Pancreatitis: Autodigestion Gone Bad!

Diane Byrum

CONTENT DESCRIPTION
This session will provide information on etiologies, signs/symptoms and management of the patient with pancreatitis with the potentially lethal complications of pancreatic-fluid collections, pseudocysts and necrosis. Acute pancreatitis is a potentially lethal disease that is increasing in incidence. Ten to thirty percent of all patients with severe acute pancreatitis will eventually die as a result of systemic inflammatory response, septic shock and multiple organ failure. The target audience for this session is critical care nurses caring for patients with pancreatitis. The outcome of this session is to recognize multidisciplinary management strategies for the prevention and treatment of pancreatitis complicated by pancreatic fluid collection, pseudocysts, and necrosis.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Discuss the normal functions of the pancreas.
2. Identify etiology and pathophysiological changes that occur with acute pancreatitis.
3. Discuss multidisciplinary management strategies for severe acute pancreatitis.

SUMMARY OF KEY POINTS
I. Definitions:
A. Acute pancreatitis (AP) is an acute inflammatory condition of the pancreas that may extend to local and distant extrapancreatic tissues.
1. AP is broadly classified as mild or severe
2. Acute edematous or interstitial pancreatitis
3. Severe AP
   a. organ failure
   b. local complications
   c. pancreatic necrosis or hemorrhage
      (1) disruption of pancreatic blood supply leads to ischemia.
   d. two or more occasions with elevation of the serum pancreatic enzymes - recurrent
   e. chronic pancreatitis - fibrosis and loss of glandular function.

II. Tidbits:
A. 220,000 hospital admissions/year
1. Acute: 19.5/100,000 Chronic:8.3/100,000
   a. Native Americans 4/100,000
   b. White 5.7/100,000
   c. African Americans 20.7/100,000 (age 35-64 at 10 times higher risk)
B. 20% have a severe course
C. 10%-30% will die - ***Despite improvements in ICU treatment rate of death is unchanged III.

III. Causes of Acute Pancreatitis (% of Cases)
A. Gallstones: 45% (females > 60 years)
   1. Biliary stone lodges pancreatic duct or ampulle of Vater
   2. Obstruction of the pancreatic duct
   3. Extravasation of enzymes into the parenchymal tissue.
B. Alcohol: 35% (> men than women)
   1. Ethanol leads to intracellular accumulation of digestive enzymes
   2. Premature enzyme activation and release
   3. Ethanol increases protein content, decreases HCO3 levels and trypsin inhibitor
   4. Protein plugs blocks pancreatic outflow leads to obstruction
C. Other 10%
   1. Medications (thiazides, azathioprine, estrogens, corticosteroids, sulfonamides, furosemide, NSAIDS, mercaptopurine, methylodopa, tetracyclines)
   2. Hypercalcemia (calcium-mediated activation of trypsinogen and subsequent glandular autodigestion)
   3. Hypertriglycerideremia (> 1000 mg/U)
   4. Duct Obstruction
   5. PUD
   6. Post-ERCP
   7. Hereditary
   8. Trauma
   9. Vascular factors (ischemia or vasculitis)
   10. Viral infections (mumps, coxsackievirus, cytomegalovirus, hepatitis, Epstein-Barr, rubella
   11. Bacterial infections (mycoplasma)
   12. Paracites (interstitial)
   13. Postcardiac bypass/abdominal bypass (self-limiting related to gland ischemia)
D. Idiopathic: 10%-20%

IV. Pancreatic Functions
A. Exocrine functions
   1. Secrete pancreatic juices (enzymes)
      a. Lipase (carbohydrates)
      b. Amylase (fats)
      c. Trysin
B. Endocrine functions
   1. cells - glucagon in response to decreased blood glucose
   2. cells - insulin in response to increased blood glucose
   3. cells - somatostatin or growth hormone release inhibiting hormone (GHRIH)

V. Pathophysiology
A. Inappropriate activation of trypsinogen to trysin + lack of elimination of active Trypsin
1. Activation of digestive enzymes with inappropriate inflammatory response.
2. Inflammatory response out of proportion
3. Intracellular free calcium is tightly controlled by acinar cells
4. Increased intracellular calcium activates trysino-gen to trysin
5. Trysin conversion normally done in duodenum
6. This increased calcium causes calcium to be sequestered in the pancreas leading to calcification within the duct of the pancreas
7. More calcium leads to more activated trypsin and calcification
8. Can lead to rupture of the pancreatic duct leads to spilling of contents into peritoneum – chemical peritonitis and systemic inflammation

V. Presentation (Connecting Pathophysiology to Presentation)

VI. Complications
A. Pancreatic Fluid Collections
   1. 57% have one fluid collection
   2. 39% have two fluid filled areas
   3. 33% have three or more fluid filled areas
   4. Characteristics: ill-defined, evolve over time, managed conservatively
   5. If enlarged, painful or infected – endoscopic or surgical management
B. Pseudocysts – effusion of pancreatic juices walled off by granulation
C. Ascites
D. Hemorrhage – peritoneal or retroperitoneal cavity with erosion of large vessels
E. Effusions - ARDS
F. Necrosis – loss of tissue perfusion on CT scan
   1. Can occur in the first days
   2. Occurs related to inflammation, hypovolemia, hypotension

VII. Diagnostic Studies
A. KUB can reveal pancreatic calcification
B. CT most reliable
   1. Graded
      a. Grade A – normal
      b. Grade B – focal or diffuse gland enlargement
      c. Grade C – abnormality noted as haziness
      d. Grade D – Single-ill defined collection or phlegmon
      e. Grade E – two or more ill-defined collections, presence of gas

VIII. Laboratory values

IX. Collaborative Management

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Passion, Products, and Good Data: Preventing Pressure Ulcers

Tory Schmitz
Sponsored by Sage Products, Inc.

CONTENT DESCRIPTION
This session will provide a detailed description of a successful pressure ulcer prevention initiative at a large academic medical center. Methods for promoting leadership and staff passion, improving the quality of the data collected, designing innovative educational strategies, and fostering effective use of products will be discussed. Specific strategies used in a Medical ICU and a Cardiovascular ICU will be presented.

LEARNING OUTCOMES
By the end of this session the participant will be able to:
1. Describe at least one approach to reducing hospital-acquired pressure ulcer incidence.
2. List at least five methods for generating passion around a clinical goal.
3. Describe a strategy for improving the reliability of data collection regarding the incidence of hospital-acquired pressure ulcers.

SUMMARY OF KEY POINTS
I. Our project
   A. Improve measurement methods
   B. Reduce pressure ulcer incidence
   C. “SKIN” bundle
   D. Menu of interventions
   E. Weekly skin check rounds
II. Our passion
    A. Institutional support
    B. Team involvement
    C. Use of stories
    D. Ask questions
    E. Bedside rounds
III. Our products
    A. Simplify, simplify
    B. All-in-one cleansing and barrier product
    C. Pillows to suspend heels
    D. Other positioning devices
IV. Our data
   A. Historical data
      1. Quarterly surveys
      2. Each RN assess own patients
   B. Identification of Stage I pressure ulcers
   C. Excoration/Incontinence-Associated Dermatitis
   D. Training and validation
   E. Consistent observers
V. Our results
   A. 70% reduction in incidence of hospital-acquired pressure ulcers in all ICUs
   B. Sustainability

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2006;52:48-59.
Institute for Health Care Improvement. Protecting 5 million lives from harm. 2007.

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Paws Forward: Utilizing and Researching Animal Assisted Therapy

Katherine Connor

CONTENT DESCRIPTION
Animal Assisted Therapy (AAT) is a new and innovative modality that successfully improves outcomes for critically ill patients. The bedside utilization of AAT has gained recent momentum in the area of practice and research. Validation through this research has earned this unique tool respect among the healthcare community. Not only thought of as a “feel good” practice but an actual method of healing. This session will explain how AAT works and the proactive steps healthcare professionals can take in making AAT an accepted and healing part of their own facility. The target audience for this session includes practicing nurses, advance practitioners and administrators. Participants should bring a desire to incorporate unique approaches in bedside care as prerequisite knowledge.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify the difference between Animal Assisted Therapy (AAT) and Animal Assisted Activity (AAA). What is required for certification of a therapy team. Identify what patient populations benefit the most from any AAT/AAA.
2. Encourage and enhance the knowledge and creativity needed for healthcare professionals in the bedside utilization of AAT.
3. Discuss and target areas of current research with AAT and practices that could benefit from further research

SUMMARY OF KEY POINTS
I. Introduction
   A. Human speaker introduction
   B. Video
II. Definitions
   A. Animal Assisted Activity (AAA)
      1. Acute care, Rehabilitation, Hospice, Nursing Homes
   B. Expansion
      1. R.E.A.D.www.therapyanimals.org/read
      2. Special needs/ community events
      3. Psychiatric settings
   C. Animal Assisted Therapy (AAT)
      1. Rehabilitation
      2. Acute Care
   D. Personal Pet Visitation
III. Prerequisites for setting up an AAT program - Policies and Procedures
   A. National Resources
      1. www.therapet.org
2. www.deltasocity.org
3. liability insurance coverage
B. Road blocks and speed bumps
   1. Administration
   2. Infection Control
      a. Zoonosis
      b. Restricted patient populations
         (1) Immunocompromised patients - Neutropenic
         (2) Isolation patients
         (3) Transplant patients
         (4) Burns and open wounds need to be covered
         (5) Agitated and combative patients
         (6) Pediatric patients - animals need a reliable down stay
   3. Policy and Procedures
      a. Organization and application
      b. Revision and review
      c. Performance Improvement - ongoing
      d. Risk management
IV. Implementation of Animal Assisted Therapy
   A. Volunteer animal requirements
      1. Immunization records
      2. Types of animals utilized
      3. Finding suitable volunteers
      4. Temperament evaluation
      5. Certification
      6. Renewals
      7. Continuation of participation
      8. Retirement
   B. Volunteer Human Requirements
      1. Application
      2. Health screening
      3. Orientation to AAT
   C. Education of Administrators, Staff, Health Care Workers
      1. new employee orientation, inhouse inservices, newsletters
      2. therapy animal contact information
      3. team availability
   D. Special patient and animal precautions
      1. Immunosuppressed
      2. Burns
      3. Open wounds and sores
      4. Allergy or fear of animals
      5. Unresponsive patients without consent of family members
      6. Tracheostomy
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7. Hemodynamic monitoring
8. Ventilators
9. ICP monitors
10. Identifying stress in animals and volunteers
E. Co-treating with Allied Healthcare Professionals
   1. Occupational therapy
   2. Physical therapy
   3. Speech therapy
   4. Child Life Specialists
F. Bedside Practice
   1. Range of Motion
   2. Diversion/relaxation
   3. Balance
   4. Coma Stimulation
   5. Reality orientation/communication
   6. motivation
   7. Family involvement
G. Bedside devices
   1. IV’s
   2. Suction and drains
   3. Orthopedic devices
   4. Monitors and ventilators
   5. Skin integrity
V. Research - Past, Present, Future - Validation
   A. Play therapy benefits
   B. Stress reduction during therapy and procedures
   C. Stress reduction in children during hospitalization
   D. Reduction in length of hospitalization stay
   E. Zoonosis: risks outweigh the benefits of AAT
   F. Functional Improvement
VI. Conclusion and questions
   A. Invitation for discussion and comments about AAT

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Pediatric CXR Interpretation for Life Threatening Conditions

Cathy Woodward

Level: Beginner

CONTENT DESCRIPTION
The participants will learn how to review pediatric CXR’s using a systematic approach. Acute, potentially life threatening and subtle findings will be included with opportunity for the participants to practice their new skills.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify the appearance of a normal pediatric CXR
2. Outline the system for evaluation a CXR
3. Identify correct placement of chest tubes, ETT’s and central lines
4. Describe the CXR findings associated with respiratory illness, CHD and trauma

SUMMARY OF KEY POINTS
I. Terminology:
   X-Ray
   Radiopaque
   Radiolucent
   Interface
   Systematic Interpretation of CXR
   Quick Look
   Detailed Exam
   Bones/Tissues
   Fractures and Dislocations
   Air
   Pneumothorax
   Atelectasis
   Water
   Pleural Effusion
   Hemothorax
   Pericardial Effusion
   FLT’s
   Foreign Bodies
   Tubes and Wires
   XR Interpretation Practice

BIBLIOGRAPHY/WEBLIOGRAPHY

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Pediatric Fluid & Electrolyte Imbalances: A Case Study Approach

Kathryn E. Roberts

CONTENT DESCRIPTION
The care of the critically ill infant or child is often further complicated by disruptions in fluid and/or electrolyte balance. Prompt recognition of these disruptions is essential to the care of these patients. This session will provide an overview of the principles of fluid & electrolyte balance. Key concepts to be covered include composition of body fluids, movement of fluids & electrolytes, regulation of fluid & electrolyte balance, assessment of fluid & electrolyte balance, and the support of fluid and electrolyte balance. A case study approach will be utilized to examine the assessment, diagnosis, and current strategies in the management of specific fluid and electrolyte imbalances. This session is targeted at critical care nurses and advanced practice nurses who care for critically ill pediatric patients. Prerequisite knowledge includes a basic understanding of fluid and electrolyte regulation.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify 2 mechanisms of fluid and electrolyte regulation in the critically ill child.
2. Describe the clinical manifestations and ICU management of the critically ill child with a disturbance in fluid balance.
3. Describe the clinical manifestations and ICU management of the following electrolyte imbalances: hyponatremia, hypernatremia, hypokalemia, hyperkalemia, hypocalcemia, hypercalcemia, hypomagnesemia & hypermagnesemia.

SUMMARY OF KEY POINTS
I. Introduction
   A. Total body water
   B. Intracellular Fluid
   C. Extracellular Fluid
II. Movement of Fluids & Electrolytes
   A. Osmosis
   B. Diffusion
   C. Osmolarity = 2(serum Na) + glucose/18 + BUN/2.8
III. Regulation of Fluid & Electrolyte Balance
   A. Renal
   B. Hormonal
      1. Antidiuretic Hormone (ADH)
      2. Aldosterone
      3. Natriuretic Factors
IV. Assessment of Fluid & Electrolyte Balance
V. Relationship between fluid balance and sodium balance
VI. Fluid Volume Deficit
   A. Causes
   B. Clinical manifestations and severity of deficit
   C. Impact of Na imbalances
   D. Management
VII. Fluid Volume Overload
   A. Causes
   B. Clinical Manifestations
   C. Management
VIII. Electrolyte Imbalances
IX. Case Studies
X. Conclusion

BIBLIOGRAPHY/WEBLIOGRAPHY

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CONTENT DESCRIPTION

This session will provide a comprehensive review of the initial stabilization and treatment of the critically ill pediatric trauma patient. Anatomic and physiologic differences between the adult and pediatric trauma victim will be discussed. Focus will be not only on managing the various system injuries but also on the importance of managing the systemic effects that are often evident on arrival to the PICU. The lethal triad (hypothermia, metabolic acidosis and coagulopathy) has been described in the adult trauma literature. In the context of a case review, the synergistic effects of this triad and their implications for the pediatric trauma patient will be reviewed and management strategies will be discussed. Other new treatment options with implications for the pediatric trauma patient will be reviewed as well. At the end of this session, participants will have a better understanding of the importance of early stabilization and management for pediatric trauma patients to improve patient outcomes.

