Ann Miles Carr  I would change how some younger and older nurses perceive nursing and bedside care. I love bedside, if I didn’t have to chart it would be perfect, but now if you don’t have or are not working towards a doctorate then you are “just a nurse.”

Corey Norgard  If we are short staffed, ensure that we have a reliable float pool to cover deficits.

Bethany Hubbard  Having nurses that don’t stab you in the back and that want to be there to help each other out and not chit chat behind closed doors on the clock, better staffing ratios, nurse retention.

Nicole Kupchik  The crappy documentation system! Let me nurse the patient, not the chart!

Jennie Erickson  To keep staffing in ICU 1:2 at ALL times. Otherwise, my job is fantastic & fulfilling.

Diane Ogren Stevens  Getting flexed off without pay when census is low.

Sarah Lebo  An Apple-platform charting system for ICUs ...

Jennifer Dodimead  Assisting those who just don’t care to find a new career path!

Linda Gail Wakefield  Managers that do not help on the floor when staff is underwater with patient loads/admits/dirty rooms.

Amanda Wesley Young  Rumor mill/communication/accountability

Laura Lynn Evans  Better timing of medications so that each of my patients do not have q1 HR or q 2 hr med passes.

Alicia A Kolesnikoff  Keep bean counters out of medicine and let us do our work as we know we can and should!

Phyllis McCauley Richards  Always perfect staffing

Ellen Eric Johnson  Nurse to patient ratios!!!

Sandy DeTuncq  Nothing. God has me where He wants me.

Ted Norman  The hours

Kevin Smith  Require all nurse managers to have BA IN BUSINESS ADMINISTRATION; that way they know how to MANAGE MANAGEMENT and PROTECT NURSING STAFF.

Mary Lawson Carney  Scripted speeches which are required to be delivered with every patient contact.

Chrsiten Stevens  Less resistance to evidence-based practices being implemented

Karen Kean-Conboy  Nursing retention and staffing ratios

facebook.com/aacnface
This past year, I’ve traveled around the country and heard many powerful stories of Courageous Care. Stories of nurses courageously leading change to improve patient outcomes.

Leading change means questioning care, and that is never easy. And when we lead change that overcomes barriers to practice, improves work environments or leads to better outcomes for patients and their families, so many stand to benefit.

That’s why it’s so important that we act courageously to be a catalyst for change that drives clinical excellence. We can all recall moments when we served as a stimulus for change that made a big difference for a patient and their family.

Nurses are the professionals best positioned to transform healthcare. This means we — not others — own our practice. It means we — not others — lead the design of solutions that most effectively overcome barriers and drive improvements. To improve our healthcare system we need to be bold and courageous. When we speak up, we inspire others to drive excellent patient care.

We all try to understand the obstacles that block our ability to provide the best possible care at the bedside. This past year I’ve had the privilege to speak with so many of you who shared your barriers to providing the high-quality patient- and family-centered care to which you aspire.

Topping the lists are barriers such as suboptimal staffing, abusive behavior by patients and families, bullying by peers, struggles with documenting in the electronic health record and meeting ever-increasing regulatory requirements.

But identifying the areas that need to change is only part of the solution. We need to use our collective bold voice to remove the barriers and improve our work environments. So, how do we reach this goal?

Our colleague Mary Bylone suggests we need to ask questions that unearth the root causes of barriers and educate ourselves on the problems we are trying to resolve. Once we know the cause of the roadblock and have objective data to support our solution, we can seek out key hospital leaders to better understand and overcome these obstacles.

These barriers also tell us that our efforts to define the ideal healthy work environments are as relevant and essential as ever. We recently released the second edition of “AACN Standards for Establishing and Sustaining Healthy Work Environments.” This document cites the evidence that unhealthy work environments absolutely impact patients’ outcomes and nurses’ well-being. Studies confirm that healthy work environments are not just vital to nurses and other healthcare professionals; they are unquestionably linked to optimal outcomes for patients and families.

So, it makes sense for us to reinvigorate our commitment to establishing and sustaining healthy work environments, which are essential for the work we do.

Providing Courageous Care helps us use our strongest instinct to foster healing, calm fear, alleviate suffering, inspire hope and comfort the grieving. It helps us know that our work matters. That the care we provide matters. And that we have made a lasting difference in the lives of others.

That is what drives us. It’s what inspires us to lead changes that improve outcomes. It’s what demands we maintain a strong knowledge base. And it whispers to us that we must also take care of ourselves — we must renew ourselves.

It moves us each and every day to do our work. It says there can be no greater calling than to greet each new day with enormous pride and renewed joy, knowing that we provide Courageous Care.

Thank you for the opportunity to serve as your president this past year. Please email me at courageous@aacn.org, and let me know how the Courageous Care you provide makes a lasting difference in the lives of others.

Courage is very important. Like a muscle, it is strengthened by use.
—Ruth Gordon
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