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Tele-ICU Certification
High-tech demands intense preparation

By Greg Thompson

Shortly after emergency personnel whisked a young man into a small rural hospital, a tele-ICU physician ordered immediate medications for the patient who was experiencing severe chest pain.

Nurses obtained labs, spoke with the patient’s cardiologist, and collaborated on the urgent plan of care to facilitate transfer of the patient to a larger facility with a cath lab.

“From the time of the initial ECG to his arrival in another hospital’s CCU - including having a cath and a stent placed to open the clogged artery - the time was less than 3 hours,” said Connie Barden, RN/CNS, MSN, CCRN-E, CCNS, a past president of the American Association of Critical Care Nurses (AACN) and co-chair of the AACN tele-ICU task force.

“Not only did the patient receive exquisite and timely care, the nurses felt totally supported in the process. ”

Linking critical care physicians and nurses to ICUs in remote hospitals is a growing trend. As one of the first tele-ICU clinical nurse specialists in the country, Barden knows the power of the technology, particularly in the hands of certified personnel.

Terms, Technology & Testing
The AACN has adopted the term “tele ICU” to describe the delivery of remote intensive care services where monitoring systems are used.

Tele-ICU nurses monitor critically ill patients and clinical data, providing crucial consulting and coaching to bedside staff at a remote location.

“We have so many underserved areas,” said Mary Beth Flynn Makic, PhD, RN, CNS, CCNS, CCRN, research nurse scientist, critical care, University of Colorado Hospital.

“If we can provide a remote service that is going to enhance patient care, why not? Not every hospital can have a four-bed ICU with all sorts of technology. If we can augment care in a rural setting, or even in an urban settings with limited resources, why wouldn’t we?”

Certification Challenge
High-tech demands intense preparation, so the CCRN-E tele-ICU certification is not easy.

“Certification is a rigorous process that meets national requirements in a specialty or subspecialty area,” explained Kelli Lockhart, certification manager, AACN.

“To become certified by the AACN, a registered nurse must meet specific clinical practice requirements and take an exam based on a national job analysis. For employers, certification contributes to creating an environment of professionalism and a culture of retention. For nurses, certification gives a critical sense of confidence and achievement, and positions them for appropriate recognition,” Lockhart tol ADVANCE.

Administrators of the exam note research is beginning to back up the notion that tele-ICUs staffed by certified nurses can save money for hospitals and improve patient care.

Greg Thompson is a frequent contributor to ADVANCE.

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Adverse events occur at the rate of 81 per 1,000 patient-days in ICUs. Nearly half are considered preventable. These errors are made in ordering or carrying out medication orders, reporting or communicating clinical information and failure to take precautions or follow protocols. Many adverse events are considered “sentinel events,” described by the Joint Commission as “unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof.” The National Patient Safety Goals (NPSGs) were established in 2002 by the Joint Commission to help healthcare facilities address areas of concern for patient safety and reducing adverse events.

Preventing Medication Errors
Three NPSGs guide the ICU nurse’s practice in regard to carrying out medication orders. These include:
- NPSG.01.01.01 - Use at least two patient identifiers when providing care, treatment and services.
- NPSG.03.06.01 - Maintain and communicate accurate patient medication information (medication reconciliation).
- NPSG.03.05.01 - Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

The intent behind using two identifiers is to match the correct service or treatment to the correct patient. Patient identifiers include the patient’s full name and an identifier such as a social security number or facility identification number. The patient’s room number cannot be used as an identifier.

Medication Reconciliation
Medication reconciliation is to eliminate unintentional omission or duplication of medication. There is evidence medication changes cause discrepancies that adversely impact patient outcomes. Ninety-four percent of the patients have orders changed after an ICU stay. While 33 percent of patients discharged from the ICU had one or more of their medications mistakenly omitted at discharge.
all the patient’s medications at all transition points: admission, transfer and discharge, verifying the list with the most recent physician’s orders. In emergent cases, if there is no list generated by another health professional prior to admission, a family member may need to be contacted. Many facilities supply patients or the parents of child patients with medication history forms. Other strategies to reduce medication errors include a good handoff from one clinician to another and from one unit to another; a second check of medications by someone other than the prescribing clinician, often by the nurse; computerized physician order entry; pharmacists’ inclusion in patient rounds; and standardized protocols.6

**Anticoagulant Therapy Safety**
The safe use of anticoagulant medications NPSG applies to facilities that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis where the clinical expectation is that the patient’s lab values for coagulation will remain outside normal values. It does not apply when short-term prophylactic anticoagulation is used; for example, for venous thromboembolism prevention related to procedures or hospitalization when the clinical expectation is that the patient’s lab values for coagulation will remain within, or close to, normal values. Facilities need a written policy stating which lab tests are required; protocols for the initiation and maintenance; and institution of evidence-based methods that provide for safety.

**Timely Reporting**
According to the Joint Commission, breakdown in communication is a top contributor to sentinel events.7 Hence, NPSG.02.03.01, *Critical Tests and Lab Values Reporting*, outlines the procedure for providing a timely report to the treating provider of any critical results of tests and diagnostic procedures, that is, those results that fall significantly outside the normal range and may indicate a life-threatening situation.

