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# CNS Communiqué

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The CNS Communiqué is an electronic publication of the National Association of Clinical Nurse Specialists. The purpose of this publication is to keep our members updated on the NACNS headquarters news; connect our members with fast-breaking clinical news; and update clinical nurse specialists on state and federal legislative actions.



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## Featured Articles

1. [CMS Publishes CNS Definition – Conditions of Participation](#)
2. [Drug Shortages](#)

## Headquarters News

3. [NACNS Summit, Washington, DC – July 24, 2012 to Focus on APRN Consensus Model Implementation](#)
4. [NACNS Launches – Family/Individual across the Lifespan CNS Competencies Work](#)
5. [APRN Consensus Model Implementation – Grandfathering Scenarios](#)
6. [2013 Annual Meeting](#)
7. [Committee Chair Calls with President](#)

## Clinical Headlines

8. [CMS Publishes Final Rulemakings](#)
9. [ICU Rate of Blood Infection Declines](#)
10. [Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association?](#)
11. [Hip Replacement Concerns](#)
12. [IOM Report on Obesity](#)

## Association News

13. [Bullying in the Workplace](#)
14. [ANA Poll on Retirements](#)
15. [New AACN Data Show an Enrollment Surge in Baccalaureate and Graduate Programs](#)

## Federal and State Policy News

16. [AHRQ Notes Disparity Challenges for Ethnic and Racial Minorities](#)
17. [CMS GNE Grants](#)
18. [CDC Re-Issues Position on Single Use Vials](#)
19. [Distracted Driving Research](#)
20. [Joining Forces](#)

We want your feedback on the CNS Communique! Please complete this 8 question survey to help us decide if we should increase publication to once a month!  
<http://www.surveymonkey.com/s/7XL8WVP>

## Featured Articles

### 1. CMS Publishes CNS Definition – Conditions of Participation

The Centers for Medicare and Medicaid Services announced two rulemakings on May 10, 2012. One of these focuses on the Hospital Conditions of Participation. As part of the Conditions of Participation Rulemaking, CMS finalized their definition of Clinical Nurse Specialist. This final definition rejected comments that requested that CNSs be defined based on their certification, stating it would be “unfair” to require national certification for the CNS. This statement is based on the unavailability of these tests for all CNSs. Of course, if the state requires national certification, CMS will follow the state’s requirements.

Here is the published definition:

From: 11. [Personnel qualifications \(§485.604\)](#) )

the term “clinical nurse specialist” is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed in accordance with State nurse licensing laws and regulations; and holds a master’s or doctoral level degree in a defined clinical area of nursing from an accredited educational institution. Adding the phrase “in accordance with State nurse licensing laws and regulations” will ensure that an existing CNS will continue to be evaluated based on their State licensing laws and regulations. We agree with the commenter that it would be unfair to require national certification for CNSs and we will not require such certification. We believe that requiring CNSs to have a graduate level education and to be authorized to practice based on State nurse licensing laws and regulations reflect the statutory definition of a CNS.

Please see story below for further information about this rulemaking and the burden reduction rulemaking. Please see NACNS [web focus](#) on this issue.

### 2. Drug Shortages – Where Do They Come From?

While there are many reasons for drug shortages in the clinical setting, much of the current drug shortage is attributed to manufacturing issues. At a recent meeting, Sandra L. Kweder, MD, Deputy Director of the Office of Drugs, with the FDA presented their experience working with drug manufacturers and an overview of the many factors that contribute to the current shortage. The majority of the current hard-to-obtain drugs are sterile injectable medications (SIM).

The SIMs that are most frequently affected by the recent round in drug shortages are those used in anesthesia, cancer, pain, and the treatment of other serious illness. This is concerning because many of the shortages are medications that are used in critical care and emergency care. At a recent meeting, a panel of individuals that are actively involved in solving the “on the front line” issues of drug shortages in emergency care spoke to the decisions they have had to make. The choices are challenging and in essence they have been forced to ration medications in some situations. Some providers reported need to re-distribute SIMs such as epinephrine and sodium bicarbonate from crash carts on in-house units to ambulances in order to make sure these high-need environments were stocked with these drugs. Other systems have hired compounding pharmacies to fill the need and make the SIMs. This is a more expensive solution that is not available to all. In addition, the compounded versions of the medications typically do not contain preservatives and therefore have a shorter shelf life.

