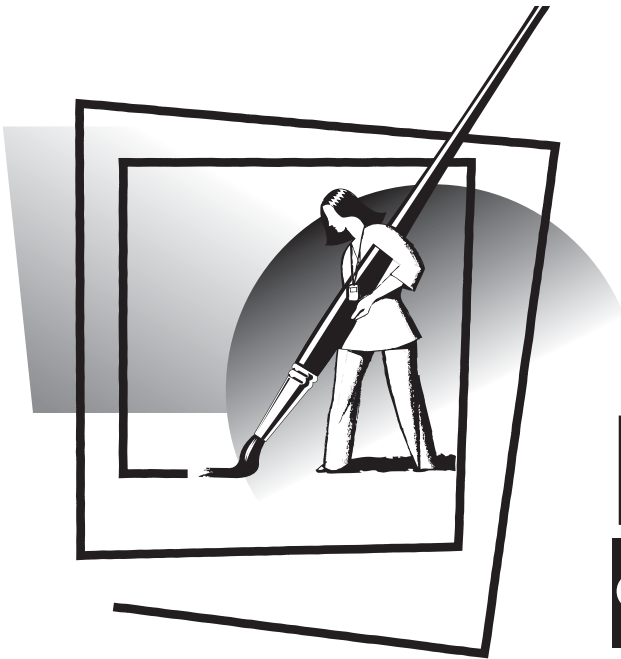


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# RECLAIMING OUR PRIORITIES

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Hanson is a clinical nurse specialist at Clarian Health - Methodist Hospital in Indianapolis, Indiana. He previously worked as a staff nurse, team leader and nurse educator. In addition to time spent in the adult ICU, Hanson has also worked in the cardiac catheterization lab, postanesthesia care unit and emergency department.

He previously served on the AACN Board of Directors from 2001 to 2007, as president-elect for 2006-2007 and as treasurer from 2002 to 2004.

We are gathered here this week in record numbers. More than 9,000 nurses in one place—watch out Chicago! I'm not sure the Windy City will ever be the same! I am honored and humbled to stand before you as your host for the 2008 National Teaching Institute.

I'd like to start my conversation with you today by talking about numbers. I know, I know. Yawn. If you're anything like me, numbers make your eyes glaze over. Don't worry though. The numbers I want to talk about are numbers that inspire and inform—numbers that remind us of our awesome responsibility and power.

Let's start with the number one. By reclaiming one priority today, we could prevent more than 675,000 medication errors by the time we gather again next year in New Orleans. Imagine 675,000 medication errors. And that's possible counting only those of us in this room today. Each one of us alone could prevent 75 medication errors in that same timeframe.

Where am I getting my numbers? Allow me to show my work as they say.

Conservatively, on average, we are each responsible for more than 300 patient days per year. A recent Institute of Medicine study found that at least one drug error occurs per patient per day—and 25% of the errors are preventable. That's where my math begins. One nurse, 300 patient days per year. On average, one drug error per patient day—and 25% of them are preventable. More than 9,000 of us are here today. So, if our reclaimed priority were putting an end to medication errors, there is the potential for us to avert 675,000 errors over the coming year.

Here's another number: 90,000. That's how many patients are in the ICU on any given day in the United States. Over a typical lifetime, nearly every one of us will come to know an ICU from the inside, as a patient. Certainly, if not us, a loved one will be in the care of our colleagues in an ICU or progressive care unit somewhere, sometime.

In our work as nurses, we have tremendous power to influence the outcomes of our patients—to put their care first, above all else.

We are only 9,000 nurses in this room. Imagine how our influence would grow if we added the other half million nurses who are currently caring for acutely ill and critically ill patients in the United States. Our impact would grow exponentially, raising the number of medication errors we could avert to 37 million.

The numbers—and the implications—are staggering. The responsibility, profound. This responsibility we share with our colleagues is something we hold constant in our minds and in our actions. I think that's why the theme *Reclaiming Our Priorities* has resonated so well this year. Reducing or averting medication errors is just one priority we could choose to reclaim (there may be another priority that is more urgent for you and your organization). For me, this priority has taken a front seat because I've seen firsthand how devastating the results can be when a medication error occurs.

