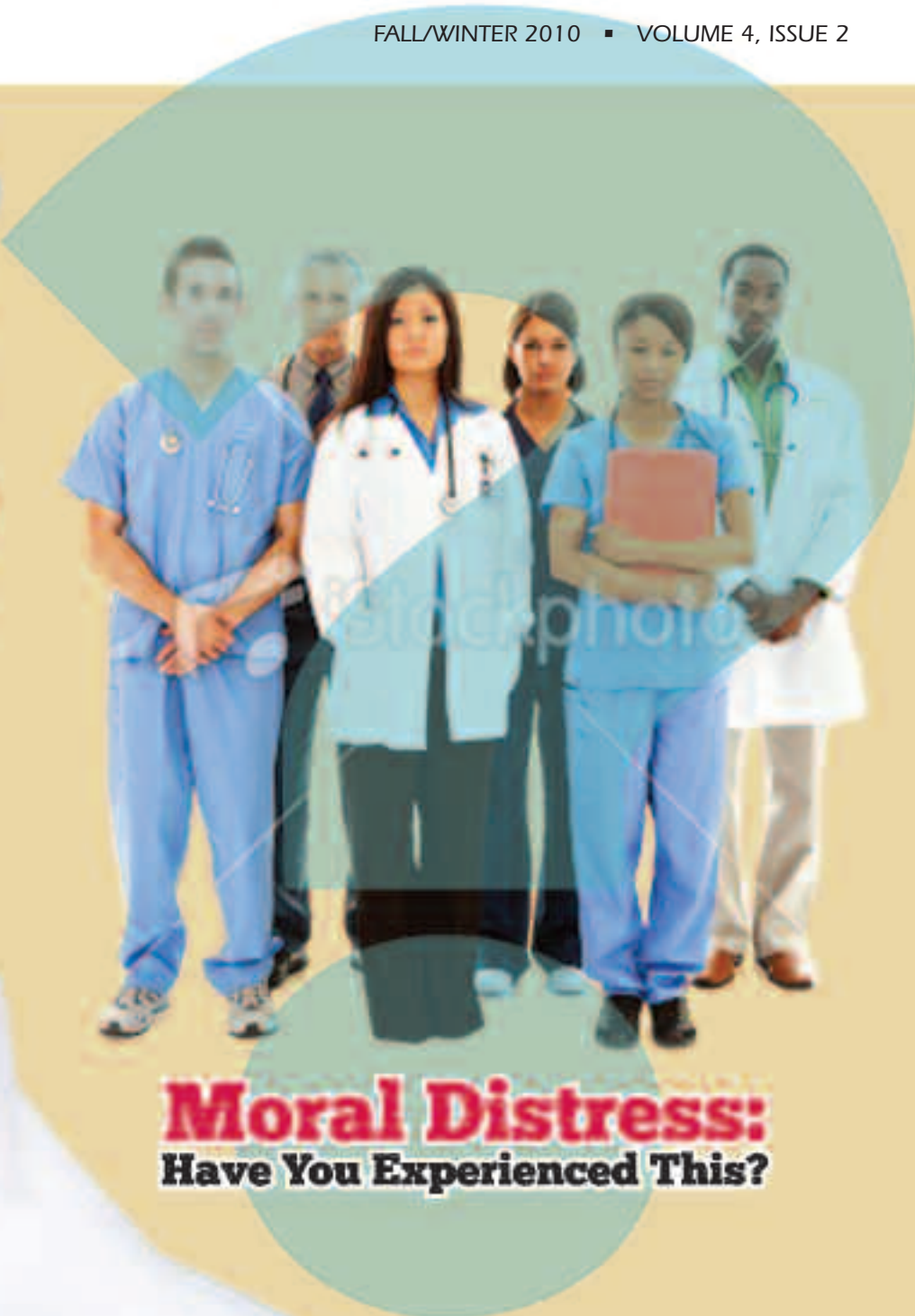




Cooper Bridges

A publication for nurses and healthcare professionals

FALL/WINTER 2010 ■ VOLUME 4, ISSUE 2



Moral Distress:
Have You Experienced This?

Professional Calendar

JANUARY 2011

- 4 • Advanced LifePak 20 Training
- 18 • Dysrhythmia Interpretation Review
- 24 • Stress Management Using Acupressure: The Emotional Freedom Technique
- 27 • Balance Boundaries and Burnout
- 28 • Wound Care Update

FEBRUARY 2011

- 4 • Parenting with Consequences
- 16 • It's How You Say It
- 21 • Wound Care Update
- 22 • Dysrhythmia Interpretation Review

MARCH 2011

- 1 • Advanced LifePak 20 Training
- 4 • Pediatric Code Review
- 10 • Sim Lab Facilitator Course
- 16 • Overcoming Public Speaking Jitters with Acupressure
- 24 • Wound Care Update
- 28 • Stress Management Using Acupressure: The Emotional Freedom Technique
- 31 • Emotional Intelligence

APRIL 2011

- 1 & 8 • Cancer Chemotherapy and Biotherapy
- 5 • Neonatal Developmental Series
- 13 • Dysrhythmia Interpretation Review
- 18 & 25 • Oncology Overview (2 days)
- 20 • It's How to Say It
- 27 • Caring for Dialysis Patient
- 29 • Orthopaedic Updates

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From the Chief Nursing Officer

Dianne Charsha, RNC, MSN, NNP-BC • Senior Vice President for PCS/CNO



The first thing that you may have noticed about this edition is that our name has changed. It is official, the nation has noticed our peer-reviewed nursing journal. With the recent Gold Aster Award Honoring Excellence in Medical Marketing for a Newsletter/Internal Series that we received a few months ago, we were notified by another healthcare company that they had rights to our previous title. It appears that great minds brainstorm and select similar titles to portray a similar message. So, our editorial board met and decided to make this journal reflect the essence of who we are: *Cooper Bridges*. I hope that you like the new name and are proud that others in the healthcare field have noticed the outstanding work contained within our journal's pages.