At times, comparable medications are stocked on units in order to have the “next line” treatment available. Whenever substitute medications are used in place of familiar drugs, the potential for medication errors exists. These drugs may be unfamiliar, and may require education in order to ensure that they are given in the proper manner and the patient observed for the unique side effects that may be associated with these drugs. This is challenging under the best circumstances; and is very stressful in the highly charged emergency settings. The panel provided the insight and wisdom of their lessons learned. These drug shortages have resulted in pharmacy, nursing and medical leaders working closely together to quickly implement plans to ameliorate the immediate drug shortage. “Drug huddles” have been used in some institutions to provide real time information and education of staff on the changes. In this way, the staff can be routinely updated on the challenges and solutions for that day.

SIMs are frequently made by generic medication manufacturers. Due to the limited profit margin on these drugs, a company may hold a license to produce a specific SIM, but they may not always have this product manufactured at their facility at all times. SIMs generally may come from a sole manufacturer.

Dr. Kweder discussed the importance of adequate advance notice of a manufacturer’s discontinuation of a SIMs. She reinforced that lack of redundancy in the manufacturing of certain drugs in this industry leads to these challenges. Generic drug manufacturers that produce SIMs may be the only U.S. source for that particular medication. These manufacturing plants tend to run at full capacity; so another generic SIM manufacturer can not easily enter the market and take over production of a certain drug.

In 2011, in an effort to help alleviate this problem, President Obama signed an Executive Order (EO) aimed at helping to alleviate drug shortages of certain prescription drugs and to expedite regulatory reviews that can help prevent or respond to shortages. According to Dr. Kweder, this EO resulted in a six fold increase in reporting of anticipated drug shortages.

There are seven main manufacturers that have contracts to make SIMs. Kweder indicated that FDA was anxious to work with the manufacturers to assist in easing drug shortages. Significant numbers of drug shortages have been averted due to earlier notification and collaborative efforts with the industry. The most frequent reason for delay/shortage of SIM is related to quality or impurities of the medication in the production process. Other reasons - 25% are related to delays in manufacturing or the capacity of the manufacturing plant; 5% are related to issues with raw materials; and 4% are related to new demand in the market.

The American Society of Health System Pharmacists (ASHP) ([www.ashp.org](http://www.ashp.org)) has taken a leadership role in communicating drug shortages for the health care community. This [site](#) provides frequently updated lists of drug shortages, resolved shortages and drugs no longer available. As of May 2012, some of the key drugs used in emergency situations are on the shortage list: atropine sulfate, digoxin, dopamine, epinephrine, furosemide, heparin sodium, ketamine, lidocaine, sodium bicarbonate, magnesium sulfate, mannitol injection, morphine, naloxone, phenytoin, rabies immune globuline, and vasopressin. The site allows you to link to a page that describes the reason for the specific drug shortages and related drugs that are affected and anticipated resupply dates.

Clinical nurse specialists (CNSs) need to be up-to-date on this list of anticipated drug shortages and are a critical link between pharmacy and the clinical setting to allow the successful use of "next tier" medications and substitutes. CNSs are urged to stay on top of the drug shortage list and make sure they understand how a particular drug shortage will be handled in their clinical setting. Often the CNS will be in the position to deliver short turn-around, real-time education on drug substitutes if a primary medication is unavailable. This shortage has a number of concerns. The most dramatic is what has been seen in oncology where patients have needed to wait until their oncology medication was available to them. This is a problem that will not resolve quickly, but the partnership of clinicians in the clinical setting can help decrease unintended consequences.