I'm sure many of you recall the tragic events I shared at last year's NTI in Atlanta. In September 2006, my hospital was shaken to its core when a heparin dosage error claimed the lives of three infants. The deaths at my hospital made national and international headlines and exposed a weakness in my healthcare system that has since been corrected.

I like to think of myself as a good nurse—a professional nurse committed to delivering safe, quality nursing care to patients and their families. On occasion, I've even reflected that if I were ever a patient, I'd feel confident if I (Dave Hanson) were my nurse. How's that for confidence?

I've also taken tremendous pride in telling friends and family about the significant contributions and important work of nurses. In fact, there was a time when I would have bragged about my error-free record related to medication administration. But the heparin error at my own hospital stopped me cold. That could have been my error. My reflection on this incident has led me to greater awareness about myself, my career and even my sense of what it means to be a good nurse. I now recognize and understand that I haven't made a medication error that I'm aware of. The truth of the matter is that I could indeed have administered a wrong drug or given a wrong dosage, but never knew about it so therefore never reported it.

That heparin error at my hospital didn't happen to just one nurse, or a few nurses. It happened to each one of us. Even now, I find myself wondering if it could happen again. Don't you also wonder? Then it did. Last November, 10 days after twins were

born at a Los Angeles hospital, they were given an incorrect dose of medication. Again, the drug was heparin—the same medication involved in the catastrophic events at my own hospital just a year earlier. Fortunately, in that more recent incident, no lives were lost. Once more, I asked myself if such an error could happen again.

Despite of intense public scrutiny and incredible personal soul searching in the days, weeks and months that followed the incident at my hospital, we have witnessed a remarkable spirit emerge between and among caregivers who recognized that, given the right set of circumstances, the error could have happened to anyone, anywhere. In the face of this adversity, the nurses where I work have developed a powerful voice that we are using to strengthen our profession, taking the lead in reclaiming priorities that will ensure the safety of our patients.

We, the nurses at Clarian Health, have strengthened our influence, but it will take all of us here using our rich AACN nursing network to act boldly and speak confidently and skillfully to fulfill our promise to patients. *Reclaiming Our Priorities* means living AACN's mission every day.

How? We can start by reclaiming just one priority. Preventing medication errors is one option. Many others compete for our time and focus. We must identify the biggest impediments to patient safety and maintain a laser-sharp focus on them. The impediments will vary from hospital to hospital, from unit to unit. Despite being asked countless times, I cannot give you a list of the specific priorities you should reclaim because every unit and every hospital culture is are unique.

I know determining which priority to reclaim seems daunting. Like me, you've probably been disheartened by the doom and gloom stories in healthcare. The problems seem so vast. But where I had been disheartened in the past, I have become inspired and energized. Traveling as AACN's president has given me a much broader and more optimistic view.

I've heard countless positive stories from nurses around the country. More than I can recall in past years, I've heard how individuals and hospitals are making significant changes that are resulting in heightened patient safety. There seem to be pockets of individual and organizational excellence all around the country that deserve the spotlight. I'll share some of these examples with you today because I think they serve to inspire all of us about what is possible, and what big things one determined nurse can change.

The number one is pivotal I think. As the old proverb goes, a

journey of a thousand miles begins with one step. So what if I ... you ... we concentrate on the power of one.

One focus. One time. One person.

### **One Focus**

By one focus, I mean we must focus on doing what only nurses can do. We cannot continue to divert our nursing focus by regularly doing nonnursing tasks. We've all grown up to embrace the ability to multitask as a virtue. I'd like to challenge that thinking. During every shift, there are many times when we should and must be wholly focused on a single task. For example, when we are obtaining or administering medications.

How often are we interrupted during the course of obtaining medications to the time we administer a drug to our patient? If we do not maintain a concentrated focus on this vital responsibility, we risk contributing to a serious error. Realizing that, many hospitals have put into place systems to protect this vital time and attention.