LEARNING OUTCOMES

At the end of the session the participant will be able to:

1. Discuss the unique ways a pediatric trauma victim responds to a traumatic injury and the importance of managing the systemic effects of trauma.
2. Describe the three elements of the “Lethal Triad”, their synergistic effects and their implications for pediatric trauma victims.
3. Review other new trends and research in the management of pediatric trauma patients

SUMMARY OF KEY POINTS

I. Discuss the unique ways a pediatric trauma victim responds to a traumatic injury and the importance of managing the systemic effects of trauma (30%)
   A. Review the anatomic and physiological differences in the pediatric patient in response to trauma
   B. Focus on the systemic symptoms, not just the system injuries

II. Describe the three elements of the “Lethal Triad”, their synergistic effects and their implications for pediatric trauma victims (40%)
   A. Case Study Approach
      1. Hypothermia:
         a. Review contributing factors for hypothermia and potential complications that result from trauma related hypothermia
         b. Discuss the latest management strategies for hypothermia
            (1) Re-warming: what the literature says
            (2) Implications for traumatic brain injury patients
         c. Metabolic acidosis:
            a. Identify causes of the acidosis
            b. Review treatment strategies
         d. Coagulopathy:
            a. Identify contributing factors to the coagulopathy often seen with pediatric trauma victims
            b. Coagulation cascade
            c. Discuss current management strategies and new therapies on the horizon

4. Synergistic Effects of the Lethal Triad:
   a. Review how these 3 elements can potentiate each other’s effects
   b. Recognize the downward spiral
   c. Importance of reversing the trend!

III. Review other new trends and research in the management of pediatric trauma patients: (30%)
   A. Glycemic control in adult trauma patients and implications for pediatric trauma. What the early pediatric literature is saying!
   B. Management aimed at prevention of ARDS and MODS
   C. Role of nutrition in maximizing recovery and outcome after pediatric trauma
   D. Other new trends on the horizon

BIBLIOGRAPHY/WEBLIOGRAPHY


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The Perfect Storm: Hypothermia, Acidosis and Coagulopathy

Allen C. Wolfe Jr.
Brett A. Dodd

CONTENT DESCRIPTION
The lethal combination of hypothermia, acidosis and coagulopathy poses a potential threat to every trauma patient. Hypothermia, which is more prevalent in the severely injured patient, is associated with increased mortality. With the increase in oxygen consumption associated with hypoperfusion related to shock, acidosis develops, as the oxygen supply becomes inadequate to meet the tissue oxygen demand. Treatment for acidosis should focus on the correction of hypoperfusion and hypothermia. The relationship between hypothermia, the degree of shock (acidosis) and to the development of coagulopathy produces increases the mortality by 90%. This lecture will explain the interesting interrelationship between these conditions and the treatment options.

LEARNING OUTCOMES
By the end of this session the participant will be able to:
1. Discuss the importance of nursing assessment and intervention in the diagnosis and patient management.
2. List the components of the Perfect Storm.
3. Describe the role of blood administration in resuscitation

SUMMARY OF KEY POINTS
I. Introduction
II. Statistics
III. Hypothermia
A. Pathophysiology
B. Clinical Presentation
C. Treatment Options
D. Complications and Long Term Effects
IV. Acidosis
A. Pathophysiology – ABG and the Numbers
B. Causes in Trauma Patients
C. Clinical Presentation – Low Flow States
D. Quick Guide to Diagnosis
E. Treatment in Trauma Patients
1. Components of Oxygen Delivery Extraction
F. Complications and Long Term Effects
V. Coagulopathy
A. Pathophysiology
B. The Clotting Cascade
C. Causes
D. Clinical Presentations
E. Lab Values and Quick Diagnosis
F. Early Treatment and Options
G. Complications
VI. Unwelcome Family Union
A. Hypothermia, Acidosis and Coagulopathy
VII. Resuscitation and Nursing Challenges
VIII. Reversing the Triangle of Death
IX. Evidence Base Practice
X. Trends in Management
XI. The Role of Nursing in Assessment and Management
XII. Case Studies
XIII. Summary

BIBLIOGRAPHY

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Physiologic Changes During Pregnancy: Impact on Illness

Christie Artuso  
Level: Intermediate

CONTENT DESCRIPTION
The normal physiologic changes that occur during pregnancy can present unique challenges for the nurse caring for acutely ill patients. Pregnant women with and without pre-existing health conditions can develop unusual complications with unique clinical sequelae. Obstetric care in the 21st century has evolved to include an increasingly complex high risk patient population. These patients include women who were once premature themselves, women with underlying cardiac disease, women with immune system dysfunction, and women of varying ages. The successful management of the patient population begins with a thorough understanding of the normal physiology of pregnancy and the impact that these changes may have on patients with underlying medical conditions. Through case study discussions, the participant will develop a solid understanding of the physiology of pregnancy, thromboembolic disease during pregnancy, sepsis during pregnancy, cardiac disease during pregnancy, respiratory failure during pregnancy and the effects of hemorrhage in the antenatal period. The essential element of a multidisciplinary team approach to managing the care of the acutely ill obstetric patient will be threaded throughout the presentation. At the end of this presentation, the participant will be able to identify potential risks for obstetric patients with a variety of pre-existing conditions, through the application of physiologic principles. The final component of this workshop will include a mock patient scenario, and an interactive plan of care developed by the participants identifying key elements of concern in the management of the patient.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Verbalize an understanding of the physiologic changes that occur during pregnancy;
2. Verbalize an understanding of the impact of pre-existing cardiac disease and respiratory failure in the acutely ill obstetric patient;
3. Identify the impact of sepsis in the acutely ill obstetric patient including appropriate treatment modalities and the potential impact on the fetus;
4. Verbalize the risk for thrombotic disease in the pregnant patient and the impact of hemorrhage in the antepartum period related to hematologic changes of pregnancy.

SUMMARY OF KEY POINTS
I. Normal Physiologic Changes During Pregnancy
   A. Cardiovascular changes during pregnancy
      1. Clinical manifestations of normal cardiovascular changes during pregnancy

   B. Respiratory changes during pregnancy
      1. Clinical manifestations of normal respiratory changes during pregnancy
      2. Potential impact of normal respiratory changes on mother and fetus

   C. Renal system changes during pregnancy
      1. Clinical manifestations of normal renal system changes during pregnancy
      2. Significance of renal system changes during pregnancy

   D. Gastrointestinal changes during pregnancy
      1. Clinical manifestations of normal gastrointestinal changes during pregnancy
      2. Significance of gastrointestinal changes during pregnancy

   E. Endocrine system changes during pregnancy
      1. Clinical presentation of endocrine system changes during pregnancy
      2. Significance of endocrine system changes during pregnancy

   F. Hematologic system changes during pregnancy
      1. Clinical presentation of hematologic system changes during pregnancy
      2. Significance of hematologic system changes during pregnancy

II. Cardiac Disease in the Obstetric Patient
   A. Cardiac disease in the obstetric patient
   B. Clinical presentation of patients with pre-existing cardiac disease
   C. Acquired cardiac disease in the obstetric patient
   D. Potential impact on mother and fetus
   E. Treatment modalities and clinical management

III. Respiratory Failure
   A. Common causes of respiratory failure
   B. Clinical signs and symptoms of respiratory failure
   C. Impact on mother and fetus
   D. Treatment modalities and management

IV. Sepsis
   A. Common causes of sepsis in the obstetric patient
   B. Clinical presentation
   C. Potential impact on mother and fetus
   D. Treatment modalities and management

V. Thrombolytic disease during pregnancy
   A. Risks for thrombolytic disease during pregnancy
   B. Clinical management and prevention
   C. Impact of hemorrhage during antepartum period and effects on mother and fetus
BIBLIOGRAPHY/WEBLIOGRAPHY


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Piecing Together the Puzzle of Generational Diversity

Cheryl Herrmann

CONTENT DESCRIPTION

“Who do they think they are?” “They haven’t paid their dues?” “All the boomers do is work!” Does this sound familiar? Today is truly one of the most unique times in the history of America as four different generations with unique wants, needs, and feelings converge into one place. The veterans are exiting the workplace and taking decades of expertise, wisdom, and knowledge with them. The trendsetting baby boomers are becoming the aging workforce, and being the trendsetters, they are redefining aging and retirement. Gen Xers are the new generation of leaders, with Gen Yers being the fastest growing workforce segment. The generations clash over all work issues from scheduling, dress codes and incentives, to respect for authority, work ethic, and management style. There is growing realization that the gulf of misunderstanding and resentment between the generations is growing and can be problematic. These differences between generations are tension producing and potential flash points. The purpose of the session is to identify ways organizations and individuals can bridge the gaps between the generations. Key concepts to be discussed will be influential events, characteristics, values and behaviors of each generation. Strategies to engage workers of all generations to share their time, talents, expertise, and experience will be discussed. Implementing these strategies will build a collaborative and highly productive team. The targeted audience is managers, educators, CNSs, and nurses who want to understand generational diversity.

LEARNING OUTCOMES

At the end of the session the participant will be able to:
1. Discuss influential events, characteristics, values and behaviors of each generation.
2. Apply strategies to manage and lead each generation
3. List 3 key action steps that you are willing to do to bridge the generation gap.

SUMMARY OF KEY POINTS

I. Introduction
II. Classification of Generations
   A. Veterans
   B. Baby Boomers
   C. Gen X
   D. Gen Y
   E. Gen Z
III. Generation influential events, characteristics, values, & behaviors
   A. Veterans
   B. Baby Boomers
   C. Gen X
   D. Gen Y
   E. Gen Z
IV. Strategies to lead, teach, & understand each generation
V. Bridging the generation gap
   A. Show respect
   B. Provide understanding of differences
   C. Appreciate each other’s strengths
   D. Value experience
   E. Let go of stereotypes
VI. Questions & Answers

BIBLIOGRAPHY


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Policy, Politics and You: Let Your Voice be Heard

Todd Grivetti

CONTENT DESCRIPTION
This session is intended for nurses at all levels of practice. Policy and politics has not been identified as a serious issue. However, 2008 brings new changes to the political arena with the changing of the executive administration in the United States. As we fast approach Election Day 2008, nurses need to have deeper understanding of the political arena and to have the tools to successfully contact their federal, state and local legislators and law makers. Key concepts include: politics, policy, healthcare. Given the spectrum of healthcare, nurses should have the information to further facilitate the communication with their representatives through all levels of government.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify the three levels of government.
2. Identify their local source to locating their local, state and federal legislative representatives.

SUMMARY OF KEY POINTS
Policy and Politics are sometimes known as taboo subjects among nursing. As critical care nurses, we are the voices that can be the difference between a change in policy and change in patient care delivery. Through AACN’s public policy forum, members have the ability to communicate their concerns with federal, state and local legislators which will help impact nursing and health care. Learn what you can do and how to attain valuable resources in delivering critical information to those who serve you, in order for you to serve your patient’s better.
CONTENT DESCRIPTION
Implementing research-based practices at the bedside is a complex endeavor. It is all too easy to discover that clinically important research findings are either not known by the practitioner, or not being followed in practice. Efforts to instill and sustain research-based practices significantly improve when staff nurses are involved from the start. This presentation will discuss infrastructures that can ensure and sustain research-based practices while unleashing the talent and creativity of clinicians as they question practice and ponder the merits of current research. Fostering participation in clinical inquiry will summon professional growth, influence the lives of patients, and help each nurse develop a unique personal professional legacy.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Discuss infrastructures that can promote and sustain research-based practices.
2. Describe strategies to secure clinician engagement in research conduct and evidence-based practice initiatives.
3. Discuss the roles of administrative and clinical leaders in fostering participation in research conduct and evidence-based practice initiatives.
4. Discuss the benefits of clinician involvement on professional growth, improving patients’ lives, and developing a unique personal professional legacy.

SUMMARY OF KEY POINTS
I. Establishing a foundation for research and evidence-based practice
   A. Building a nursing culture for research and evidence-based practice: How to get there
   B. Effective vs. ineffective programs: Take time to lay the groundwork
   C. Using a framework
         Figure 1: Linear framework of structure, process and outcome (Donabedian, 1966, 1988; Mitchell, et al., 1998).
      2. This linear framework reflects the relationship of how structure impacts process, which in turn impacts outcome.

II. Effective hospital nursing research and evidence-based practice programs
   A. Build structures where processes can occur
   B. Implement processes that engage clinicians
   C. Secure staff nurse early involvement, unleash staff creativity
   D. Educate staff through the process of involvement
   E. Create internal expertise for research and evidence-based practice
   F. Ensure principled implementation of research and evidence-based practice
      1. End product of activities is experienced by patients and their families
      2. Accountability for evidence-based practice
      3. Sustainability for evidence-based practice

III. Structures and processes to advance research and evidence-based practice
   A. Evidence-Based Practice Fellowship Program for Staff Nurses
   B. Research Institute
   C. Advanced Practice Institute
   D. Transform traditional Clinical Practice Committees

IV. Teaching, Coaching, and Mentoring
   A. “Tell me, and I will forget; show me, and I will remember; involve me and I will understand” (Confucius).
   B. Use a collaborative approach for idea generation. Practice intellectual humility while unleashing more bottom-up innovation
   C. Advanced Practice Nurses (APNs) ideal role, with clinical expertise combined with the ability to facilitate innovation
   D. APNs maximize their leader influence and move organizations and individuals toward higher levels of innovation
   E. Research mentor
   F. In the process, summon professional growth, influence the lives of patients and help each nurse develop a personal professional legacy.
G. Recognizing mentors and mentorship.

V. Summary

BIBLIOGRAPHY/WEBLIOGRAPHY


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Power, P Values, and Effect Size: Evaluating Research for Practice

Kenneth J. Rempher

CONTENT DESCRIPTION
The mandate to develop nursing practice based on sound scientific evidence is well known among advanced practice nurses. This mandate, coupled with the sophisticated transformation of nursing research in recent years requires that APNs understand and interpret research findings to determine relevance for clinical practice. Possessing technical knowledge of research from the “consumer” perspective is well within the requirements of the APN role. This presentation will clarify important terms and concepts associated with research outcomes and the process of research analysis. In addition, the presentation will familiarize participants with the concepts of power, p values, and effect size, and discuss the emerging debate over the relative importance of each of these in determining statistical significance of study outcomes. Requisite skills and knowledge include a basic understanding of research article

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe two models of evidence-based practice
2. Define the common components of a research study and identify the necessary elements within the components representative of good research.
3. Explain the concepts of “statistical significance”, “p values”, and “statistical power” and incorporate these elements into decisions about a study’s clinical relevance.
4. Describe the impact of variations in effect size and the subsequent implications in determining whether or not a study is “meaningful”.