## NACNS News



### 3. Save the Date – July 24, 2012 – NACNS Summit in Washington, DC

The NACNS Summit, to be held July 24, 2012, will focus on CNS issues that have come to light with the implementation of the APRN Consensus Model. Traditionally, the NACNS Summit has been held as an invitational conference, but this year, we will be opening the conference to interested CNSs as well as our association colleagues. If you are interested in receiving an invitation to this meeting or for more information about this program, please email your request to [info@nacns.org](mailto:info@nacns.org). Due to space constraints, a limited number of invitations will be sent.

### 4. NACNS Launches – Family/Individual across the Lifespan CNS Competencies Work

One of the challenges with the implementation of the APRN Consensus Model is the availability of tests that certify the CNS based on the defined populations outlined in the APRN Consensus Model. Currently, there are certification tests available for Adult/Geriatric across the Lifespan through ANCC and AACN Certification Corporation. The NACNS Board of Directors is in the process of forming a task force to write CNS competencies for another of the identified populations in the APRN Consensus model, the Family/Individual across the Lifespan. It is hoped that these competencies can be the basis for the

development of certification in the future.

### 5. APRN Consensus Model Implementation – Grandfathering Scenarios

One of the implementation challenges of the APRN Consensus Model is the grandfathering of CNSs. There can be a significant variation between states in the recognition of CNS practice. The issue of grandfathering will impact CNSs that does not currently meet the criteria for the APRN Consensus Model and wishes to move to another state to practice. NACNS has opened discussions with NCSBN and other organizations on this issue and is in the process of preparing a document that highlights different scenarios that might be seen with the grandfathering of the CNS.

### 6. 2013 Annual Meeting

Save the date! The NACNS 2013 Annual Conference will be held at the Hyatt Regency San Antonio in San Antonio, Texas. The dates are March 7-9, 2013. Abstract submission will open in early July with a due date of September 12.

### 7. Committee Chair Calls with NACNS President

As part of NACNS President Rachel Moody's effort to ramp up volunteer efforts and encourage open communication, NACNS will be holding quarterly conference calls between the NACNS committee chairs, Board liaisons and Executive Committee. It is anticipated that these calls will provide an opportunity to learn all the exciting work the committees are engaged in and allow a forum for creative discussion that can lead to committee "cross fertilization" and partnerships between committees. The dates for these calls will be posted on the Web site and communicated to the committee chairs and other participants.

## Clinical Headlines



### 8. CMS Publishes Final Rulemakings

The Centers for Medicare and Medicaid Services announced [two rulemakings](#) on May 10, 2012 that they estimate that one could offer hospitals annual savings of in excess of \$900 million in the first year through the Conditions of Participation and the other rule – the Medicare Regulatory Reform rule could save around \$200 million in the first year. These cost savings will come directly from reduced regulatory burdens, and are not accompanied by reimbursement reductions.

The final rules were developed through a retrospective review of existing federal regulations called for by President Obama's January 18, 2011 Executive Order 13563 to "modify, streamline, or repeal" regulations that impose unnecessary burdens, including those on hospitals and other providers that must comply with requirements through Medicare. These final rulemakings are the result of more than 1, 800 comments during the public comment period. NACNS provided comments on these rulemakings.

The CoPs are federal health and safety requirements ensuring high quality care for all patients. Hospitals and CAHs must meet these conditions to participate in Medicare and Medicaid. The final rule is designed to reduce the regulatory burden on hospitals by:

- Requiring that all eligible candidates, including APRNs and PAs, must be reviewed by the medical staff for potential appointment to the hospital medical staff and then allowing for the granting of all the privileges, rights, and responsibilities accorded to appointed medical staff members.
- Supporting and encouraging patient-centered care, through such changes such as allowing a patient or his or her caregiver/support person to administer certain medications (both those brought from the patient's home and those dispensed by the hospital), and by allowing hospitals to use a single, interdisciplinary care plan that supports coordination of care through nursing services.
- Encouraging the use of evidence-based pre-printed and electronic standing orders, order sets, and protocols that ensure the consistency and quality of care provided to all patients by allowing nurses the ability to implement orders that are timely and clear.
- Allowing hospitals to determine the best ways to oversee and manage outpatients by removing the unnecessary requirement for a single Director of Outpatient Services.
- Increasing flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system.
- Allowing CAHs to partner with other providers so they can be more efficient, and at the same time, ensure the safe and timely delivery of care to their patients.