You may have already heard about the "no interruption zone" that Sentara Leigh Hospital in Norfolk, Virginia implemented a couple of years ago. Many other hospitals have now adopted a similar approach in which a red boundary is created on the floor around the medication dispensing system. This "no interruption zone," which can be indicated with colored tape or tile or a small rug, clearly calls out that a nurse is not to be interrupted—ever, at all—when he or she is in that red box.

Talking with other nurses around the country, I learned that Stanford Hospital in California has taken this approach one step further. They call it a Medication Pass Time Out. The new procedure is part of the broader Integrated Nurse Leadership Program funded by a grant from the Gordon and Betty Moore Foundation. The new process builds in a protected hour early in a shift for a nurse to focus exclusively on reconciling medication orders, administering medications, checking medication labels and charting the administration of medications. Except for emergencies—that means no phone calls, no pages, no patient inquiries, no physician visits—all other daily intrusions are delayed during that time. During a 6-month pilot experiment, the test unit significantly reduced the number of interruptions and, as a result, medication errors decreased.

If you're like me, your reaction to this idea started positively. Wow, what a great idea. How did they manage that? Then your brain quickly became cynical. You thought, well that's quite a luxury. It would never work at my hospital. What if those phone calls are really important? What if someone needs me for something else? What if...? What if...? What if...?

Don't you think it's time we learn to adjust our thinking? With a simple shift in my outlook, I was able to imagine how to make this possible at my own hospital rather than talk myself out of it.

Our work is complex. We have every right and every obligation to simplify it, especially where the risk is highest for our patients. One element of our work that is in high need of simplification is our task load. I'm confident that every one of us in this room agrees there is not enough time to do everything that needs to be done for our patients. Our documentation is often left to the end of the shift, potentially forgotten and sometimes not done at all.

While we struggle to get to our documentation and all the other things we so desperately want to do for our patients, we nurses routinely do a lot of jobs that could or should be done by other more appropriate personnel. Somehow as the nurse, we have this belief that everything depends on us and if we don't do it, it won't get done. Says who? Who are these mythical people who believe that the professional nurse is responsible for not only nursing, but environmental services, dietary, central supply, patient transportation and receptionist duties?

Such nonnursing jobs, though certainly essential to the delivery of professional nursing care, ultimately take us away from the patient's bedside—the one place that gives us the best vantage point for ensuring patient safety, quality and reliability.

Many of you flew a long distance to get to NTI. Think back to the moment when you walked onboard the aircraft. Did you happen to catch a glimpse of the captain and first officer in the cockpit? I'm sure they were busy, focused on carrying out all the critical safety checks before departure. Once you took your seat, did you notice the baggage handlers loading luggage in the underbelly of the aircraft? Perhaps you even saw mechanics walking around the plane making last-minute checks and repairs.

Now, imagine that you're comfortably seated with your seatbelt securely fastened about you, your seat and tray table in the upright position. But this time the captain makes the following announcement: "Good afternoon ladies and gentlemen. I know that you are eager to get to Chicago for the start of the NTI, but I've got some disturbing news to share. Unfortunately, one of the tires on our aircraft is flat. To complicate matters, we're short staffed today among ramp personnel who are responsible for repairing the flat. So we're not delayed further, even though my first officer is relatively new, I've decided to cut short my safety checks here on the flight deck and fix the flat myself. Oh, and one more thing: There will be at least one error on today's flight. This error may harm you or cost you your life. But don't worry folks; we'll be fine and off the ground in no time. Now sit back and enjoy the flight."

You think to yourself: a flat tire? Short-staffed ramp personnel? The captain interrupting her critical safety checks to go out and make the repairs herself? And a novice first officer left to manage the cockpit? Wait a minute! I definitely want to get to NTI, but I want to get there safely, in one piece and most especially alive.

It's an absurd example, isn't it? But stop for a moment to imagine that the passengers are patients who are wondering why we're busy cleaning the room next door instead of monitoring their condition or providing them with comfort.