SUMMARY OF KEY POINTS

I. Introduction
II. General Comments
III. Research utilization versus evidence-based practice
IV. Rosswurm & Larrabee Model
V. Iowa Model
VI. ACE Star Model
VII. Basic elements of a published research study
   A. Statement of the problem
      1. Is the statement of the problem clearly written?
      2. Is the statement of the problem significant and logical?
   B. Review of the literature
      1. Are there gaps in the researcher’s review of the literature?
      2. Are concepts associated with the research clearly defined?

3. Are the study variables in the research project clearly defined?
4. Did the researchers state their hypothesis?
C. Meta-analysis versus systematic review of the literature
D. Conceptual Framework
E. Methods/Design/Data Collection
   1. Are the methods clearly described?
   2. Did the authors address reliability and validity?
   3. Is the research design appropriate for the study?
   4. Have the ethical rights of subjects been protected?
F. Data Analysis and Findings
   1. Are the statistical tests used by the researchers appropriate?
   2. Has sufficient information about the study and process been provided?
   3. Are the tables in the report clear and logical?

VIII. P Value Overview
   A. Probability Values
   B. Association with “statistical significance”
   C. Why “.05”?
   D. Interpreting P values
   E. Ban on P values

IX. Statistical Significance Testing
   A. Arguments opposed to significance testing
      1. Failure to inform about magnitude of effect
      2. Statistical significance does not always consistent with practical importance
      3. Statistical significance does not always imply clinical significance
   4. Statistical significance is consistently misinterpreted
      a. Misinterpretation and replicability
      b. Mininterpretation and “odds against chance”
      c. Misinterpretation and sampling
   d. Misinterpretation and evaluation of results
   e. Misinterpretation and test score characteristics

B. Arguments in favor or significance testing

X. Overview of Statistical Power
   A. Sampling theory
   B. Hypothesis testing logic
   C. Calculating Power
   D. Interpreting Power

XI. Effect size overview
   A. Magnitude of difference
   B. Dependence on sample size
   C. Role of effect size in meta-analaysis
   D. Relationship of effect size to statistical significance
   E. Interpreting effect size
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Sheldon, T., Guyatt., G., & Haines, A. When to act on evidence. 1998;317, 139-142.

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The Power to Influence: Conquering the Art of Public Speaking

Kathleen M Vollman

CONTENT DESCRIPTION:
The skills to communicate effectively to one person or an audience of one hundred provide the critical care nurse with the essential tools for shaping the care agenda, achieving success at the bedside, within the multidisciplinary team or in front of an audience. Public speaking skills, a professional image and improved communication can facilitate advancement along any career ladder. The greater your fear, the more self-confidence you will gain by stepping out of your comfort zone and conquering it. This session will describe techniques to manage the anxiety produced when attempting to articulate your thoughts. Identifying mechanism for enhancing your professional image in order to score during the initial impression period and strategies for organizing and presenting your message in a clear and concise format will be outlined. A formula for thriving during the question and answer period will conclude the presentation.

Health care practitioners must effectively articulate their thoughts and ideas in order to influence care priorities within their unit/organization and advance the profession of nursing.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe 2 methods to reduce speaker anxiety
2. Outline verbal and non-verbal techniques that will enhance a presentation to a small or large group.
3. Describe key program planning techniques to improve overall effectiveness of a presentation.

SUMMARY OF KEY POINTS:
I. Fear of public speaking
   A. Change: capitalizing on chaos
      1. comfort zone
      2. decision making
   B. Fear: the biggest barrier to success
      1. signs and symptoms of nervousness
      2. good nervousness vs. bad: channeling the energy
   C. Techniques to overcome fear
      1. prepare
      2. practice
      3. night before routine
      4. ABC’s: affirming, breathing and composure
      5. effective visual aids

II. Organizing the presentation
   A. Preparing to speak
      1. selecting the right topic
      2. assess the prospective audience
      3. defining the purpose
      4. crafting the message
         a. organizing strategies
         b. powerful introduction, solid body and a call to action conclusion
      5. effective visual aids

B. Methods to support the body of a presentation (Hooks)
   1. Use of humor
   2. analogies
   3. personal experiences
   4. use of questions
   5. anecdotes & stories

C. Creating effective visual aids
   1. powerpoint slides
      a. add not distract
      b. simple versus glitzy
      c. 7 points per slide
      d. use incomplete sentences
      e. check spelling
      f. use bright colors
   2. You are your best visual aid
      a. Keep accessories simple; >8 < 14
      b. Select best color tone: warm or cool palette

III. Readying the Room
   A. arrive early to allow for changes
   B. control audience seating
   C. check the sound system & AV equipment
   D. adjust room temperature

IV. Stepping up to the podium
   A. strategies to get audience attention
   B. engage in eye contact
   C. building rapport
   D. vary your voice
   E. body language/gestures
   F. learn to expand & contract content

V. Managing audience participation with ease
   A. anticipate questions
   B. listen attentively, never be sarcastic
   C. be brief in your response
   D. be honest

BIBLIOGRAPHY/WEBLIOGRAPHY:
www.nsaspeaker.org (National Speakers Association)

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PowerPoint Pearls: Putting “Pizzazz” into your Presentation

Pamela Bolton

CONTENT DESCRIPTION
PowerPoint presentations serve as an adjunct to the speaker’s lecture and provides a visual avenue to highlight the vital features of the message. PowerPoint provides the basic tools for slide presentation with pre-defined and designed templates. With a simple point and click a less artistically inclined individual is able to create a multi-colored, rich, and lively presentation. For individuals with a more imaginative mind, PowerPoint allows one the ability to use creative and innovative techniques to create pizzazz in a presentation. Gaining knowledge of PowerPoint is vital to presenting information in the most effective, creative, and ingenious manner to obtain the results desired. This session will provide a foundation for creating a PowerPoint slide presentation. Emphasis will be placed on a straightforward and uncomplicated method of navigating the program. Background design, color fundamentals, establishment of text, slide and text transition and the use of graphics will be included. The impact of using advanced strategies such as internet pictures, sounds, video clips, and sound tracks will also be discussed.

LEARNING OUTCOMES
1. Identify the basic principles of establishing a PowerPoint presentation.
2. Illustrate an effective use of color in the presentation background and text formation.
3. Discuss advanced strategies to create an effective, creative and innovative presentation.

SUMMARY OF KEY POINTS
I. Introduction
   A. Presentation considerations
      1. Target audience
      2. Time allotted
      3. Type of healthcare presentation (i.e., clinical, data-driven, financial, management, etc)
      4. Goals of presentation
   B. PowerPoint slide creation
      A. Slide views: normal, slide master, slide sorter and notes page
      B. Slide layout, design and background
         1. Color fundamentals
         2. Template designs for background
         3. Obtaining backgrounds from the internet
         4. Creating your own background
      C. Text design
         1. Formatting type and size
         2. Text boxes and shadowing
      D. Navigating the slide presentation
         A. Custom animation
         1. Manual
         2. Automatic
         B. Slide transition
         C. Slide sorter
         D. Slide show
         E. Remote Control & Wireless Laser
   C. Special effects
      A. Autoshapes
      B. Rotation option
      C. Diagram, tables or organizational chart
      D. Fill and line color
      E. Action buttons
      F. Transparency
   D. Advanced strategies
      A. Use of the internet
      B. Inserting documents
         1. Pictures
         2. Sounds
         3. Video clips
         4. Sound tracks
      C. Modifying pictures
         1. Size
         2. Color
         3. Cropping
      D. Projector effects
      E. Diagram, tables or organizational chart
      F. Fill and line color
      G. Action buttons
   E. Successful presentation strategies
      A. Understand your presentation style
      B. Incorporate slide information based on presentation style
      C. Be clear, concise and organized
      D. Ensure proper grammar, spelling and punctuation
      E. Place microphone in the proper position to allow you to view your slides
      F. Rehearse! Rehearse! Rehearse!
   G. Sample presentation using slide show
   H. Summary / Questions & Answers

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http://traffic.esearchnetwork.com/?dn=wwmicrosoft.com&pid=1POQ27EE8
http://pptfaq.com/index.html
CONTENT DESCRIPTION
AACN offers evidence-based Practice Alerts on key clinical issues to link research with practice and provide the best outcomes for critically ill patients. How can nurses move quickly to implement the practice alerts and measure outcomes for at-risk patients? The purpose of this session is to explore effective strategies for initiating and sustaining four Practice Alerts and measuring key outcomes in critical care settings. Four AACN Practice Alerts serve as the focus of this session, specifically the Practice Alerts on verification of feeding tube placement, dysrhythmia monitoring, prevention of ventilator associated pneumonia, and oral care in the critically ill. The four recommendations are overviewed, and the evidence for each is updated. Then, a step-by-step guide is offered for initiating and sustaining practice changes. Successful and unsuccessful approaches to education and execution are relayed. Tips are provided for communicating changes and motivating nurses to adopt new ideas. Four exemplars illustrate how to apply principles of changes in implementing the Practice Alerts. Methods for measuring outcomes for each Practice Alert are reviewed. Guidelines for developing organizational structures and processes that support the implementation and measurement of practice recommendations are reviewed. Nurses will benefit from this session if they understand and value the basic concept of evidence-based practice and are open to practice changes. In addition, nurse managers and leaders will gain renewed momentum to continue implementing evidence-based practice changes.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify three strategies for initiating evidence-based practice recommendations from AACN Practice Alerts.
2. Relate three strategies to effectively sustain the use of the AACN recommended practices in critical care units.
3. Discuss strategies for measuring outcomes of oral care, QT monitoring, VAP prevention, and tube placement verification.

SUMMARY OF KEY POINTS
Objective #1: Identify three strategies for initiating evidence-based practice recommendations from AACN Practice Alerts or protocols.
I. Overview of Four AACN Practice Alerts
   A. Overview and Evidence Update on the AACN Practice Alert for Ventilator Associated Pneumonia Prevention
   B. Overview and Evidence Update on the AACN Recommendation Regarding Oral Care in Critically Ill Patients
   C. Overview and Evidence Update on the AACN Practice Alert on QT Measurement in Dysrhythmia Monitoring
   D. Overview and Evidence Update on the AACN Practice Alert on Verification of Feeding Tube Placement
II. Introducing Practice Changes: Case Study Presentation
   A. Clinical Inquiry Process
   B. Literature Review and Critique
   C. Initial Strategies
   D. Educational Approaches: What Worked and What Did Not
   E. Case Study Analysis
III. Creating a Supportive Culture for Practice Changes: A Research Council Experience
   A. Assessing Organizational Readiness for Evidence-based Practice Changes
   B. Developing a Culture that Supports Practice Change
   C. Budgeting for Practice Changes
Objective #2: Relate three strategies to effectively sustain the use of the AACN recommended practices in critical care units.
IV. Sustaining Change Through Communication: Case Study Presentation
   A. Communication to Groups
      1. Unit meetings
      2. Newsletters
      3. Intranet
      4. The Value of Visuals
      5. Meaningful Recognition
   B. Informal Communication
      1. Peer-to-peer
      2. Bathroom walls
V. Sustaining Change Through Accountability: Case Study Presentation
   A. Rounding for Results
   B. Peer Review
   C. Performance Evaluation
VI. What To Do When Changes Don’t Last: Case Study Presentation
   A. Why Some Changes Fade Away
   B. Strategies for Renewal
Objective #3: Discuss strategies for measuring outcomes of oral care, QT monitoring, VAP prevention, and tube placement verification.

VII. Determining Best Outcome Measures and Processes
   A. VAP
   B. Oral Care
   C. QT intervals
   D. Feeding tubes

VIII. Evaluating Outcomes and Processes
   A. The Perfect Audit

X. Discussion and Questions

BIBLIOGRAPHY/WEBLIOGRAPHY


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Priorities Reclaimed: Assessment and Management of Skin Failure

Crystal S. Clark
Kara A. Snyder

LEVEL: Beginner

CONTENT DESCRIPTION
The purpose of this session is to review the pathophysiologic complexity of skin failure and provide tools and techniques for preventing and managing skin failure in critically ill patients.

LEARNING OUTCOMES
At the end of this session the participant will be able to:
1. Describe the pathophysiology of skin failure and mechanism of injury for natural barrier loss
2. Describe early identification and prevention strategies for the patient at risk for skin failure
3. Identify creative and evidenced-based strategies for management of complex wounds

SUMMARY OF KEY POINTS
The skin is the largest organ in the body and may be the most under-recognized organ failure in critical illness. Fundamental to its management is the ability of the health care team to identify these patients and take early intervention to minimize damage and side effects related to skin failure. Not only is the skin’s immune function lost in these circumstances, but long-term appearance and scarring can be devastating without appropriate management.

A case study approach will be used to explore the identification and management of skin failure caused by the open abdomen approach to trauma care, “road rash,” and nosocomial skin failure. Basic principles and advanced therapies for managing alterations in skin integrity will be discussed as well as a review of evidence and creative solutions for optimal patient outcomes.

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CONTENT DESCRIPTION
An expanding body of knowledge supports the use of progressive mobility protocols in the ICU. Critical care nurses recognize mobility in the form of rotational therapy to treat the respiratory system. However, it is a less common practice for critical care nurses to manage the patient’s musculoskeletal and cardiopulmonary integrity through an early mobility protocol. Barriers include the labor-intensive nature of “getting the patient out of bed,” the assumption that mobility therapies are the domain of the physical therapists, and concerns about patient safety.

This session is intended for bedside nurses who work with critically ill patients susceptible to complications from bed rest. The goal of this presentation is to enhance the nurse’s understanding of the purpose and process of implementing a comprehensive, nurse-drive, early mobility standard of practice that encompasses a continuum from lateral rotation therapy to Progressive Upright Mobility (PUM). This session will discuss the physiological hazards of immobility, including orthostatic intolerance due to deconditioning of the carotid-aortic baroreceptor reflexes. Components of the PUM standard of practice and the use of specialty beds to facilitate upright mobility will be discussed. In addition, practical tools to develop and implement a mobility protocol will be shared, as well as approaches to overcoming barriers to implementation. At the conclusion of the session, the critical care nurse will come away with strategies to improve ICU patient outcome through implementing strategies that reclaim the patient priority of mobility.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe the physiological hazards of immobility
2. Identify strategies to improve mobility in the ICU patient
3. Evaluate strategies to overcome barriers in implementing a progressive mobility protocol.

SUMMARY OF KEY POINTS
I. What’s the problem with immobility?
   A. Hazards of immobility on major systems
   B. Effect of bed rest on the deconditioning of the carotid-aortic baroreceptor reflexes, resulting in orthostatic intolerance.