### Medicare Regulatory Reform

The Medicare Regulatory Reform rule will identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for health care providers and suppliers, including hospitals, ambulatory surgical centers, end-stage renal disease facilities, durable medical equipment suppliers, and a host of other health care providers and suppliers regulated under Medicare and Medicaid. The goal of this final rule is to both reduce regulatory burdens and help providers improve care for patients.

By reducing unnecessary burdens on health care providers, this rule allows them to dedicate more resources to improving patient care. Some of the more than two dozen finalized regulatory changes include:

- Eliminating obsolete regulations, including outmoded infection control instructions for Ambulatory Surgical Centers (ASCs); outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of Organ Procurement Organizations.
- Requiring only higher risk End Stage Renal Disease (ESRD) facilities to comply with the full National Fire Protection Agency Life Safety Code requirements. CMS estimates that this burden reduction could save an estimated \$108.7 million for ESRD providers.
- Eliminating the specific list of emergency equipment ASCs must have in the facility, and allowing facilities, in conjunction with medical staff and their governing bodies, to develop policies and procedures that specify emergency equipment appropriate to the services they provide.
- Replacing inflexible time-limited agreements with open-ended agreements for Medicaid-participating Intermediate Care Facilities that serve people with intellectual disabilities. The regulation also implements a recommendation from stakeholders to replace the term "mental retardation" with "intellectual disability," which is the same change that Congress has made to most of the federal law's references to the term.

Updating e-prescribing technical requirements so Medicare Prescription Drug Plans meet current standards.

### 9. ICU Rate of Blood Infection Declines

The number of bloodstream infections in intensive care unit (ICU) patients with central lines decreased by 58 percent in 2009 compared to 2001, according to a new [CDC Vital Signs](#) report. During these nine years, the decrease represented up to 27,000 lives saved and \$1.8 billion in excess health care costs. Bloodstream infections in patients with central lines can be life threatening, killing as many as 1 in 4 patients. The challenge of blood infections remains in the general hospital setting and dialysis units. Dr. Frieden, MD, MPH calls on health care providers to apply what we have learned in the ICU setting to other patients with central lines.

A CDC report found that about 60,000 bloodstream infections in patients with central lines occurred in non-ICU health care settings such as hospital wards and kidney dialysis clinics. About 23,000 of these occurred in non-ICU patients (2009) and about 37,000 infections occurred in dialysis clinics patients (2008). Infections are one of the leading causes of hospitalization and death for hemodialysis patients. At any given time, about 350,000 people are receiving hemodialysis treatment for kidney failure. Seven in 10 patients who receive dialysis begin that treatment through a central line.

To prevent bloodstream infections in patients with central lines, hospitals, dialysis centers, and other medical care locations can:

- Make sure [CDC infection control guidelines](#) are followed every time a central line is put in and used.
- Encourage staff members to speak up when guidelines aren't followed.
- Use data for action. Track infection rates and germ types with CDC's [National Healthcare Safety Network](#) (NHSN) to learn where and why infections are happening, target actions to stop them, and track

- progress.
- Recognize staff members or units that work hard to prevent central line infections or that solve issues with infection control.
- Join state-based prevention programs such as the AHRQ-funded expansion of [On the CUSP: Stop BSIs](#).

The CDC urges patient's to advocate for themselves and tell their doctors and nurses to clean their hands before and after touching patients. In addition, ask which infection prevention methods will be used, why a central line is needed, and how long it will be in. Tell a nurse or doctor if the area around the central line becomes sore or red or if the bandage falls off or looks wet or dirty.

#### **10. Periodontal Disease and Atherosclerotic Vascular Disease: Does the Evidence Support an Independent Association?**

An April 19, 2012 article in [Circulation](#) looks at the evidence to support and independent relationship between periodontal disease and atherosclerotic disease. There are three main points that are discussed in this article:

- There is an association between periodontal disease and atherosclerotic vascular disease.
- It has not been demonstrated that periodontal disease is a cause of atherosclerotic vascular disease.
- It is not confirmed that heart disease or stroke can be prevented, or the clinical course of atherosclerotic vascular disease modified, by therapeutic periodontal interventions.