I use this metaphor to make an important point about our work: We are the captains of patient safety and quality. Our patients are the sickest and most vulnerable in the hospital. Why then do we often abandon our most critical role as the nurse to do the work of others? By continuing to do others' work—nursing work—we enable incompetent and broken systems to continue limping along. We are complicit in delivering incomplete, inhumane, dangerous and potentially lethal nursing care. The bottom line: Continuing to do nonnursing work means we'll never successfully reclaim the priorities that really matter to us and to the patients and families who have entrusted us with their care.

At Indiana University Hospital, RN Senior Partner Karen Payne helped the organization identify how often nurses were performing nonnursing jobs. She developed a simple tally form on which nurses tracked the tasks that were taking them away from the bedside and cutting into their time for patient care and documentation.

Common tasks were listed such as picking up food trays, answering the telephone and finding equipment. For 2 weeks, more than 750 nurses on all the units at Indiana University and Methodist Hospitals recorded their activities. Over those 2 short weeks, they reported more than 11,000 instances of performing nonnursing tasks!

Does that number seem high? Not to me. Answering telephones was the number one item checked—more than 4,000 times. Nearly 3,000 instances of nurses cleaning rooms were documented. The survey results prompted the housewide clinical practice council to collaborate with environmental services to ensure that housekeeping tasks could be completed by the appropriate staff. The bottom line: Numbers speak louder than words. With a quick tally, the nurses had sufficient evidence to work with ancillary departments to change their processes.

That's what I mean by one focus. Nurses doing only nursing jobs. Are you with me so far?

### **One Time**

Now I'd like to talk about what I mean by "one time" by sharing a

quote that has stayed with me ever since I read it. James Reason wrote, "Unsafe acts are like mosquitoes. You can try to swat them one at a time, but there will always be others to take their place. The only effective remedy is to drain the swamps in which they breed."

We can choose to drain the swamp one time, or we can swat mosquitoes all day, every shift, all year long. Don't you think there are some swamps that need to be drained in our organizations?

But when it comes to problems, do you find yourself more frequently fixing them with Band-Aids rather than initiating full-blown repairs?

Quality improvement research identifies two types of approaches: One is a short-term remedy known as a patch and the other technique focuses on repairing the actual root cause and thus preventing future occurrences. As nurses, we are so busy "patching" to ensure that patients get the care they need, that we often have little energy to address the root cause or systems that will prevent us from facing the same challenge repeatedly. We even reward nurses who are good at patching problems by promoting them.

Is it because we like making patches? In a study by Anita Tucker and Amy Edmondson, 7 out of 9 nurses reported feeling gratified when they figured out a way to work around an obstacle, thus illustrating that working around broken and dysfunctional systems has become commonplace. Have work-arounds really become rewarding to us? Why is that? Is it acceptable?

Just because we nurses are experienced and capable problem solvers doesn't mean we have to solve all the problems or solve them alone. Because of the complexity of our systems, we will encounter failures during the course of our work. The real skill comes, not in solving the problem on our own, but in using our influence to engage others in solving problems together. This is hard for us sometimes, because it often means saying no when we're asked to do things that we think will be harmful to our patients or to ourselves.

I worry that we measure ourselves by how many times we say yes. Is that measure realistic? If we continually say yes to everything, especially those things we should be saying no to, we risk diluting the gift that we bring to patients and their families. In his book *The Power of a Positive No*, author William Ury suggests that no is the most powerful but underused word in our vocabulary. He describes a positive no as a shield of protection—something that should be used as a means of preserving a core value and our relationships.

Ury explains that saying no can be a positive response—and with practice, it becomes simple. A positive no actually starts with a yes

and ends with a yes. Using his technique you clearly articulate a no to communicate that you are saying yes to what really matters.