II. Can we really mobilize ICU patients?
   A. The status-quo
   B. Common barriers to mobilizing ICU patients
   C. Evidence based literature to support early activity in the critically ill

III. How do we start a comprehensive, evidence-based, and nurse-driven early mobility program in the ICU?
   A. Literature review
   B. Background assessment of current practices in all ICUs
   C. Identify available or necessary resources
      1. Interdisciplinary team of clinicians
      2. Administration
      3. Technological (i.e. beds)
   D. Write a nursing standard of practice/protocol
      1. Review components of the standard through case studies
      2. Review the continuum of mobility therapy, utilizing the algorithm through case studies

IV. Now what? How do we implement this program?
   A. Overcoming barriers
   B. Leadership
   C. Education
   D. Define goals daily
   E. Accountability and autonomy
   F. Share successes and outcomes

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Bailey, P (2007). Early activity is feasible and safe in respiratory failure patients. Critical Care Medicine, 35(1), 139-145.
Swadener-Culpepper, L. (2004, September). Continuous lateral rotation therapy (CLRT): Development and implementation of an effective protocol for the ICU. [monograph]. Medical Center of Central Georgia, Macon, GA.

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CONTENT DESCRIPTION

The Incidence of ARDS in the United States ranges from 250,000 to 400,000 annually. Mortality rates remain as high as 50 percent in spite of recent advances in the care of critically ill patients over the past 20 years. A variety of treatment modalities are used to support the lungs of the ARDS patient and improve gas exchange. This presentation will review the pathophysiology related to ARDS. Various treatment options for ARDS will be discussed including pertinent research findings related to each option. Treatment options that will be discussed include: positive pressure ventilator management, use of PEEP, positive pleural gradients and patient positioning. Techniques will be described that have been shown to improve gas exchange in the critically ill ARDS patient. Relevant research findings will be incorporated into the discussion for each treatment option identified. The positive aspects of patient positioning as well as the potential complications of these techniques will be discussed. Incorporated into the discussion will be the physiological rationale behind all of these interventions so that the critical care nurse understands appropriate application of techniques discussed for patients with ARDS. Various mechanisms for accomplishing therapeutic positioning including indications as well as techniques to decrease the potential complications associated with these procedures will be discussed. Research behind appropriate positioning and outcomes achieved by utilizing various techniques will be discussed. A case study will be utilized to emphasize clinical application of treatment options discussed.

LEARNING OBJECTIVES

At the end of the session the participant will be able to:

1. Identify pathophysiology of ALI and ARDS.
2. Identify treatment options for patients with ARDS
3. Understand therapeutic positioning and rationale for use of these techniques

SUMMARY OF KEY POINTS

I. Introduction
   A. Definitions of ALI and ARDS
II. Pathophysiology of ALI and ARDS
   A. P/F ratio
   B. Ventilator induced lung injury
   C. Inflammatory response
   D. Risk factors
III. Treatment of ARDS
   A. Ventilator management
      1. Review research related to ventilator management
         a. Low TV
         b. PEEP
      2. Other treatments
      3. Kinetic therapy and Prone positioning
         a. Review of pertinent research related to positioning
IV. Prone positioning
   A. Mechanisms for accomplishing prone position
   B. Indications
   C. Contraindications
   D. Potential complications
V. Case study application
   A. Application in improvement of outcomes
VI. Conclusion

BIBLIOGRAPHY/WEBLIOGRAPHY

Sebat, F. et. al. (pre-publication). The utility of an automated prone and Kinetic Therapy™ bed and its effect on lung recruitment and ventilator days in patients with acute lung injury.

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Protect Yourself from Malpractice Claims

Deanna L. Reising
Patricia N. Allen

CONTENT DESCRIPTION
Increased technology and patient/family knowledge about health care has increased the number of malpractice claims. Malpractice claims can be costly both financially and emotionally. Two legal nurse experts will share case studies from real malpractice suits that illustrate common areas ripe for malpractice claims. The experts will present the audience with strategies to reduce the risk of malpractice suits.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Delineate the general types of malpractice claims.
2. Discuss the structure and form of malpractice claims.
3. Identify strategies critical care nurses can use to minimize their risk for being named in a malpractice suit.

SUMMARY OF KEY POINTS
I. Introduction of Speakers/Affiliation
II. Types of Legal Claims Relevant to Health Care Providers
   A. Constitutional
   B. Statutory
   C. Criminal
   D. Civil
III. Malpractice
   A. Definition
   B. Elements of Malpractice
      1. A duty exists
      2. A breach of that duty
      3. Injury to the patient
      4. A causal relationship between the breach and the injury
   C. 6 Most Common Malpractice Claims against Nurses
      1. Failure to follow standards of care
      2. Failure to use equipment in a responsible manner
      3. Failure to communicate
      4. Failure to document
      5. Failure to assess and monitor
      6. Failure to act as a patient advocate
   D. Anatomy of a Malpractice Claim
      1. Notice of Intent
      2. Suit is filed
      3. Discovery/Depositions/Experts
      4. Out-of-court settlement or juried court
   E. Standards against Which Nurses are Judged
      1. State Nurse Practice Act
      2. Published Standards of Care for Specialty
      3. “Reasonable” Nursing Care
   F. State Variation
IV. Case Examples—Areas in Critical Care Ripe for Claims
V. What You Can Do To Protect Yourself
   A. Know and Follow Your Nurse Practice Act
   B. Know and Follow Your Institution’s Policies
   C. Stay Up-To-Date in Your Field
   D. Openly Communicate with Your Patient and the Family
   E. Carry Your Own Malpractice Insurance
VI. What to Do If You Are Named in a Suit
   A. Anything Written Can Be Used
   B. Any Discussions You Have with Colleagues Can Be Used
   C. Notify Your Insurance Carrier
   D. Conduct during Depositions/Testimony

BIBLIOGRAPHY/WEBLIOGRAPHY

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**CONTENT DESCRIPTION**

The purpose of this session is to assist the staff nurses and/or managers by providing the information necessary to avoid potential liability. Examples of areas to be discussed are the common reasons why people sue nurses and hospitals. There will be a detailed discussion of the purpose of the medical record and the “dos” and “don’ts” of medical record documentation to assure appropriate accounts of the patient’s medical condition. There will be an overview of the concepts of “standard of care”, the ANA “Standards of Care”, the ANA “Standards of Practice” as well as a review of the importance of the AACN Specialty Standards. Case studies will be shared as appropriate. The discussion will conclude with an overview of what you can do to protect yourself from liability and the chain of command.

**LEARNING OUTCOMES**

At the end of the session the participant will be able to:

1. List reasons why patients sue hospitals
2. Describe the “Standard of Care”
3. Describe ways that healthcare workers can avoid lawsuits

**SUMMARY OF KEY POINTS**

Healthcare in the United States today is very complex. The sickest patients are being admitted to hospitals and getting very complex procedures and medications. With the nursing shortage, staffing can be an issue and regulations are placing additional burdens on hospitals and healthcare systems. In order to keep patients safe, nurses need to be alert and take every step to make sure the appropriate medications and procedures are being given to the right patients. As care becomes more complex, the risk of liability increases.

This concurrent session will be an overview of reasons why patients sue hospitals. Many times patients and families sue based on the way they have been treated, not specifically because of an act that caused harm. When a lawsuit is filed, the plaintiffs need to prove an injury occurred and resulted in some form of disability. Solutions to these issues will be addressed.

The next area to be discussed is the concept of the “Standard of Care”. This will be followed by information about the ANA Standards of Care, the ANA Standards of Practice and the AACN Standards. Nurses must also know their Nurse Practice Act and their responsibilities in their Practice Act. Case studies will be included as appropriate based on real life cases.

The final section will describe general guidelines of the medical record and the “dos” and “don’ts” of the medical record. The concepts surrounding proof of negligence and the chain of command will be addressed in detail for nurses to know how to avoid lawsuits.

**BIBLIOGRAPHY/WEBLIOGRAPHY**


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Protocols ... Is That All There is to Weaning?

Suzanne M. Burns  
Level: Intermediate

CONTENT DESCRIPTION
Weaning patients from long-term mechanical ventilation continues to be a challenge in most acute and critical care units across the country. For many years the focus was on predicting weaning potential but shifted to methods using weaning trial protocols when studies demonstrated their positive effect on outcomes. In addition many other care elements, which have also been linked to the clinical outcomes of ventilated patients, have been assigned to protocols or algorithms in an attempt to assure compliance. These include the management of sedation, tight glucose control, and timing of tracheostomy. Despite these advancements in the science of weaning clinicians still struggle with how to make weaning easier, especially when the patient doesn’t respond as expected. This session is designed to teach the critical care nurse how to apply the science in ways that are effective because “protocols are not...all there is to weaning”!
Case examples are used to make the content come alive for the participants.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe the science related to weaning predictors, weaning protocols, ventilator modes, glycemic control, sedation, and tracheostomy placement.
2. Identify key components of protocols for weaning and other algorithmic processes of care such as system initiatives designed for the long-term ventilated patient population.
3. Discuss how clinicians can improve outcomes of ventilated patients by managing key elements of care.

SUMMARY OF KEY POINTS
I. Introduction: the case for efficient and effective approaches to weaning.
   A. The long-term ventilated patient (>3 days)
   B. The cost to the patient, family and institution.
   C. Have we improved how we approach weaning?
II. Weaning Predictors fall short use of predictors: the science and practice
   A. Weaning protocols: the studies
   B. But protocols work for other elements of care too (outcomes etc).
      1. “Tight glucose control”
      2. Sedation management: daily interruptions etc
      3. Timing of tracheostomy
III. Why protocols work: the case for protocols is strong!
   A. Weaning protocols: the evidence
   B. But protocols work for other elements of care too (outcomes etc).
   1. “Tight glucose control”
   2. Sedation management: daily interruptions etc
   3. Timing of tracheostomy
IV. The weaning process: assessment, wean screens and protocol development.
   A. The BWAP: one approach to a systematic assessment. What is the relationship of the factors to weaning outcomes?
   B. Weaning protocols: “the components” (wean screen, signs of intolerance and the weaning trials)
   C. Do modes of mechanical ventilation make a difference? A case for thinking about application of selected modes...or not.
V. System initiatives: driving out variation.
   A. Do protocols hold the answers”
   B. What about compliance?
   C. What clinicians can do to make it work!
VI. Summary and conclusions

BIBLIOGRAPHY/WEBLIOGRAPHY

Speaker Contact Information smb4h@virginia.edu
PTSD Following the ICU Experience

Brenda Pun

CONTENT DESCRIPTION
Posttraumatic stress disorder (PTSD) is a common development in patients who survive a critical illness. The existing literature reports an incidence of 2-51% depending upon the population studied. The life-sustaining therapies used in ICU, such as endotracheal intubation and mechanical ventilation, commonly result in pain and anxiety. In addition, critically ill patients are under a great deal of psychological and physiological stress. Risk factors for ICU related PTSD include young age, female gender, baseline cognitive impairment, and pre-existing psychiatric disorder. Recent reports indicate that patients with more delusional memories and no recall of factual events in the ICU are more likely to develop PTSD. The daily interruption of sedatives and careful titration to lighter levels of sedation may facilitate such periods of alertness. In addition, delirium which impairs the development of factual memory may predispose to PTSD. It is likely that both critical illness itself and the treatments rendered in the ICU play a role in the development of this disorder.

Accurate identification and prompt modification of the risk factors may help decrease the incidence of PTSD and improve the quality of life of ICU survivors. Critical care nurses are on the frontline and control the assessment and delivery of treatment for pain, anxiety and delirium. Therefore it is imperative that nurses understand ICU related PTSD and the risk factors associated with it. The session will provide an overview of ICU related PTSD, a review of risk factors, and strategies for modifying these risk factors and decreasing the incidence of PTSD. This session is for critical care staff nurses, educators, and advance practice nurses. There are no prerequisite skills for the session.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Define Posttraumatic stress disorder (PTSD)
2. Identify the Risk Factors for ICU related PTSD
3. Describe Strategies for modifying risk factors
4. Describe strategies for early detection and treatment post discharge

SUMMARY OF KEY POINTS
I. Posttraumatic stress disorder (PTSD) - Definition
   A. DSM-IV Definition (6 criteria)
   1. Exposure to a traumatic event
   2. Persistent re-experiencing of the event
   3. Avoidance of event related stimuli
   4. Persistent symptoms of increased arousal
   5. Duration of symptoms
   6. Significant levels of distress or impairment
   B. Compare and Contrast PTSD related to various situations (e.g. combat, accidents, personal assault, medical treatment, etc)
II. Risk Factors for ICU related PTSD
   A. Age and Gender
   B. Pre-existing Cognitive Impairment and Psychological Disorders
   C. Factual vs Delusional Memory
   D. Sedatives
   E. Delirium
III. Strategies for modifying risk factors
   A. Screening
   B. Decrease Traumatic Events
   C. Enhance Factual Memory
      1. Sedation Focus – tight titration
      a. Pain Control
      b. Goal oriented sedation titration
      c. Daily Awakening trials
      d. Delirium prevention and treatment
      e. Sleep promotion
   2. Educate family members and patients
      a. Journals and Diaries
      b. Discharge education
      c. Counseling
IV. Strategies for early detection and treatment post discharge
   A. Diagnosis (assessment tools)
   B. Co-morbidities
   C. Treatment of PTSD
V. Incidence of PTSD among nurses and family members

BIBLIOGRAPHY/WEBLIOGRAPHY


Speaker Contact Information brenda.pun@vanderbilt.edu
Publishing in AACN Journals

JoAnn “Grif” Alspach
Marianne Chulay
Kathleen Dracup
Peter Morris

CONTENT DESCRIPTION
This session provides an opportunity for participants to meet and hear the AACN journal editors describe their publications for prospective authors.

LEARNING OUTCOMES
At the end of this session the participant will be able to:
1. Distinguish among the intended audiences for each of AACN’s journals.
2. Identify the types of manuscripts appropriate for each of AACN’s journals.
3. Describe the review process for each of AACN’s journals.