#### **11. Hip Replacement Concerns**

The March, 2013 issue of [Arthritis Today](#) looks at the issues with metal-on-metal hip implants. According to the article, hip replacement for severe hip arthritis can bring about pain relief and improved mobility for about 15 years. But a new study shows that some metal-on-metal implants are likely to fail much sooner, especially in women. The study adds to a growing list of problems linked to metal-on-metal implants, including bone and tissue destruction and high levels of metal ions in the blood.

One study, published online in the [The Lancet](#), is based on data from the National Joint Registry of England and Wales – the world's largest joint replacement registry – to track more than 400,000 patients who underwent primary hip replacement from 2003 to 2011. The researchers specifically looked at the data on the 31,171 patients that received metal-on-metal implants. (This is where the replacement hip has a ball and cup made of a cobalt and chromium alloy.) Compared with implants made of other materials, all-metal joints had a substantially higher overall failure rate. After five years, 6.2 percent of metal-on-metal hips had failed, whereas only 3.2 percent of ceramic hips and 1.7 percent of metal-on-plastic implants had. Failure rates were highest for younger women and for implants with larger heads – 36 millimeters or more – in both men and women.

The larger head replacements, when studied outside the body, showed less wear and loosening. These replacements were often used in younger patients who would need their hip to last longer. The data in the study indicates that the larger head of the hip replacement was associated with an increase in revisions for pain and loosening, particularly in women.

Metal-on-metal implants have raised other concerns in addition to early failure rates. One concern that may require further study is the potential harm from cobalt and chromium ions released into the bloodstream when metal parts rub together. In February, the journal [BMJ](#) published results of a comprehensive investigation of metal implants. Among other findings, investigators concluded that systemic metal ions can cause cardiovascular problems and may damage DNA. Unlike Great Britain, the U.S. does not have a national registry or formal guidelines/protocols for hip replacements.

#### **12. New Institute of Medicine Report Aims to Accelerate Progress in Preventing Obesity**

The Institute of Medicine (IOM) released on May 8, 2012 a [report](#) sponsored by the Robert Wood Johnson Foundation (RWJF) that outlines comprehensive strategies for addressing the nation's obesity epidemic and calls on leaders in all sectors to accelerate action to advance those strategies. The release was a highlight of the second day of the 2012 Weight of the Nation conference, hosted by the Centers for Disease Control and Prevention.

The report, *Accelerating Progress on Obesity Prevention: Solving the Weight of the Nation*. It highlights five key goals for reversing the epidemic:

- Make physical activity an integral and routine part of life.
- Create food and beverage environments that ensure healthy food and beverage options are the routine, easy choice.
- Transform messages about physical activity and nutrition.
- Expand the role of health care providers, insurers and employers in obesity prevention.

Make schools a national focal point for obesity prevention.

## **Association News**

#### **13. Bullying in the Workplace – ANA's New Resource**

Many CNSs work diligently to orient new nurses and have seen first hand the destructive potential of bullying in the workplace. This [new resource](#) gives nurses and nursing leaders tools to understand the genesis of workplace bullying as well as tools to deal with the issue. This publication is available electronically, in print and a separate "tip sheet" is available for use in the clinical setting. To build a nursing workplace for the future, we must approach and deal with bullying in the workplace. The CNS is clearly positioned to open this conversation and be a key leader in changing culture.

#### **14. ANA Poll**

The American Nurses Association hosted a website [poll](#) during April 2012 called - "Have Your Say" online poll. The poll asked respondents if they are planning to retire in the next 3 years. According to the results, 87% of respondents have no plans to retire. The results were based on 1134 online responses.