**Reducing ICU-Acquired Infections**
The Joint Commission recognizes the importance of reducing or preventing healthcare-associated infections (HAI) from multidrug-resistant organisms (MDRO).

- NPSG.07.03.01 - Implement evidence-based practices to prevent HAI due to MDRO in acute care hospitals.
- NPSG.07.06.01 - Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI), a goal for 2012 with full implementation as of Jan. 1, 2013.

Preventing HAI is a two-pronged approach. Facilities need to use evidenced-based techniques provided by the CDC or WHO; and implement a surveillance process where results are shared with the entire unit. The Joint Commission states evidence-based guidelines to reduce CAUTIs need to include limiting the use of indwelling urinary catheters, securing catheters for unobstructed urine flow and drainage, providing sterility of the urine collection system, and monitoring infection rate and prevention processes.

**Staying Current (Keeping Patient Safe)**
To stay up-to-date on NPSGs, ICU nurses can: join groups writing protocols and procedures for patient safety; create an ICU climate that supports safety activities; develop a code of conduct to assure staff treat each other in a civil manner; volunteer to collect surveillance data for ongoing patient safety initiatives; provide ongoing safety education; include patients and their families along with the staff in creating a culture of safety; and request Human factors engineering methods implementation in the ICU. ❖

References for this article can be accessed at www.advanceweb.com/Nurses. Click on Resources, then References.

*Joan M. Lorenz is a clinical specialist in adult psychiatric mental health nursing.*
Critical Care

New Leadership for AACN

The American Association of Critical-Care Nurses (AACN) announced new leadership and members of its board of directors for fiscal year 2013.

Kathryn E. Roberts, MSN, RN, CNS, CCRN, CCNS, begins a term as president of the AACN board of directors. Roberts, a clinical nurse specialist in the pediatric ICU at The Children’s Hospital of Philadelphia since 1998, began her career at the hospital in 1990.

Vicki Good, MSN, RN, CENP, begins a 1-year term as president-elect. Good served on the AACN board from 2008-2011. As administrative director of patient safety for CoxHealth in Springfield, MO, she develops safety programs.

Melissa Hutchinson, MN, RN, CCNS, CCRN, CWCN, begins a 1-year term as secretary. A clinical nurse specialist in the medical intensive care unit at VA Puget Sound Health Care System, Seattle, WA, she serves as an adjunct clinical faculty member at the University of Washington, Seattle.

Mary Bylone, MSM, RN, CNML, begins a 1-year term as treasurer. Vice president for patient care services and chief nursing officer at The William W. Backus Hospital, Norwich, CT, she is co-author of AACN’s Essentials of Nurse Manager Orientation.

Joining the board as directors and serving 3-year terms are:

Linda M. Bay, MSN, RN, ACNS-BC, CCRN, PCCN, works as a clinical nurse specialist at Clement J. Zablocki VA Medical Center in Milwaukee. She has a longstanding relationship with AACN and has been involved in the Greater Milwaukee Area Chapter, serving as president in 2008-2009.

A past president of AACN’s Houston Gulf Coast Chapter, Riza V. Mauricio, MS, RN, CCRN, CPNP, helped develop the CCRN pediatric exam in 2003-2004. She is a pediatric ICU nurse practitioner at The Children’s Hospital of the University of Texas: MD Anderson Cancer Center in Houston.

Kathleen K. Peavy, MS, RN, CCRN CNS-BC, is a critical care clinical nurse specialist at Southern Regional Medical Center in Riverdale, GA. She has been active with AACN chapters, both as past president of the Atlanta Area Chapter and on the Chapter Advisory Team in 2003-2004 and 2004-2005 and leading the group in 2005-2007.

A clinical nurse specialist in cardiovascular critical care with Emory University Hospital in Atlanta, since 1985, Mary Zellinger, RN, MN, ANP, CCRN-CSN, CCNS, serves as adjunct faculty at the university’s Nell Hodgson Woodruff School of Nursing. She has published articles on cardiac surgery, wound care, hemodynamics and organ transplantation.

Returning to the board are the following directors:

- Sheryl Leary, PhD, RN, CCRN, CCNS, PCCN, clinical nurse specialist, VA San Diego Healthcare System;
- Karen McQuillan, MS, RN, CNS-BC, CCRN, CNRN, FAAN, critical nurse specialist, R Adams Cowley Shock Trauma Center, University of Maryland Medical Center, Baltimore, MD; Pamela Popplewell, MSN, RN, CCRN, ANP-BC, director of nursing, surgery, VA Puget Sound Health Care System, Seattle, WA; Maureen Seckel, MSN, RN, APN, ACNS-BC, CCNS, CCRN, clinical nurse specialist, Medical Pulmonary Critical Care, Christiana Care Health System, Newark, DE; and Clareen Wienczek, PhD, RN, ACHPN, ACNP, nurse manager, Thomas Palliative Care Unit, Massey Cancer Center, Virginia Commonwealth University Health System, Richmond, VA.

AACN members elect the board through a process initiated by AACN’s Nominating Committee. Newly elected officers and directors begin their terms July 1, 2012 and conclude them June 30, 2015. For more information, visit www.aacn.org.
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