SUMMARY OF KEY POINTS
I. Introduction and Overview
II. AACN Journals
A. Critical Care Nurse
   1. Intended audience
   2. Appropriate manuscripts
      a. Content
      b. Desired length
      c. Acceptable formats
   3. Review process
   4. Hints for prospective authors
B. AACN Clinical Issues: Advanced Practice in Acute and Critical Care
   1. Intended audience
   2. Appropriate manuscripts
      a. Content
      b. Desired length
      c. Acceptable formats
   3. Review process
   4. Hints for prospective authors
C. American Journal of Critical Care
   1. Intended audience
   2. Appropriate manuscripts
      a. Content
      b. Desired length
      c. Acceptable formats
   3. Review process
   4. Hints for prospective authors

III. Questions and Answers

BIBLIOGRAPHY/WEBLIOGRAPHY
Pulmonary Hypertension: Beyond the Swan Ganz Catheter

P. Lynn Clark

CONTENT DESCRIPTION
Example: The pathophysiology and etiology of pulmonary hypertension will be presented along with the WHO classification system. Diagnostic methods will be explored along with physical exam findings. Treatment methods will be discussed while linking the therapies with the pathophysiology of the disease process.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Understand the pathophysiology and etiology of pulmonary hypertension
2. Discuss diagnostic methods for and physical exam findings in pulmonary hypertension
3. List several treatments for pulmonary hypertension

SUMMARY OF KEY POINTS
I. Definition
A. MPAP > 25 mmHg at rest or > 30 mmHg with exercise
   1. Causes of PHTN in the ICU
      a. Pre-existing pulmonary disease
      b. Lung disease
      c. Liver disease
      d. Cardiac disease
      e. ARDS
      f. Acute LV dysfunction
      g. Pulmonary embolism
      h. Post operative cardiac/thoracic surgery

II. Classification
A. Arterial
   1. Idiopathic
   2. Familial
   3. Associated – collagen vascular disease
   4. Congenital systemic to pulmonary shunts
   5. Portal HTN
   6. HIV
   7. Drugs and toxins
   8. Miscellaneous: Thyroid disorders, glycogen storage disease, Gaucher disease, hereditary hemorrhagic telangiectasia, hemoglobinopathies, myeloproliferative disorders, splenectomy

B. Venous
   1. Pulmonary veno-occlusive disease
   2. Pulmonary capillary hemangiomatosis
   3. Left sided atrial/ventricular heart disease
   4. Left sided valvular disease
   5. COPD/ILD

   6. Sleep disordered breathing
   7. Alveolar hypoventilation disorders
   8. Chronic exposure to high altitudes
   9. Developmental abnormalities
   10. Chronic thrombotic/embolic disease
   11. Miscellaneous: Sarcoidosis, histiocytosis X, Lymphangiomatosis, pulmonary vessel compression

III. Pathways Implicated in Pulmonary Hypertension
A. Nitric oxide
B. Prostacyclin
C. Endothelin 1

IV. Hemodynamic Consequences of Pulmonary Hypertension
A. Increased PVR
B. RV strain
C. Impaired RV filling
D. RV volume and pressure overload
E. RV dilatation
F. RVH
G. Increased RV wall stress
H. Decreased left sided preload, CO and coronary perfusion
I. TR
J. Arrhythmias

V. Diagnosis
A. Right heart catheterization
B. Echocardiogram
C. ECG
D. Spiral CTA
E. V/Q scan
F. Labs

VI. Physical Exam Findings
A. Treatments
   1. Prostacyclin Analogs
   2. Phosphodiesterase-5 Inhibitors
   3. Endothelin Receptor Antagonists
   4. Treatment for Left Sided Heart Disease
   5. Inhaled Nitric Oxide
   6. Serotonin Antagonists
   7. Pulmonary Thromboendarterectomy
   8. Anticoagulation
   9. Supplemental Oxygen
10. Diuretics
11. Digoxin
12. Calcium Channel Blockers
13. Transplantation
BIBLIOGRAPHY/WEBLIOGRAPHY


Speaker Contact Information mcgug001@mc.duke.edu
Pulmonary Hypertension: The Other High Blood Pressure
Laura Savage
Level: Intermediate

CONTENT DESCRIPTION
This session will describe the latest theories in the development of PAH. The current WHO classification will be reviewed. Using case studies, the etiology and signs and symptoms of PAH will be illustrated. Treatment modalities currently available will be compared and contrasted. The session will conclude with a look to the future providing an overview of current clinical trials.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Develop a better understanding of the etiologies of PAH.
2. Identify the three modes of treatment and relate these modalities to the pathophysiology
3. Describe implications for nursing care of the patient with PAH

SUMMARY OF KEY POINTS
I. Historical perspective/Background
II. WHO Classification
   A. Group I PAH
      1. Idiopathic (IPAH)
      2. Familial
      3. Associated with:
         a. Connective tissue disease
         b. Congenital systemic to pulmonary shunts
         c. HIV infection
         d. Drugs/toxins
   B. Group II
      1. PH associated with left heart disease
   C. Group III
      1. PH associated with respiratory disease and/or hypoxemia
         a. COPD
         b. Interstitial lung disease
         c. Sleep disorder
   D. Group IV
      1. PH due to chronic thrombotic or embolic disease
   E. Group V
      1. Miscellaneous
III. Definition
IV. Pathophysiology
   A. Vasocconstriction
   B. Intimal proliferation
   C. Thrombosis
   D. Impaired endothelial function
V. Presentation
   A. Dyspnea
   B. Fatigue
   C. Palpitations
   D. Chest pain
   E. Raynaud’s phenomenon
   F. Cough
   G. Syncope in children
VI. Diagnosis
   A. Diagnosis of exclusion
   B. EKG
   C. Chest x-ray
   D. Echocardiogram
   E. PFTs
   F. V/Q Scan
   G. Cardiopulmonary exercise testing
   H. Labs
   I. Right heart catheterization
VII. Treatment options
   A. Vasodilators:
      1. Calcium channel blockers
         a. Procardia/Cardizem
   B. Prostanoids
      1. FlolanTM (Epoprostenol)
      2. RemodulinTM (Treprostinil) 2004
         a. Subcutaneous
         b. Intravenous
      3. VentavisTM (Illoprost) 2004
   C. Endothelin Receptor Agonists
      1. NON-SELECTIVE
         a. Tracleer (Bosentan) 2001
      2. SELECTIVE:
         a. Ambrisentan (Letairis) 2007
         b. Sitaxsentan
   D. PDE-5 inhibitors
      1. Revatio (Sildenafil) 2005
VIII. Case study
IX. Future of PAH

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Speaker Contact Information lsavage@mcvh-vcu.edu
Pulmonary Hypertension: Patient Care Pearls

Deborah Lazzara  Level: Intermediate

CONTENT DESCRIPTION
Pulmonary Hypertension (PH) is a life threatening condition characterized by elevated pulmonary pressures that often result in right heart failure and death. PH patients can be cared for in the intensive care setting during initial evaluation and/or initiation of treatment. In addition, the PH patient may require ICU care due to acute cardiac and respiratory complications and disease exacerbations.

This presentation highlights the comprehensive care of the PH patient. The session begins with an overview of the disease process, the assessment and diagnostic findings associated with PH, as well as the classification of PH and populations at risk. Acute management of the critically ill PH patient will be presented. Pharmacologic aspects of care, including the latest, evidence-based information on the use of advanced modalities such as prostacyclin analogs (epoprostenol, treprostinil, and iloprost), endothelin receptor antagonists (bosentan), and phosphodiesterase-5 inhibitors (sildenafil) will also be discussed.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Understand the classification, clinical manifestations, and diagnostic evaluation of PH.
2. Identify key treatment considerations and interventions necessary for the early stabilization of the critically ill PH patient.
3. Discuss evidence-based treatment interventions for the PH patient and the nurse’s role in their implementation.

SUMMARY OF KEY POINTS
I. Introduction and Overview
   A. PH is defined as a persistent elevation of pulmonary artery (PA) pressure with normal left sided pressures.
   B. Findings on PA catheterization:
      1. Mean PA pressure > 25 mmHg at rest; >30mmHg with exercise
      2. Pulmonary capillary wedge pressure 15mmHg or less
   C. World Health Organization (WHO) Classification (2003) based on mechanism
      1. Group 1 Pulmonary Arterial Hypertension (PAH): Includes idiopathic and familial origin and PAH secondary to diseases that affect the pulmonary system such as collagen vascular disease, congenital heart disease, portal hypertension, HIV, anorexigen
      2. Group 2: Pulmonary Venous Hypertension secondary to left heart disease
      3. Group 3: PH associated with respiratory system disorders or hypoxemia
   4. Group 4: PH due to chronic thrombotic or embolic disease
   5. Group 5: PH caused by inflammation, mechanical obstruction, or compression of pulmonary vasculature
   D. Disease prognosis and progression

II. Clinical Manifestations and Diagnostic Findings
A. Patient complaints include shortness of breath, dyspnea on exertion, syncope, chest pain
B. Physical exam:
   1. Jugular vein distension, accentuated “a” wave, reduced carotid volume, right ventricular heave, right sided S4, loud P2, tricuspid murmur, peripheral edema, hepatomegaly, ascites
   2. Important to differentiate between diastolic right and left heart failure symptoms: May present with cardiogenic shock with warm extremities without pulmonary edema
C. Diagnostics:
   1. CXR: Cardiac enlargement, prominent proximal PA, “pruning” of the distal PA,
   2. EKG: Right axis deviation, right ventricular hypertrophy
   3. Transthoracic ECHO: evaluates right ventricular pressures, chamber dimensions, left side contractility and valve function, can also for shunts using contrast
   4. Right heart cath is definitive diagnostic tool
   5. Other testing is geared toward confirming and/or eliminating possible etiologic factors and can include pulmonary function tests, CT and/or V/Q scan, HIV, testing for connective tissue disease, etc.

III. Acute Management
A. Watch for low cardiac output signals: mentation changes, drop in oxygen saturation, drop in urine output, drop in BP, nausea, emesis, abdominal pain
B. Low output
   1. Inotropes: Dopamine
   2. Vasoconstrictors: Phenylephrine
C. Fluid overload
   1. High dose diuretics
   2. Combination therapy
   3. May need to add an inotrope/pressor to support BP
   4. Other considerations

IV. PH Treatments
A. Traditional Therapies
   1. Digoxin
   2. Oxygen
   3. Calcium channel blockers
   4. Anticoagulation
B. Prostacyclins
   1. Epoprostenol (Flolan®)
   2. Treprostenil (Remodulin®)
   3. Iloprost (Ventavis®)
C. Endothelin Receptor Antagonists
D. Phosphodiesterase Inhibitors
E. Lung transplantation
V. Summary: Top Ten Pearls for Practice

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Barst, et al. Diagnosis and differential assessment of pulmonary arterial hypertension. Journal of the American College of Cardiology 2004; 43(12); 40S-47S.
RAAS: Managing the Renin-Angiotensin-Aldosterone System

Kiersten Henry

CONTENT DESCRIPTION
The purpose of this session is to review the management of the renin-angiotensin-aldosterone system in the setting of heart failure and hypertension.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Discuss the role of the renin-angiotensin-aldosterone system in the development of heart failure and hypertension.
2. Identify the five classes of medications used to inhibit the renin-angiotensin-aldosterone system and discuss the indications for each.
3. Discuss the evidence-based guidelines for management of the renin-angiotensin-aldosterone system in the setting of heart failure and hypertension.

SUMMARY OF KEY POINTS
I. The Renin-Angiotensin-Aldosterone System
   A. Heart Failure
      1. Incidence/Prevalence
      2. Systolic vs. Diastolic Dysfunction
      3. Role of the RAAS
   B. Hypertension
      1. Incidence/Prevalence
      2. Role of the RAAS
II. Medications used to inhibit the RAAS
III. Guidelines for the management of heart failure and hypertension
   A. Heart Failure Society of America
   B. American College of Cardiology/ American Heart Association
   C. JNC7

BIBLIOGRAPHY/WEBLIOGRAPHY
Heart Failure Society of America. Heart failure in patients with left ventricular systolic dysfunction: HFSA 2006 comprehensive heart failure practice guideline. 1999 (Revised 2006 Feb.).

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Reclaiming Our Priorities: Chapter Leadership Transition

Kathleen (Kathy) Klein Peavy
Joy Speciale

Level: Beginner

CONTENT DESCRIPTION
One of the many challenges facing chapters is the development and continued success of basic chapter operations specifically the roles and functions of chapter officers that ensure chapters remain in “good standing” and promote healthy chapter work environments. In order for a chapter to be successful and truly live the mission, vision and values of AACN, effective chapter leadership transition is essential for continued growth and the maintenance of a strong, reliable chapter infrastructure. The purpose of this session is to discuss each of the chapter officer roles and functions and how to effectively transition the individual roles and responsibilities to incoming chapter officers. Key concepts include chapter officer job descriptions including qualifications and responsibilities, chapter record keeping and reporting requirements. The specific components and key strategies to successful transition will be discussed as well as chapter planning and timelines. At the conclusion of this session, participants will have new strategies and insight to successful chapter leadership transitioning. The target audience is any chapter leader, future leader and/or members interested in identifying the key roles and responsibilities of chapter officers and how to effectively transition chapter leaders for continued success. There is no prerequisite knowledge required for this session.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe transition and the relationship between transition and effective chapter management.
2. State the qualifications, role and responsibilities of each chapter officer.
3. Identify three key components for effective transitioning per chapter officer role.

SUMMARY OF KEY POINTS
I. Transition
   A. Definition

B. Examples
   1. Overlapping Terms
   2. Pass “The Box”
   3. Retreats – Face to Face
   4. Sample Tools

C. Relationship to effective chapter management
   1. Leadership Development
   2. Succession Planning
      a. Qualifications, Role and Responsibilities of Chapter Officers
         (1) President
         (2) President-elect
         (3) Secretary
         (4) Treasurer

II. Chapter Officer Transition Essentials and Examples
   A. President
   B. President-elect
   C. Secretary
   D. Treasurer

BIBLIOGRAPHY/WEBLIOGRAPHY

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Reclaiming Our Priorities: Our Patients, Our Nurses, Our Units

Pamela Bolton
Kirsten Skillings
Clareen Wiencek

Level: Beginner

CONTENT DESCRIPTION

This session will address strategies to be used by AACN chapters and members to reclaim the priorities of patient and family centered care through the implementation of AACN initiatives. Certification, Healthy Work Environments (HWE), and the Beacon Award will be examined as ways to refocus on critically ill patients and their families, critical care nurses, and critical care units.

LEARNING OUTCOMES

At the end of the session the participant will be able to:

1. Discuss current challenges to patient and family centered care in the critical care setting
2. Identify strategies that can be used by chapters and AACN members to reprioritize patient and family centered care, critical care nurses, and critical care units

SUMMARY OF KEY POINTS

I. Current challenges to patient and family centered care in the critical care setting
   A. National trends
   B. Demographic trends
   C. The nursing shortage
   D. Reports and recommendations
      1. FOCCUS: Framing Options for Critical Care in the United States

II. Strategies to reprioritize patient and family centered care
   A. Certification
      1. CCRN, CCNS, CMS
      2. Chapter programs to promote certification
      3. Chapters and critical care managers: working together
   B. Regional or National initiatives
   C. Evidence based practice

III. Healthy Work Environments: Reprioritizing the needs of critical care nurses
   A. Communication
   B. Collaboration
   C. Chapter strategies to promote HWE standards

IV. Beacon process: Strong critical care units
   A. Beacon: a process not a destination
   B. The Beacon Award: how to maintain and renew
   C. Chapter programs to promote the Beacon Process

BIBLIOGRAPHY/WEBLIOGRAPHY

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CONTENT DESCRIPTION
Pressure ulcers (PUs) are a deleterious patient outcome, resulting in a 25% greater risk of developing a nosocomial infection. The prevalence of hospital-acquired PUs ranges from 6.8% to 8.6% despite efforts aimed at reduction. In addition to increased pain and discomfort caused by PUs and impaired skin integrity, the costs associated with treatment are substantial and resource utilization is also significantly increased. The Institute for Healthcare Improvement’s 5 Million-Lives Campaign challenged health-care providers to prevent incidents of medical harm. One of the IHI proposals is to prevent PUs by using science-based guidelines for prevention. As there is a statistically significant relationship between PU development and nursing care measures, nurses are in a unique position to aid in achieving these goals.