I dedicated one of my *AACN News* columns to this subject because I think it's so important. Shortly after the column was published, I received a letter from Angela Benefield, a member who works at St. Jude Medical Center in Fullerton, California. She wrote to me about how she used the power of a positive no in her hospital to initiate a system repair that had been patched over for years. She wrote:

*Dear Dave,*

*As a loyal member of AACN, I share your outlook on the power of a positive no and I want to share with you an example that we used in our facility.*

*As a new employee, but an experienced CCRN, I noticed that, because of system inefficiencies, the ICU nurses were spending too much time on ancillary work instead of direct patient care. Many of the nurses were unsatisfied and fatigued and they routinely complained to one another.*

*To remedy the situation, I approached the administrative team and we formed an improvement committee to address the concerns. We gathered data about how much time each nurse spent away from the bedside and the impact on patient care outcomes. We supported our data with studies from the Institute of Medicine.*

*Using the evidence we gathered, we proposed hiring critical care technicians to do the ancillary duties and keep nurses at the bedside. Our proposal was welcomed and implemented. In essence, we said our first yes—to our need to be vigilant in monitoring our patients. We then clearly spelled out our no—that we cannot do nonnursing work because the absence of nurses from the bedside has been directly linked to compromising the care of our patients. We immediately followed by offering a constructive yes—improving the work environment. Our proposal resulted in correcting system inefficiencies, improving productivity, decreasing nursing dissatisfaction and providing quality care.*

*Without a doubt, utilizing the power of a positive no is an essential skill for all nurses. Thank you so much for bringing this essential communication technique to the forefront.*

*Sincerely,*

*Angela Benefield RN, CCRN, CSC, CMC*

*Angela Benefield. One person who made fixing it one time a reclaimed priority.*

## **One Person**

Throughout history it has been proven that one person, courageous and determined, can be the catalyst for great and lasting change.

One person.

Florence Nightingale.

Rosa Parks.

Martin Luther King, Jr.

You know these names. You know the history they've made. You know their courageous acts and the priorities they reclaimed to change the course of the world we live in.

Chances are you haven't heard these names yet:

Allison Morgan.

Shannon Collins.

Anne Marie McCarthy.

Let me introduce them to you. I had the pleasure of meeting them at our recent Staff Nurse Advisory Team meeting. These three staff nurses were among several others who came from around the country to advise AACN leaders on the state of their work environments and the challenges they face in delivering excellent care. They also shared solutions that have worked for them in overcoming the challenges of reclaiming priorities. Their contribution to the future work of the association is immeasurable.

Many of them are new to nursing—one just started her nursing career last July. Others had more than 20 years of experience. Their stories inspired and reminded me that one person—one nurse—can make all the difference in the world, whether to one patient, one family or the culture of a unit.

Allison Morgan. One person. One nurse who began her nursing career less than 2 years ago is a role model for reclaiming priorities that benefit her patients. When two residents from different departments extended their petty feud to her patient's chart, Allison didn't stand for it. After the first physician scribbled out the other physician's orders, the second physician retaliated by writing an order that said "no new ICU orders" on the patient's chart. Seeing this ridiculous and potentially dangerous order, Allison took action. She called both physicians to the unit saying there was an urgent problem with their patient. When the docs arrived, she showed them the chart, explained that what they had done was dangerous and unacceptable and she asked them if they could commit to collaborating. They did.

Shannon Collins. One person. One nurse who was astonished to learn from the other team members that she was the only one in

the group who had to handle her newly admitted patients all by herself. As the other nurses explained the systems and teamwork they had in place to support them during admissions—like resource nurses, charge nurses without patient assignment or just other staff nurses coming to help—Shannon's eyes grew wide with possibility. Skeptical that her unit culture could change quickly or drastically, Shannon took the advice of her newfound network of colleagues. They suggested she start by offering to help a colleague when he or she got a new admission. By taking that first step, the group was confident other nurses on Shannon's shift would soon follow suit. Since returning home to her unit, Shannon has been committed to leading by example. And, in less than 2 months, she is seeing the subtle signs of change.