## 15. New AACN Data Show an Enrollment Surge in Baccalaureate and Graduate Programs

A March 22, 2012 [report](#) released by the American Association of Colleges of Nursing (AACN) announced that enrollment in baccalaureate, master's, and doctoral nursing programs increased last year (2011). The report indicates that a significant number of qualified student applications have been turned away from 4-year colleges— 75,587 to professional nursing programs and 14, 354 to graduate programs. The report notes that these student applicants were declined due to limited faculty and resource restrictions. The AACN survey found that total enrollment in all nursing programs leading to the baccalaureate degree is 259,100, an increase from 238,799 in 2010. Within this population, 169,125 students are enrolled in entry-level baccalaureate nursing programs. In graduate programs, 94,480 students are enrolled in master's programs, 4,907 are enrolled in research-focused doctoral programs, and 9,094 are enrolled in practice-focused doctoral programs in nursing.

## Federal and State Policy

### 16. AHRQ Notes Disparity Challenges for Ethnic and Racial Minorities

On April 10, 2012, the Agency for Healthcare Research and Quality (AHRQ) released a report: *National Healthcare Disparities Report* that shows that access to health care was not improving for most racial and ethnic groups in the years 2002 through 2008 leading up to enactment of the Affordable Care Act.

The data contained in the *National Healthcare Disparities Report* and the companion *National Healthcare Quality Report* predate the Affordable Care Act; however, some provisions in the new health care law are aimed at improving health care quality and addressing health care disparities. The *HHS Action Plan to Reduce Health Disparities*, announced in April 2011, outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minorities, building on important efforts made possible by the Affordable Care Act and other ongoing private-sector and state-led initiatives.

The congressionally mandated disparities and quality reports, which AHRQ has produced annually since 2003, are based on over 40 different national sources that collect data regularly. Today's reports, which include about 250 health care measures, show the persistent challenges in access to care faced by most racial and ethnic groups. Fifty percent of the measures that tracked disparities in health care access showed no improvement between the years 2002 and 2008, while 40 percent of those measures were getting worse.

Specifically, for 2002 through 2008, Latinos, American Indians and Alaska Natives experienced worse access to care than Whites on more than 60 percent of the access measures, while African Americans experienced worse access on slightly more than 30 percent of the access measures. Asian Americans experienced worse access to care than non-Latino Whites on only 17 percent of the access measures.

The 2011 *National Healthcare Quality Report*, also issued today, tracks the health care system through quality measures such as the percentage of adult smokers who received advice from a provider to quit or the percentage of children who received recommended vaccinations. Based on the same data and measures used in the disparities report, the congressionally mandated quality report found that overall health care quality improved slowly for the general population between the years 2002 and 2008. Both reports will serve to track progress on the Affordable Care Act in the future.

To view the *National Healthcare Quality Report* and *National Healthcare Disparities Report*, visit: <http://www.ahrq.gov/qual/qdr11.htm>. In addition, AHRQ's NHQRDRnet is an online query system that allows you to access national and State data on the quality of, and access to, health care from scientifically credible measures and data sources. To use the interactive tool, visit: <http://nhqrnet.ahrq.gov>.

### 17. Graduate Nurse Education Solicitation Stresses Resources at CMS

The much awaited announcement on the Graduate Nurse Education (GNE) Solicitation from the Centers for Medicare and Medicaid Service's (CMS), [Center for Innovation](#) has received a vigorous response from the nursing community. Two conference calls have been hosted with the nursing community in an effort to spread the word about the demonstration as well as answer technical questions. Despite this outreach, questions remain, prompting the Nursing Community to send a letter to CMS Director, Marilyn Tavenner to request a 30 day extension of the submission date.

<http://www.aacn.nche.edu/news/articles/2012/cms-gne>.