Interventional patient hygiene (IPH) is a systematic approach to prevention of negative outcomes and has been defined as “a nursing action plan directly focused on fortifying patients’ host defenses through use of evidence-based care, including oral care, skin cleansing, and incontinence management”. This session focuses on 2 components of IPH: skin cleansing and incontinence management. Such care, when delivered using simple tools and specific protocols based on clinical evidence, empowers caregivers to assess and observe, communicate findings, intervene early, and decrease skin complications associated with pressure and incontinence.

LEARNING OUTCOMES
By the end of this session the participant will be able to:
1. Discuss the clinical and economic impact of pressure ulcers.
2. Discuss evidence-based best practices for early prevention, identification, and treatment of pressure ulcers
3. Outline strategies for implementing an Intervventional Patient Hygiene program and monitoring outcomes.

SUMMARY OF KEY POINTS
I. Significance of Pressure Ulcers
A. Prevalence and incidence
   1. Avoidable vs. unavoidable
B. Financial impact
   1. Actual cost to treat
   2. Incremental costs associated with Pus
   3. Changes in reimbursement
II. Evaluation and Implementation of Evidence-based Practice Guidelines
A. Bathing
B. Incontinence management
   1. Cleansing
   2. Application of appropriate barrier
C. Tools for assessing risk
D. Product evaluation
E. Protocol development
III. Implications for Clinical Practice
A. Staff empowerment
B. Early identification of skin changes
C. Assessment of patient risk
D. Implementation of quality-improvement initiatives
E. Task delegation
F. Communication among caregivers
G. Accountability

BIBLIOGRAPHY/WEBLIOGRAPHY

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Reducing CV Risk with CAM and Lifestyle Modifications

Margaret Latrella
Carolyn Strimike

CONTENT DESCRIPTION
Cardiovascular (CV) disease remains the number one cause of death in the United States today. The purpose of this presentation is to provide an overview of modifiable CV risk factors, the Metabolic Syndrome and its impact on CV risk, traditional medical management, effective complimentary alternative methods (CAM) and lifestyle modifications employed to decrease CV risk. Although traditional medical treatment is highly effective, the general population today is increasingly seeking natural and alternative methods in healthcare. Uncontrolled risk factors are accountable for a majority of CV events. Approximately 80% of heart attacks are preventable with aggressive risk factor management. By increasing awareness and educating patients and families about CV risk reduction through primary and secondary prevention, the incidence of CV disease and mortality and morbidity secondary to CV disease will decrease. The key concepts to be discussed are the recognition of modifiable CV risk factors, diagnosing the Metabolic Syndrome, and applying traditional, CAM, and lifestyle modifications to decrease CV risk. The presentation is targeted to all nurses wishing to educate patients and their families about CV risk reduction. Two outcomes are for the participants to identify modifiable CV risk factors and offer traditional and alternative risk reduction strategies, and to improve patient outcomes by preventing future CV events and minimizing future hospitalizations.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify modifiable cardiovascular risk factors
2. Discuss the Metabolic Syndrome and its impact on cardiovascular risk
3. Discuss traditional, CAM, and lifestyle modifications employed to decrease cardiovascular risk

SUMMARY OF KEY POINTS
I. Modifiable CV risk factors
   A. Smoking
   B. Hypertension
   C. Diabetes Mellitus
   D. Overweight/Obesity
   E. Physical Inactivity
   F. Dyslipidemia
   G. Stress
II. The Metabolic Syndrome
   A. Components:
      1. Fasting Glucose>100mg/dl
   2. Blood Pressure >130/85 mmHg
   3. Triglycerides > 150 mg/dl
   4. Waist Circumference >35” in women; >40” in men
   5. HDL < 50 mg/dl in women; < 40 mg/dl in men

B. Increased CV risk associated with the Metabolic Syndrome
II. Traditional, CAM, and lifestyle modifications employed to decrease CV risk
   A. Pharmacotherapy
      1. Statins
      2. Anti-platelet(ASA/Plavix)
      3. ACEI/ARBs
      4. B-Blockers
   B. Diet modifications
      1. Low fat/low cholesterol diets
      2. Low carbohydrate diets
      3. Sodium restrictions
      4. ADA diets
      5. Mediterranean diets
      6. Portion distortion
      7. Natural/Alternative supplementation
   C. Physical Activity
      1. AHA exercise guidelines
      2. 10,000 step program
   D. Stress management
      1. Yoga
      2. Meditation/Relaxation techniques
      3. Exercise
      4. Humor
      5. Personal preferences
   E. Alternative Methods
      1. Acupuncture
      2. Hypnosis

BIBLIOGRAPHY/WEBLIOGRAPHY
Kris-Etherton, P, et al. The Lyon Diet Heart Study: Benefits
of a Mediterranean-Style, National Cholesterol Education Program/ American Heart Association Step 1 Dietary Pattern on Cardiovascular Disease. Circ 2001;103: 1823-1825.

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Relaxation Using Self-hypnosis: Learn to Decrease Stress

Timothy Holt Smith
Lynn Gerber Smith

CONTENT DESCRIPTION
Nursing is considered the second most stressful occupation in the United States today. The purpose of this session is to educate nurses about their innate abilities to reduce their stress and to teach nurses to utilize these skills on a daily basis. The demands on the nurse continue to increase. Complex patients and heavy work loads are just two of the nurse’s daily stressors. Supply and equipment shortages and malfunctions, new medications and equipment, patient and family needs for education and support, all demand the nurse’s time and attention. Add in the ever changing shift work and chronic nursing shortages across the country and suddenly the nurse is overwhelmed. Stop. Take a deep breath. The nurse can be in control and reduce their own stress. Using relaxation techniques and creative imagery, self-hypnosis allows the nurse to “reframe” their perspective on events. Self-hypnosis has no known toxic effects and is free. During this session the principles of self-hypnosis will be explained. Foundation techniques will be demonstrated, and participants are encouraged to practice and return demonstrate self-hypnosis. Participants will then be able to practice these techniques just 5 minutes, 2-3 times a day to feel calmer, more relaxed and in control.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Identify the stressors in their work environments.
2. Describe the principles of self-hypnosis
3. Demonstrate self-hypnosis relaxation techniques and creative imagery.

SUMMARY OF KEY POINTS
I. Stress
A. Definition
B. Second most stressful occupation
1. Medical/Caring Professionals
2. Nursing-Critical Care Nursing
C. Identify the stressors in the work environment
D. Identify the stressors in our life and home life
E. Identify work and home stress that cannot be changed

II. Principles of Self-Hypnosis
A. History of hypnosis
1. Beginning when humans began communicating
2. Western hypnosis in last 250 years
   a. Franz Mesmer
   b. James Braid
   c. James Esdaile
   d. Florence Nightingale
   e. The Mayo Brothers/Alice Magaw
   f. Milton Erickson
   g. Mehmet Oz
B. Definition of hypnosis
1. Formal definitions
2. Working definition
3. Why hypnosis
C. What hypnosis is and what it is not
1. Phenomenon of hypnosis
2. Misconceptions
3. Frequently asked questions
4. Why hypnosis- It Works!!
D. Anatomy and physiology of conscious and subconscious
1. Conscious-Analytical
2. Subconscious-Literal
3. Suggestibility
E. Anatomy and physiology of stress
1. Hypothalamic-Pituitary-Adrenocortical Axis
2. Hypothalamic-Sympatho-Adrenomedullary Axis
3. Neuroendocrine Pathways
4. Physical response
5. Autonomic response
6. Emotional-stress symptoms
7. Behavioral-stress symptoms
8. Effects on the immune system
   a. Function
   b. Problems

III. Demonstration and Participation of Self-Hypnosis Techniques
A. Proper breathing technique-The key to the door.
B. The “Lemon Test”
C. Basic relaxation techniques
1. My Method- Emile Coué
   a. Self-talk Affirmations
   b. “Everyday, in everyway, I am getting better and better”
   c. Hypnagogic and hypnopompic
2. Contraction/Relaxation
D. Creative imagery
E. Questions and Answers

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West Sussex, England: John Wiley and Son.
www.cdc.gov/niosh
www.google.com
www.quintcareers.com
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Research: Focusing on FUN (Furthering Understanding of Nurses)

Ruth Kleinpell

CONTENT DESCRIPTION
Interpreting and using research and evidence based practice in clinical practice helps to ensure best practices and promotes positive outcomes for patients. Yet, it is often difficult for nurses to devote time to these activities as the daily demands of practice often take precedence. Difficulty in interpreting and using research in clinical practice has been cited as a barrier to clinical nursing research. This session will identify key strategies for implementing research and evidence based practice in clinical practice. Furthering the Understanding of Nurses or FUN can be used as a format for promoting the use of research in clinical practice. A number of strategies can be used to advocate for the use of research in clinical practice and making it FUN at the same time. This session will highlight the components of the research process using examples of clinical research projects in acute and critical care settings. Topics covered will focus on identifying clinical research projects, the steps in conducting research, and dealing with research challenges, focusing on FUN.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Review the research process and essential components to consider when conducting research
2. Discuss strategies for integrating research in clinical practice
3. Identify strategies for implementing research in acute and critical care

SUMMARY OF KEY POINTS
I. The Research Process
   A. The research process: an overview
   B. Steps in conducting research
   C. Dealing with research challenges
   D. Promoting an understanding of research for acute and critical care nurses

II. Integrating Research in Clinical Practice
   A. Making research FUN - Furthering Understanding of Nurses of the research process
   B. Examples in clinical practice

III. Strategies for Implementing Research and Acute and Critical Care
   A. Implementing research in acute and critical care setting: strategies for success
   B. Examples from clinical practice

BIBLIOGRAPHY/WEBLIOGRAPHY

Speaker Contact Information Ruth_M_Kleinpell@rush.edu
Research Grant Oral Presentations
Sponsored by Philips

CONTENT DESCRIPTION
This session will feature oral presentations of research that was supported in part by an AACN-Philips Medical Systems Clinical Outcomes Grant. The research being presented relates to care of cardiovascular patients and patients who have problems with bowel function in the acute and/or critical care setting. The background, methods, and findings of each study will be discussed; with an emphasis on clinical applicability.
In addition to the oral presentations, the research studies will be included as posters in Poster Session A. Presenters will be available at their posters to answer questions and discuss their posters with individual attendees at the “Meet the Authors” sessions on Tuesday, May 6th from 10:15 AM – 12:00 PM.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Describe two research methods used in the studies presented.
2. State two outcomes from each of the research studies presented.
3. Discuss implications of the research outcomes on patient care delivery and future research.

PRESENTATIONS
National Survey of US Cardiologists’ Perceptions and Use of Continuous ST-Segment Monitoring among Hospitalized Patients
Kristin Sandau, RN, PhD
Sue Sendelbach, RN, CNS, DNS, MSN, PhD, CCNS, FAHA
Karen Doran, RN, CNS, MSN, CCNS
Impact of Implementation of a Multidisciplinary Bowel Management protocol (BMP) on Selected Patient Outcomes in Critical Care
M. Cecilia Wendler, RN, PhD, CCRN
Research Oral Presentations

Level: Beginner

CONTENT DESCRIPTION
This session will feature oral presentation of research related to various aspects of sedation and pain management in critical care. The background, methods and findings of each study will be discussed. Opportunities will be presented for discussion of findings and implications for nursing practice.

LEARNING OBJECTIVES
At the end of this session, the participant will be able to:
1. Describe the research outcomes of studies relevant to critical care nursing practice.
2. Discuss the implications of research findings for clinical practice.
3. Describe the research methods appropriate to the study of critically ill patients.
Research Poster Presentations

CONTENT DESCRIPTION

Research presentations related to the care of the critically ill will be presented. Poster displays will provide an overview of the background, methods and findings of each study. Presenters will be available at their posters to answer questions and discuss their posters in a “Meet the Authors” sessions on Tuesday, May 6th from 10:15 AM – 12 PM.

LEARNING OUTCOMES

At the end of this session the participant will be able to:
1. Describe the research outcomes of studies pertinent to critical care nursing practice.
2. Discuss implications and findings related to patient care delivery and patient outcomes.
3. Describe the research methods appropriate to the study of critically ill patients.

POSTER PRESENTATIONS

RES200 COMPARISON OF CAPILLARY AND CENTRAL VENOUS POINT-OF-CARE GLUCOSE TESTING TO A VENOUS LABORATORY GOLD STANDARD
Rosalina Dela Rosa

RES201 THE EFFECT OF NUTRITIONAL SUPPORT ON WEANING OUTCOMES IN ADULT PATIENTS RECEIVING MECHANICAL VENTILATION
Maggie Roberts

RES202 EVALUATION OF A STRUCTURED PROGRAM FOR END-OF-LIFE CARE IN A NEUROLOGIC CRITICAL CARE UNIT: SURROGATE PERSPECTIVE
Susan Yeager

RES203 IMPROVING CPR QUALITY AND RESUSCITATION TRAINING AMONG NURSES USING NOVEL CPR SENSING TECHNOLOGY
Ronna Gersh

RES204 IT SOLUTIONS: IDENTIFYING SEPSIS EARLY
Marion Granich

RES205 OPTIMIZING STEWARDSHIP: A GROUNDED THEORY OF NURSES AS MORAL LEADERS IN THE ICU
Suellen Breakey

RES206 PEDIATRIC EMERGENCY PREPAREDNESS: ARE WE?
Kathi Huddleston

RES207 THE PENDULUM SWINGS BACK TO HYPERGLYCEMIA WHEN INTRAVENOUS INSULIN INFUSIONS ARE DISCONTINUED
Florence Li

RES208 PSYCHOMETRIC TESTING OF THE KU DELIRIUM ASSESSMENT TOOL (KU DAT) FOR INTUBATED PATIENTS
Michelle Bolen

RES209 A QUALITATIVE STUDY TO DETERMINE NURSES’ PERCEPTIONS OF GLYCEMIC CONTROL IN THE CARDIAC SURGERY PATIENT
Linda Henry

RES210 THE ROLE OF GLASGOW COMA SCORES IN MODELING APACHE®IV SCORES IN NEURO ICU PATIENTS
Kristina Riemen

RES211 WORK HOURS, MEAL BREAKS, QUALITY OF CARE, AND JOB INTENTION IN CRITICAL CARE AND PROGRESSIVE CARE NURSES
Peggy Miller

RES212 ABILITY OF AN ELECTRONIC INTEGRATED MONITORING SYSTEM TO IMPACT DURATION OF PATIENT INSTABILITY ON A STEP DOWN UNIT
Marilyn Hravnak

RES213 ACCURACY OF DIGIT AND FOREHEAD OXIMETRY IN PATIENTS RECEIVING THERAPEUTIC HYPOTHERMIA AFTER CARDIAC ARREST
Nicole Kupchik