Anne Marie McCarthy. One person. One nurse who has learned how to build good relationships with the family members of her patients, even the most difficult ones. When the staff nurse advisory team members were sharing their stories about how challenging some of their patients' families are to deal with, Anne Marie shared her approach: "I make it a point to meet my families at the door of the ICU. I introduce myself, being sure to shake their hands. Then I share with them the care plan for the day, what I think they can expect and how they can play a role in achieving the day's goals. I confidently assure them that I'm going to take really good care of their loved one. Since I started approaching families proactively like this, it seems as if they don't get in the way anymore. In fact, they often help me. Now, I actually ask for patients with the most difficult families."

Might the actions of these three nurses be considered defining moments in their careers? I think so.

Here's a quote I admire from author and spiritual pioneer Mary Mannin Morrissey: "Don't wait for something big to occur. Start where you are, with what you have, and that will always lead you into something greater."

Often when we hear the words defining moment we think of big, historic actions. About Florence Nightingale's work lowering death rates among wounded soldiers during the Crimean War. About Rosa Parks refusing to obey a bus driver's order to give up her seat to make room for a white passenger. About Martin Luther King, Jr. proclaiming his famous dream.

I think defining moments also come from the first small steps we take to turn around deeply entrenched system dysfunctions and harmful traditions. Steps like those of the nurses I've introduced you to this morning. Like them, each one of us must assert our voice to articulate the priorities that we demand be reclaimed. We do not have the luxury to sit back and hope others will do it for

us. Individually and in community, we must assert with conviction that we hold the solutions to many of healthcare's most pressing problems. As the largest group of healthcare providers, we must use our numbers to influence change, confident we can provide safe, quality patient care in healthy, healing and humane practice environments.

If ever there was a time for boldness and innovation, it is now.

You may have heard about the pending and controversial Medicare regulations that call for withholding reimbursement to hospitals when there is evidence of inpatient complications, errors, injuries and infections that could have reasonably been prevented. For example, if a patient acquires a catheter-associated infection or pressure ulcers, the hospital will not be paid for the care that is required to treat those complications.

Experts say that most complications are fundamentally linked to nursing care—putting them into the category of nursing-sensitive indicators. Experts also point to the potential implications of the new regulation on hospitals' investment in nursing and the systems, resources and environments that support what we do. A recent white paper funded by the Robert Wood Johnson Foundation predicts that some hospitals will make the necessary investment in nursing to prevent adverse outcomes. Other hospitals, they say, may foolishly opt to cut budgets and staffing in anticipation of receiving lower reimbursement.

We are at a historic crossroads. We can choose to be angry and defensive, arguing that adverse outcomes are out of our control. Or we can use the new regulation as an opportunity to show that investing in nursing is the key to ensuring good patient outcomes. Without appropriate staffing of registered nurses and the environment and systems required to support our work, it will be impossible to prevent nosocomial infections, pressure ulcers and falls. This could be a defining moment for our profession. I urge you to join me in seizing it.

There is little doubt that the patient care delivery model will look very different in 10 years from how it looks today. That means we must act now to define our role in the future.

The artwork that symbolizes the Reclaiming Our Priorities theme depicts the creation of the future I'm talking about. To paint the picture of the future we know is right for our patients, dramatic change and revolutionary thinking are required. Doing things the same way we've always done them and business as usual are no longer acceptable.

We must assert a courageous voice and articulate the contributions made by nurses. No one else can do it for us. No one is more

qualified than we are to define nursing. No one's voice is more informed. We have the solutions, possess the knowledge, own the responsibility and ultimately hold the accountability.

I know there is no shortage of priorities. They are all around us, coming from all directions. The real skill comes in identifying a select few that will drive the biggest and most needed change.

One priority.

One focus.

One purpose.

One person.

Boundless impact.

What will be your defining moment as a nurse?

What will be the next defining moment of our profession?

How can we use what we learn from others at NTI to inspire these defining moments?

What one priority will you reclaim first?

Max DePree said, We cannot become what we need to be by remaining what we are.

If you believe we are powerful.

If you believe we are influential.

If you believe we cannot become what we need to be by remaining what we are, we must use this time we have together at NTI to prepare ourselves for creating our futures.

I know we can do it. I am absolutely confident that we can.

Let's go reclaim some priorities!

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