### 18. CDC Re-Issues Policy on Single Use Vials

On April 27, 2012 the Centers for Disease Control and Prevention (CDC) re-issued its [position](#) on the use of single-dose/single-use vials for more than one patient. The position clearly supports the use of single-dose/single-use vials for a single patient. This practice protects patients from life-threatening infections that occur when medications get contaminated from unsafe use. Concerns have been raised about whether these guidelines and related policies contribute to drug shortages and increased medical costs to healthcare providers. CDC recognizes the problem of drug shortages; however, such [shortages](#) are a result of manufacturing, shipping, and other issues unrelated to the above guidelines. CDC's top priority is protecting patients from harm. CDC routinely investigates and is apprised of infectious disease outbreaks involving single-dose/single-use vials being used for multiple patients. These outbreaks cause extensive harm to patients, and they are associated with significant healthcare and legal expenses. Therefore, CDC continues to strongly support its current policies regarding single-dose/single-use vials. It is imperative that drug shortages and drug waste concerns are dealt with appropriately and do not lead to unsafe medical practices that impose increased disease risk on patients. Shortages of some essential medications may warrant implementation of meticulously applied practice and quality standards. In times of critical need, contents from unopened single-dose/single-use vials can be repackaged for multiple patients. However, this should only be performed by qualified healthcare personnel.

### 19. Distracted Driving Awareness

Car accidents are the leading cause of death and disability for adolescents. As they shift from learning to drive in classrooms and parking lots to real on-road driving situations, they encounter shifts in weather, traffic, and road conditions, as well as potential distractions.

Today's drivers encounter many possible distractions—from radios to cell phones to other passengers. Research shows that driver inattention is the primary cause of motor vehicle crashes, and that distracting tasks (such as texting) frequently cause drivers' focus to stray from the road. Reducing these distractions—especially cell phone use—is a primary prevention message.

Because many of these situations are new to them, including how to handle distractions while driving, teen drivers are more vulnerable to accidents and injuries than are drivers at any other age. As part of its commitment to adolescent health and safety, the NICHD supports and conducts research into understanding young drivers' behavior and of ways to reduce risky driving behaviors and minimize distractions while driving.

The NICHD studies described below demonstrate a range of approaches to identifying risk factors for crashes, examining behavior and safety, and evaluating driver education and licensing programs that differ from state to state. Select a link to learn more.

[Age, Gender, and Driving Risk](#)  
[Research on Graduated Licensing Programs](#)  
[Parental Restrictions on Teen Driving](#)  
[National Distracted Driving Awareness Month and Ongoing NICHD Research on Driving](#)  
[More Information](#)

### Age, Gender, and Driving Risk

According to the Insurance Institute for Highway Safety, 16-year-olds have higher crash rates than drivers of any other age, and crash rates among teens are the highest of any age group. Understanding what makes teen drivers more vulnerable could lead to ways to reduce their risk. Researchers in the NICHD Division of Epidemiology, Statistics, & Prevention Research (DESPR) have conducted a number of studies about crash risks and risk behaviors among teen drivers. In the Naturalistic Teenage Driving Study they equipped the vehicles of 42 newly licensed Virginia drivers with recording systems to collect data during an 18-month period. These data were used to examine how conditions affected risky driving patterns as well as the likelihood of crashes.

Researchers examined data from the 42 monitored cars to determine how elevated gravitational- or "g-force" events—such as hard braking or fast acceleration – affect crash and near-crash rates among adolescents and their parents. Investigators found that adolescents were four times as likely to crash or nearly crash their cars as were the adult drivers. Teenagers' risky driving rates were five times as high as those of adults in the study. In addition, the teen crash rate declined throughout the 18-month study period, but rose slightly during the final quarter of the study. For more on this finding, visit <http://www.ncbi.nlm.nih.gov/pubmed/22021319>.

The researchers found that the presence of an adult passenger reduced teenage driver car crashes and near crashes by 75%. Among teens, risky driving – identified by elevated g-force events – was reported to be decreased in the presence of an adult or teenage passenger, at night, and late at night. However, the researchers found that when a teen driver had risk-taking friends, risky driving and crash or near crash rates increased by 96%. Visit <http://www.ncbi.nlm.nih.gov/pubmed/22098768> or listen to an audio briefing at <http://www.nichd.nih.gov/news/releases/102111-teen-driving-accidents.cfm> to learn more about these findings.