RES214 ADEQUATE PRESSURE SUPPORT LEVEL TO PREVENT ALVEOLAR COLLAPSE DURING IN-LINE SUCTIONING IN A MODEL LUNG
Takeshi Unoki

RES215 ADVANCING PRACTICE: THE EXPERIENCES OF BEING CERTIFIED AS A LEVEL 3 CRITICAL & PROGRESSIVE CARE NURSE
Catherine Nosek

RES216 ANOTHER PRESSURE ULCER? A PROSPECTIVE STUDY TO REDUCE PRESSURE ULCERS IN VENTRICULAR ASSIST DEVICE PATIENTS
Carole Ballew

RES217 ASSESSMENT OF KNOWLEDGE, ATTITUDES, AND BEHAVIORS OF ICU HEALTH CARE PROVIDERS REGARDING END-OF-LIFE CARE ISSUES
Toni Balistreri

RES218 ATTITUDES AND BELIEFS OF EMERGENCY DEPARTMENT STAFF REGARDING FAMILY PRESENCE FOR MEDICAL RESUSCITATIONS
Lyndsey Nykiel
RES219 AUGMENTING OBSERVATIONAL SEDATION ASSESSMENT WITH BIS MONITORING REDUCES SEDATIVE USE.
DaiWai Olson

RES220 BLOOD PRESSURE RESPONSE TO FAMILY VISITATION AND NURSE PHYSICIAN COLLABORATIVE ROUNDS
Karen Giuliano

RES221 BUNDLING OF NURSING INTERVENTIONS - VENTILATOR ASSOCIATED PNEUMONIA
Linda Curtin

RES222 CARING IN PEDIATRIC EMERGENCY NURSING
Gordon Gillespie

RES223 CHEST PHYSIOTHERAPY IS SAFE WITH PATIENTS AT RISK FOR INTRACRANIAL HYPERTENSION
Heather Laughlin

RES224 CLINICAL OUTCOMES AND SATISFACTION WITH CONTINUOUS LATERAL ROTATION THERAPY (CLRT) IN A MEDICAL INTENSIVE CARE UNIT
Nina Fielden

RES225 COMPARISON OF FOREARM AND UPPER ARM NON-INVASIVE OSCILLOMETRIC BLOOD Pressures in Critically Ill Adults
Kathleen Schell

RES226 COMPARISON OF PATIENT CLASSIFICATION SYSTEMS FOR PEDIATRIC INTENSIVE CARE UNIT STAFFING
Gloria Lukasiewicz

RES227 CORRELATION OF SPIRITUALITY WITH DEPRESSION AND QUALITY OF LIFE IN THE CHRONIC HEART FAILURE PATIENT
Catherine Draus

RES228 CRITICAL CARE PERFORMANCE IN A SIMULATED MILITARY AIRCRAFT CABIN ENVIRONMENT
Margaret McNeil

RES229 DEVELOPMENT AND PSYCHOMETRIC TESTING OF A NONVERBAL PAIN ASSESSMENT TOOL (NPAT)
Deborah Klein

RES230 DEVELOPMENT OF AN EVIDENCED-BASED PRACTICE GUIDELINE: MUSIC THERAPY IN THE CCU
Candi Lincoln

RES231 DOES THE USE OF A MOISTURE CHAMBER DECREASE THE INCIDENCE OF CORNEAL ABRASIONS IN CRITICALLY ILL PEDIATRIC PATIENTS?
Lauren Sorce

RES232 AN EARLY NURSING INTERVENTION TEAM, A PREEMPTIVE NURSE-LED RAPID RESPONSE MODEL AN ITS EFFECT ON PATIENT OUTCOMES
Mary Lu Daly

RES233 EFFECT OF AED DEVICE FEATURES ON USE BY UNTRAINED LAYPERSONS
Vincent Mosesso

RES234 THE EFFECT OF GLYCEMIC CONTROL ON WEANING OUTCOME IN ADULT PATIENTS RECEIVING MECHANICAL VENTILATION
Melanie Hardin-Pierce

RES235 EFFICACY OF NEGATIVE PRESSURE WOUND THERAPY (NPWT) IN OBESE AND DIABETIC PATIENTS AFTER OPEN HEART SURGERY
Jesse Stephen Pasion

RES236 THE EFFECTIVENESS OF A CHILDRENS HOSPITAL PICU SEDATION WEANING PROTOCOL
Debra Ridling

RES237 END-OF-LIFE CARE: THE PRACTICE OF CERTIFIED, EXPERT NEONATAL AND PEDIATRIC INTENSIVE CARE UNIT NURSES.
Catherine Robichaux

RES238 END-OF-LIFE TRANSITION EXPERIENCES OF ICU NURSES: MINDFUL REALIZATION
Sarah Moscatel

RES239 ERRORS IN INTERPRETATION OF A TIGHT GLYCEMIC CONTROL (TGC) PROTOCOL
Badia Faddoul

RES240 FACTORS ASSOCIATED WITH INHOSPITAL CARDIOPULMONARY ARREST STUDY (FACTS)
Corinne Miller

RES241 FATIGUE AS A SYMPTOM OF ACUTE MYOCARDIAL INFARCTION (AMI)
Ann Eckardt

RES242 HEALTH CARE PERSONNEL ATTITUDES, CONCERNS, AND BELIEFS TOWARD FAMILY PRESENCE DURING CPR AND BEDSIDE INVASIVE PROCEDURES
Roberta Basol

RES243 HEART RATE, PUPIL SIZE, AND CORTICAL AROUSAL DIFFERED DURING NOXIOUS AND NON-NOXIOUS PROCEDURES IN SEDATED PATIENTS
Denise Li

RES244 IMPROVING ORGAN DONATION CONSENT RATES THROUGH THE UTILIZATION OF EFFECTIVE REQUESTORS
Cherie Bagwell

RES245 IMPROVING OUTCOMES FOR SEVERE TRAUMATIC BRAIN INJURY PATIENTS
Katherine Johnson
RES246 THE KEY TO UNLOCKING VAP: IT TAKES A VILLAGE
Jenny Cheney

RES247 KNOWLEDGE AND ATTITUDES REGARDING PAIN: A SURVEY AMONG CRITICAL CARE NURSES
Gary Yehl

RES248 MODIFICATION OF A SEDATION PROTOCOL USING DEXMEDETOMIDINE AND ITS EFFECT ON VENTILATOR DAYS AND LENGTH OF STAY
Michelle Woodham

RES249 NEW COMMUNICATION APPROACHES TO A TIME OLD PROBLEM
Charles Reed

RES250 NONPHARMACOLOGIC INTERVENTIONS FOR PROCEDURAL PAIN ASSOCIATED WITH TURNING AMONG HOSPITALIZED ADULTS
Bonnie Faijeles

RES251 NURSES’ EXPERIENCES WITH END-OF-LIFE CARE IN THE INTENSIVE CARE UNIT
Meg Zomorodi

RES252 NURSING SPECIALTY CERTIFICATION AND PATIENT OUTCOMES: AN INTANGIBLE LINK
Greta Krapohl

RES253 ON THE ROAD TO ESTABLISHING AND SUSTAINING A HEALTHY WORK ENVIRONMENT--OUR JOURNEY TO EXCELLENCE
Linda Cassidy

RES254 THE PHENOMENON OF MORAL DISTRESS AMONG ICU NURSES
Michele Benoit

RES255 POST ADMISSION DELIRIUM AS A MODIFYING FACTOR IN INTENSIVE CARE UNIT PATIENTS’ SYMPTOM REPORTS.
Shoshana Arai

RES256 POTENTIAL POINT OF CARE TEST PREDICTING INTRACRANIAL PATHOLOGY AFTER MINOR CLOSED HEAD INJURIES
Amanda Peacock

RES257 RACIAL DISPARITY IN END OF LIFE CARE: DISPARITY VERSUS CULTURE?
Bradi Granger

RES258 RELATIONSHIP BETWEEN HYPERGLYCEMIC INDEX VALUES AND OUTCOMES IN PATIENTS WITH SUBARACHNOID HEMORRHAGE
Marilyn Hravnak

RES259 RISKS OF BACTEREMIA IN THE ICU: DOES ORAL CARE MATTER?
Deborah Jones

RES260 RISK PERCEPTION OF MUSCULOSKELETAL INJURY AMONG CRITICAL CARE NURSES
Soo-Jeong Lee

RES261 SHOWER GLOVE – FROM A BEDSIDE IDEA TO REALITY
Evan Ballantyne

RES262 UNDERSTANDING THE SYMPTOM BURDEN AT END-OF-LIFE IN PATIENTS WITH LIFE-LIMITING ILLNESS IN INTENSIVE CARE UNITS
Peggy Kalowes

RES263 THE VALUE-BEHAVIOR CONGRUENCY MODEL IN END-OF-LIFE CARE
Meg Gambrell Zomorodi
Respiratory Waveforms: How to Use Bedside Graphics

Suzanne M. Burns

CONTENT DESCRIPTION
Bedside respiratory graphic displays are increasingly available on mechanical ventilators. Though the waveforms provide valuable information for clinicians, few understand how to interpret the waveforms so that accurate interventions may follow. This session is designed to teach nurses how to assess patients’ tolerance of mechanical ventilation by using bedside respiratory graphics. Concepts of pressure and flow will be covered in addition to the application of the concepts to volume and pressure modes of ventilation. Waveform analysis will include pressure/time, flow/time, and loops (pressure/volume and flow/volume). Examples of waveforms will be analyzed by the participants as they relate to specific clinical conditions. This session is designed for nurses who work with patients who require mechanical ventilation. Important prerequisites for the session are an understanding of mechanical ventilation and experience working with ventilated patients.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Discuss the relationship of volume, pressure and flow to graphical representation of selected modes of ventilation.
2. Identify selected volume and pressure modes by analyzing respiratory waveform graphics.
3. Analyze pressure/time, flow/time, and loops (pressure/volume and flow/volume) as they relate to patient tolerance, compliance and resistance and other selected clinical conditions

SUMMARY OF KEY POINTS
(Waveforms reprinted by permission of Nellcor Puritan Bennett, Pleasanton, CA)
I. Introduction and case presentation.
   A. The case of Mrs X: how waveforms helped assess her tolerance of mechanical ventilation and management.
II. Patient Selection: Common applications and use of graphics.
   A. Identification of Modes of Ventilation:
   B. Evaluation of patient ventilator Synchrony
   C. Detection of auto-PEEP
   D. Evaluating changes in compliance and resistance.
   E. Identification of end-expiration during hemodynamic monitoring.
   F. Monitoring respiratory effort when muscle relaxants are used.
III. Concepts of Pressure and Flow
   A. Volume Ventilation
      1. Volume set by clinician. Volume is maintained regardless of pressure required (not affected by resistance/compliance changes).
      2. Waveform analysis of volume breaths.
      3. Accelerating pressure waveform (pressure gradually builds as the breath is delivered).
      4. Square flow waveform (flow is maintained through the breath).
   B. Pressure Ventilation
      1. Pressure is selected by the clinician. Volume varies (affected by changes in resistance and compliance).
      2. Waveform analysis of pressure breaths
      3. Square pressure waveform (pressure is reached early in breath and maintained throughout inspiration.
      4. Decelerating flow waveform (flow decreases as lungs fill with inspired gases).
IV. Pressure/Time Waveform
   A. Intermittent mandatory ventilation (IMV)
   B. Assist Control (A/C)
   C. Pressure Support (PS)
   D. Pressure Controlled/Inverse Ratio Ventilation (PC/IRV)
   E. Patient Ventilator dyssynchrony
   F. Auto – PEEP
V. Flow/Time Waveforms
   A. Auto-PEEP
   B. Bronchodilator response
VI. LOOPS
   A. Pressure/Volume
      1. Mandatory breath
      2. Spontaneous breaths
      3. Assisted breaths
      4. Assessing compliance
      5. Assessing resistance
   B. Flow Volume Loop
      1. Typical flow-volume loop
      2. Bronchodilator response
VII. Other uses for waveforms
   A. Identifying end-expiration with hemodynamic monitoring
   B. Identifying “break-through breathing” when paralytic agents are used.
VIII. Mystery Cases and waveforms: “Name that waveform”!

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Puritan Bennett. Ventilator Waveforms: Graphical Presentation of Ventilatory Data. Pleasanton, California: Nellcor Puritan Bennett, Inc 2003Limit to 8, listed in alphabetical order by author name.

Speaker Contact Information smb4h@virginia.edu
CONTENT DESCRIPTION
You can make a difference. The leading medical errors in this country fall within nursing’s independent scope of practice. National quality and safety initiatives as well as reimbursement strategies are targeted to focus on fundamental nursing care practices to reduce medical error. Are you ready to assume ownership of basic nursing care activities with sufficient evidence to support the impact they have on patient outcomes? What role does oral care play in preventing ventilator associated pneumonia (VAP)? Should we be bathing our patients a different way for early detection of skin problems, improving the condition of the skin and reducing the spread of microorganism within the critically care environment? What nursing care strategies are key to reducing blood stream infections associated with invasive lines or surgical site infections? Does risk assessment and early introduction of prevention strategies reduce the incidence of incontinence associated dermatitis and pressure ulcers? What impact does mobility have on VAP and long term challenges of functional limitations because of the deconditioning that occurs in the critically patient?
We have the ability to change the fundamentals of our work and significantly impact patient outcomes. The challenge to incorporating new evidence into practice lies in altering our routinized behavior and current unit nursing culture in order to support new care practices. This session will provide a panel of experts in the areas of oral care, mobility, bathing, prevention of skin injury, line infections and surgical site infections. They will seek to dispel any myths and address the evidence base practice around numerous nursing care activities and provide suggestions for successful implementation leading to a change in practice.

3. Discuss possible barriers to these practice changes and realistic solutions to assist you during the implementation process.

SUMMARY OF KEY POINTS
I. Introduction: Driving Forces for Resuscitating the Basics
II. Oral Care: Role in Preventing VAP
   A. CDC Guidelines Prevention VAP
   1. Implement comprehensive oral care protocol
   B. Oral Care and VAP—the Suspected Link
      1. Colonized oropharyngeal secretions
         a. Dental plaque
         b. Tongue
         c. Endotracheal tube
   C. Current Oral Care Practices
      1. Swabs
      2. Toothbrushing
      3. Oral suctioning
      4. Deep suctioning
      5. Varied frequencies
   D. Cost Benefit Analysis
   E. Risks of Oral Care
   F. Review of the Evidence
      1. Meta analysis (Pineda)
         a. No added benefits of chlorhexidine (CHG)
      2. Systematic review (Berry, et al)
         a. 55 articles
         b. Issues precluded meta-analysis
         c. Additional research needed
      3. Recent randomized trials reduction in VAP or colonization
         a. 2005, Fourier (CHG)
         b. 2006, Koeiman (CHG or CHG/colestin)
         c. 2004, Grap (CHG via swab)
         d. 2002, Houston (CHG cardiac surgery)
         e. 2006, Munro (CHG via swab)
         f. 2006, Sequin (povidone-iodine)
   4. Which preparation works best?
      a. 2007, Senol (CHG or peroxide solution)
   G. Limitations of the Evidence
      1. Comparing something to nothing versus usual care
      2. Difficulty of conducting RCT
3. Diagnosis of VAP
4. Role of oral care in the “all or none” bundle
5. Who implemented the protocol?