NICHD researchers also analyzed data from the U.S. National Household Travel Survey to determine some of the characteristics and risk factors involved with fatal teen car accidents. By examining driver sex and passenger sex and age, the researchers made some surprising discoveries. They found that young male drivers whose passengers were 16 to 20 years old had the highest risk level for fatal crash involvement. The relative risk when passengers were 21 to 34 years old was also high, particularly when both passenger and driver were male. For more on this finding, visit PMID 20159095 or [http://www.nichd.nih.gov/news/releases/teen\\_passengers.cfm](http://www.nichd.nih.gov/news/releases/teen_passengers.cfm).

Other NICHD-funded research studies have examined and compared risky driving behaviors of teen girls and teen boys. Historically, teenage girls received lower insurance premiums than boys, reflecting male drivers' higher level of involvement in motor vehicle crashes. But in a 2008 review of data from fatal crashes, researchers found that female involvement in such crashes had increased over time, especially for female drivers age 20 or younger, a figure that partially reflects a large increase in the number of female drivers. Improper maneuvering and speeding were the leading causes of fatal car crashes by both male and female drivers. Alcohol use and failure to use seatbelts also played a role in fatal crashes by female drivers, although less so than did speeding and improper maneuvering. For details on this research, visit PMID 18760108.

### Research on Graduated Licensing Programs

Graduated licensing programs—in which privileges are granted to new drivers in phases—are in effect in various forms in all 50 states and the District of Columbia. Researchers funded through the NICHD's [Demographic and Behavioral Sciences Branch](#) sought to evaluate the effectiveness of these graduated programs in reducing fatal crashes among teen drivers. Based on analysis of the National Highway Traffic Safety Administration's database, the researchers found that fatal crashes among 16- and 17-year-olds were reduced by 8% to 14% when these licensing limits were in effect. The greatest benefit came from restrictions on nighttime driving and on the number of teenage passengers.

Comparing the elements of graduated licensing laws in different states, the researchers also found that the most effective graduated licensing programs contained at least five of the following elements:

- A minimum age of 16 for a learner's permit
- A mandatory waiting period of at least 6 months before a driver with a learner's permit could apply for a provisional license (allows a new driver to operate a vehicle, but restricts driving conditions, such as the licensee not being allowed to drive between 11 p.m. and 5 a.m.)
- A requirement for 50 to 100 hours of supervised driving before licensure
- A minimum age of 17 for a provisional license
- Restrictions on driving at night
- Limits on the number of teenage passengers allowed in the car
- A minimum age of 18 for a full license

The researchers also found that graduated licensing laws were particularly effective at reducing alcohol-related fatalities among teens. They also found that these programs work even better when combined with other restrictions, such as mandatory seat belt laws. For details on these findings, visit PMID 21972851, PMID 22017831, PMID 22105383, or <http://www.nichd.nih.gov/news/releases/110411-graduated-licensing.cfm>.

### 20. NACNS Signs Pledge to "Join Forces" in Support of Our Military Service Members, Veterans and Their Families

Joining Forces is First Lady Michelle Obama's comprehensive national initiative, to mobilize all sectors of the community to give our service members, veterans, and their families the support they deserve, particularly when it comes to employment, education, and wellness. (<http://www.whitehouse.gov/joiningforces> ).

The NACNS has signed the pledge to Join Forces in supporting the military, veterans and their families that includes:

- Educating America's future nurses to care for our nation's veterans, service members, and their families facing post-traumatic stress disorder, traumatic brain injury, depression, and other clinical issues;
- Enriching nursing education to ensure that current and future nurses are educated and trained in the unique clinical challenges and best practices associated with caring for military service members, veterans, and their families;
- Disseminating the most up-to-date information as it relates to traumatic brain injury (TBI) and psychological health conditions, such as post-traumatic stress disorder (PTSD);
- Growing the body of knowledge leading to improvements in health care and wellness for our military service members, veterans, and their families; and
- Leading and advancing the supportive community of nurses, institutions, and health care providers dedicated to improving the health of military service members, veterans, and their families.

NACNS will post on the Web site ideas for membership on ways to support the Join Forces initiative.

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