H. Various solutions
1. Sodium peroxide
2. Sodium bicarbonate
3. Chlorhexidine gluconate
4. Over-the-counter preparations

I. Edentulous patients
J. Successful Implementation Strategies
1. Comprehensive education
2. Reinforcement to sustain gains
3. All members of team involved in oral care
4. Available equipment and resources
5. Ongoing monitoring of processes and outcomes

K. Best Practices

III. Positioning and Early, Progressive Mobility in Critically Ill Adults
A. Positioning
1. Head of bed
2. Routine Turning
3. Why every 2 hours?
4. Is every 2 hours enough?
5. CLRT

B. What are the barriers to implementation?
C. Orthostatic health
1. Intermittent reverse Trendelenberg
2. Training

D. Early, progressive mobility
1. Should ICU patients experience passive/active range of motion while in bed?
2. How should progression to dangling, sitting, and even ambulation be determined?

E. Utility of protocols and aids to mobility
F. Patient safety issues
G. Staff safety issues

IV. Changing the Way We Bathe Patients: Impacting the Condition of the Skin and Reducing the Spread of Resistant Organisms
A. The bath process: the first line of defense
1. Initial identification of redness/injury
2. Strategies to communicate initial injury if unlicensed personal perform the bathing process
3. Impact of washing with soap

B. Bathing Techniques: Basin vs. Newer Technology
1. Improving efficiency
2. Reducing the impact of soap and the scrubbing motion
3. Reducing the potential spread of microorganisms.
   a. Hand hygiene
   b. Current bathing practices and the impact on bacterial load
   c. Medicated and non medicated
   d. Impact on new acquisition resistant bugs

C. Implementing Effective Source Control through Bathing
1. Defining the problem
2. Decision on measurement matrix/benchmark against national data
3. Strategies implemented to bacterial load
4. Staff education and ownership
5. Evaluating the Impact
   a. Measuring transmission rates, VAP, UTI & BSI rates
   b. Benchmark against national data
   c. Cost analysis
   d. Communicating clinical data in administrative language

V. Preventing Pressure Ulcers and Skin Breakdown in the ICU. Nursing Owned Patient Outcome
A. Epidemiology of pressure ulcers in acute care settings
1. Prevalence and incidence rates in hospital settings are unacceptably high
2. Financial implications: estimated cost for treating pressure ulcers is $9.1 - $11 billion dollars annually; the cost to treat a nosocomial full thickness pressure ulcer is $70,000
3. Negative impact on patient outcomes: an estimated 60,000 patients deaths were attributed to complications of pressure ulcers in 2004. Pressure ulcers extend a patients length of hospital stay, place the patient at increased risk of sepsis from wound infection, and cause additional pain and discomfort for the patient.

B. Are pressure ulcers preventable in acutely ill patients?
1. National position statements: most pressure ulcers are preventable
2. Patient safety initiatives: prevention pressure ulcers in hospitals

C. Updated pressure ulcer staging system
1. What is DTI?
2. What is incontinence associated dermatitis?
3. Do ICU nurses know how to accurately assess and stage pressure ulcers?

D. Nursing driven interventions to prevent pressure ulcers and skin breakdown in high risk critically ill patient populations
1. Evidence to support turning and interventions to relieve pressure points with critically ill patients
2. Skin care basics: Is soap and water harmful? What are effects of dry skin? Do nurses have adequate knowledge of skin care products?
3. What is the evidence to support or refute rectal tubes?

E. Discussion of the evidence supporting the power of nursing to reduce the prevalence of pressure ulcers in the acute hospital setting.
VI. Eliminating Central Line Associated Blood Stream Infections (CLA-BSI)
A. Incidence and Risk Factors
B. Evidence Based Strategies to Eliminate CLA-BSI
   1. Hand Hygiene
   2. Maximal Barrier Precautions
   3. Chlorhexidine for Skin Asepsis
   4. Avoid Femoral Lines
   5. Remove unnecessary lines
   6. Care of central lines
C. Additional Strategies: Evaluating the evidence
   1. Antimicrobial coated catheters
   2. Antimicrobial dressings
   3. Chlorhexidine bathing
D. Insertion Process Standardization, Education and Evaluation
   1. Central Line Insertion Checklist
   2. Line cart or central line bag
   3. Pre-procedure briefing
   4. Empower nurse to stop line insertion if break in sterile technique
   5. Nursing and Resident orientation and ongoing feedback
   6. Share data monthly, defect analysis related to each case of CLA-BSI
E. Michigan Hospital Association Keystone ICU Collaborative
   1. Strategies
   2. Results

VII. Best Practice Recommendations For Prevention of Sternal Wound Infections Following Cardiac Surgery
A. Overview of All Surgical Site Infections (SSI)
   1. Incidence
   2. Account for approximately 40% of hospital-associated infections U.S.A.
   3. Nearly 3% of all postoperative patients develop an SSI
   4. Evidence shows that approximately 40%-60% of SSIs can be prevented
B. Significance
   1. Increased mortality
   2. Prolonged hospital stay
   3. More likely to spend time in critical care
   4. Increased costs
   5. If SSI develops after discharge, five times more likely to be readmitted
C. Surgical Care Improvement Project (SCIP)-Initiated in 2003 by CMS and the CDC
   1. A national, collaborative quality initiative to substantially reduce surgical mortality and morbidity through collaborative efforts.
   2. Goal: To reduce nationally the incidence of surgical complications by 25% by the year 2010.
   3. Facilitated by CMS-Centers for Medicare & Medicaid Services
   4. Steering Committee of 10 national organizations, More than 20 organizations provide expertise to Steering Committee through an Expert Panel
   5. Key organizations of interest supporting this initiative- CMS, IHI, STS & Joint Commission
D. Cardiac Surgery and Sternal SSIs
   1. Incidence: Deep sternal wound infection ranges from 0.4% to 4% associated with a mortality of 10% to more than 20%.
   2. CDC defines of a deep sternal wound as an infection involving incisional deep soft tissue within 30 days of the operation.
   3. Issues of divergent practice patterns found in cardiac surgery
E. SCIP guidelines (with few exceptions) apply to adult cardiac surgery patients except for those with the following special needs:
   1. Active preoperative infections
   2. Undergoing cardiac transplantation
   3. On immunosuppressive therapy
   4. Aortic replacement surgery
   5. Off-pump cardiac surgery
F. SCIP Guidelines for Prevention of SSIs
   1. Appropriate use of prophylactic antibiotics
   2. Selection
   3. Timing of pre-op dose
   4. Discontinuation optimal practice = given for 48 hours or less
   5. Hair removal- method and timing
   6. Pre-op skin care (showers)/ prep (*No SCIP guideline)
   7. Glycemic control postoperatively

VIII. Questions for the Panel
IX. Summary

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Positioning and Early, Progressive Mobility in Critically Ill Adults


Changing the Way We Bathe Patients: Impacting the Condition of the Skin and Reducing the Spread of Resistant Organisms


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Preventing Pressure Ulcers and Skin Breakdown in the ICU. Nursing Owned Patient Outcome


Estabrooks, C. Translating research into practice: Implications for organizations and administrators. Canadian Journal of

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Rhabdomyolysis: Crushing and Flushing

Lynelle Scullard

CONTENT DESCRIPTION
Rhabdomyolysis is a potentially fatal complication of many patients in the critical care environment. This presentation will discuss the pathophysiology of traumatic and non-traumatic development of rhabdomyolysis, including how electrolytes play a significant role. The importance of prevention, including identifying populations at risk, and awareness of signs and symptoms will then be addressed. Lab results and treatment priorities will then be covered to further the knowledge of the participants. A variety of actual case examples will be used to apply this information into clinical practice. The first case study is a multiple trauma with large muscle injury. The second case covers a patient who first develops Diabetes Insipidus, then after severe electrolyte disturbance and dehydration develops rhabdomyolysis. The last case study presented is a patient with acute rhabdomyolysis formation and is suspected of PRIS (Propofol Related Infusion Injury). This presentation is geared to the experienced critical care nurse. An understanding of acid/base balance and electrolytes will be helpful, but is covered throughout this lecture.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Explain the pathophysiology of rhabdomyolysis.
2. Discuss the traumatic and non-traumatic causes of rhabdomyolysis.
3. Describe the assessment and treatment priorities of rhabdomyolysis to minimize renal and systemic damage

SUMMARY OF KEY POINTS
I. Definition
II. History
III. Pathophysiology
   A. Electrolytes
      1. Intracellular vs. Extracellular mechanisms
      2. Cell membrane
      3. Na+/K+ pump
      4. Severe electrolyte disturbances
   B. Mechanisms
      1. Breakdown of membrane
      2. Na+ massive influx into cell
      3. Intravascular hypovolemia (vasoconstriction)
      4. K+ leaks out of cell
      5. Lactic acid out of cell
   C. Myoglobin
      1. Dark red protein
      2. NEPHROTOXIC with coexisting oliguria and aciduria
      3. Pigment induced nephropathy by sloughing tubular endothelium
   4. The exfoliate and large myoglobin molecules obstruct renal tubules
IV. Causes of rhabdomyolysis
   A. Non-traumatic causes 5X> than traumatic causes
   B. 59% have multiple conditions
   C. Direct muscle injury
   D. Drugs and toxins
   E. Statins
   F. Propofol
      1. PRIS: Propofol Related Infusion Syndrome
      2. Often seen in children
      3. >4 mg/kg/hr x 48 hrs (66.6 mcg/kg/min)
      4. Risk factors
         a. Airway infection, HI, long term use, increased catecholamine and glucocorticoid levels, low energy supply
      5. Pathophysiology
         a. Uncouples respiratory chain in mitochondria, especially heart and muscle, hypotension, Brady
   G. Metabolic and endocrine
   H. Infectious
V. Clinical signs and symptoms
   A. Subtle early on
   B. High rate of suspicion
   C. Risk factors
   D. Tissue crushing injury
   E. Ischemia
   F. Serious infection
   G. Deep burns
   H. Subjective
   I. Objective
   J. Laboratory findings
      1. Creatinine Kinase
      2. Low Ca++
      3. Urinalysis
   K. Renal function
      1. BUN: Cr ratio falls
      2. ABG signifies metabolic acidosis
      3. Myoglobin
VI. Diagnostics
   A. MRI
   B. Compartment pressure gauge
VII. Complications of Rhabdomyolysis
   A. Electrolyte disturbances
      1. Clinical symptom and a complication
   B. Metabolic acidosis
   C. Hypovolemia
      1. Fluid follows sodium into cells (up to 12L)
      2. Fasciotomies cause large amounts of fluid to spill into bed
3. Causes vasoconstriction
4. Further reduces blood flow

D. DIC
1. Damage to endothelial cells stimulates the coagulation cascade
2. Calcium needed for clotting is shifted into cells
3. Most pronounced 3-5 days later

E. Acute muscle wasting
1. Typically skeletal muscles, but can be
   a. Heart
   b. Diaphragm
   c. Intercostal

F. Acute Renal Failure: Myoglobinuric Renal Failure
1. 33% progress to ARF
2. 7%-15% all ARF cases in the USA
3. Can be oliguric or non-oliguric
4. Aggravated by hypovolemia and vasoconstriction!

G. Breakdown of Myoglobin
1. Pigment induced nephropathy
2. Sloughing of tubular endothelium
3. Exfoliate (casts) and myoglobin obstructs renal tubules
4. Low urine ph (<5.6)
5. Facilitates cast formation
6. Promotes dissociation of myoglobin molecules into cytotoxic components

VIII. Treatment of Rhabdomyolysis
A. Early detection
   1. Urine color and amount
   2. Laboratory findings
B. Limit further damage
C. Enhancing toxin clearance
   1. Volume expansion
   2. Restore intravascular volume and induce solute diuresis
   3. Isotonic crystalloid (up to 20L/24hrs) to U/O
      150-300ml/hr (8L/d)
   4. Urine alkalinization
   5. Prevents dissociation of myoglobin
   6. Add sodium bicarbonate to crystalloid infusion
   D. Mannitol
   E. Enhancing toxin clearance

IX. Outcomes
A. “Most” regain renal function if went into ARF
B. Overall survival 77%
C. ARF from Rhabdo mortality is 8%
D. Mortality is tied to other injuries

X. Case Study 1
XI. Case study 2
XII. Case study 3

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RSV: The Seasonal Invader

Margot Thomas  Level: Beginner

CONTENT DESCRIPTION
The season for RSV (Respiratory Syncytial virus) can be a pediatric critical care nurse’s worst nightmare. For weeks and even months, the PICU struggles to continually accommodate infants and children diagnosed with RSV bronchiolitis or pneumonia during the seasonal outbreak of this highly infectious virus. RSV is the number one cause of lower respiratory disease in infants and young children and worldwide, directly or indirectly, contributes to the deaths of up to one million children under the age of five each year. The highest risk for severe disease arises in the case of premature infants, children with underlying cardiac or pulmonary disease and immunocompromised children. This session will present an overview of the unique attributes of the infant’s pulmonary system, which have implications to the development of severe disease as the virus impacts on alveolar gas exchange and work of breathing. The disease processes involved in RSV bronchiolitis/pneumonia and current treatments will be outlined. Specific nursing judgments related to assessment and supportive treatments including sedation management, nutritional support and ventilation strategies will be highlighted. In addition, specific prevention strategies that pediatric critical care nurses can implement with high-risk populations will be discussed.

LEARNING OUTCOMES
At the end of the session the participant will be able to:
1. Discuss the implications of the attributes of the infant’s pulmonary system in relation to respiratory infections.
2. Identify the disease processes involved in RSV bronchiolitis/pneumonia.
3. Specific nursing judgments related to sedation management, nutritional support and ventilation strategies in caring for the infant with RSV bronchiolitis/pneumonia.

SUMMARY OF KEY POINTS
I. Respiratory Infections: Background
   A. Classification
   B. Definitions of colonization, infection
II. RSV Virus
   A. Characteristics
   B. Risk factors
   C. Communicability
   D. Transmission
III. RSV Infection
   A. Epidemiology
   B. Pathophysiology
   C. Infant/Child characteristics
IV. Presentation

A. Clinical picture
B. Laboratory testing
V. Management
   A. Supportive therapies
      1. Hydration
      2. Fever management
      3. Airway management
      4. Mechanical Ventilation
         a. Ventilation strategies
   5. Chest physiotherapy
B. Pharmacotherapies
   1. Bronchodilators
   2. Corticosteroids
   3. Racemic Epinephrine
   4. Immunoglobulins
VI. Prevention
   A. Infection Control
   B. Prophylaxis

BIBLIOGRAPHY/WEBLIOGRAPHY

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