Dianne Charsha, RNC, MSN, NNP-BC
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"To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care."

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Clinical Trials Research Nursing: An Evolving Specialty

Jonelle A. O'Shea, RN-BC, MSN

What are Clinical Trials?

Clinical trials are defined by the National Institutes of Health as biomedical or health-related research studies in human beings that follow a pre-defined protocol (U.S. National Institutes of Health [NIH], n.d.). Clinical Trials are highly regulated and overseen on many levels by clinical investigators, sponsors of clinical trials, Institutional Review Boards (IRB), Data safety monitoring boards, the Food and Drug Administration and The Office of Human Research Protections (American Cancer Society [ACS], n.d.). The most influential document that outlines the ethical principles for human research, which the IRB uses as a guide to protect the rights and welfare of human research subjects, is the Belmont Report. The Belmont Report provides three basic principles for conducting clinical trials:

- 1. Respect for persons:** individuals should be treated as autonomous agents and persons with decrease autonomy needs increased protection
- 2. Beneficence:** maximizes benefits and minimizes possible harms to research subjects
- 3. Justice:** all participants should share the benefits and burdens of research equivalently

(ACS, n.d.; *The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research*, 1979).

How Clinical Trials are Conducted

Clinical trials can focus on treatment, prevention, diagnostic screening and quality of life (NIH, n.d.). Clinical trials are important for the development of new drugs and devices to find out if they are safe and effective. Trials may also be used for finding new uses for existing drugs and devices, to test a generic version of a drug or to develop better ways to screen or diagnose a condition (ACS, n.d.). Results from clinical trials are sometimes incorporated in the development of new standards of care.

Clinical trials begin after completion of pre-clinical work showing evidence that the intervention may be beneficial in humans (Woodin, 2004). All clinical trial research must be cleared by a central or local IRB before patients may be approached about the trial.

Drug and device clinical trials are conducted in five different phases starting with Phase 0 and ending at Phase IV. The different phases may overlap and are intended to serve as milestone in the drug development process (Woodin, 2004). Phase 0 trials are pre human or animal studies. Phase I is the first time the drug or device is given to humans (healthy volunteers), in phase II the drug or device is given to a small number of participants with the target disease, Phase III and IV involve hundreds to thousands of participants and evaluate the long term effects of the intervention (Woodin, 2004). Clinical trials have been most recognizably asso-

Clinical trials nursing is a new and exciting specialty in nursing that uses sound clinical research principals combined with the nursing standards of care to provide excellent care for patients and leadership throughout the entire clinical trial process.



The role of the CTN is diverse and vital to research. Nurses can be employed on the industry side (pharmaceutical /device companies) of clinical trials as monitors and clinical trial educators or in a variety of clinical settings.



ciated with cancer treatments but all medical specialties are conducting clinical trials.

The Clinical Trials Nurse

Clinical trials nursing (CTN) is a new and exciting specialty in nursing that uses sound clinical research principals combined with the nursing standards of care to provide excellent care for patients and leadership throughout the entire clinical trial process. Clinical trials personnel are interdisciplinary and can include, but are not limited to, physicians, registered nurses, research personnel, scientists, and students. Registered Nurses can fit into the clinical trial researcher role easily because nurses have many of the necessary skills (Table 1) through their education and work experience.

Table 1 Essential Skills for Clinical Trials Personnel

- Ability to multi task
- Strong organizational skills
- Working understanding of medical terms and conditions
- Self confidence
- Flexibility
- Problem solving skills
- Patient advocate

(Woodin, 2004; Oncology Nursing Society [ONS], 2010).

ences. Clinical trials nursing is a relatively new nursing specialty that is recognized as an integral part of the clinical trial process (ONS, 2010). “The CTN role has multiple names in diverse practices, including clinical trials coordinator, clinical research nurse, and protocol coordinator (ONS, 2010, p. 5)”. New evidence suggests that the CTN’s role in clinical trials has shown improved quality of communication, as well as increased recruitment of participants and improved adherence to protocols (Pitler, et. al., 2009).

The role of the CTN is diverse and vital to research. Nurses can be employed on the industry side (pharmaceutical /device companies) of clinical trials as monitors and clinical trial educators or in a variety of clinical settings. Nurses at Cooper University Hospital (CUH) are involved with clinical trials in various inpatient and outpatient settings. Inpatient studies in septic shock include Christa Schorr, RN, MSN as the research coordinator to



Clinical trials nurses are the trail-blazers, bringing traditional nursing skills into a new and exciting environment, helping to bring cohesion between nursing, science and medicine.

organize and implement multiple protocols. She is also the professional nursing consultant developing a protocol and data collection tools for a new clinical trial in the United States. Karen Vito, RN is actively involved with database research using Project Impact. She assists physicians and nurses by extracting data which is used to develop manuscripts and abstracts for publication in medical journals. In the outpatient setting, Christine Rickette, RN, the manager of clinical research projects for the Cooper Research Institute; assists with all phases of investigator and sponsor initiated clinical research. These are just a few of the many CTNs at CUH. All of these nurses found their way into clinical trials differently, but they all feel that their role is necessary for clinical trials to run smoothly and ethically.

Education

The results of interviews completed with nurses currently involved in clinical trials concur with current research; nurses accepted a research position on a whim, did not know much about the clinical trial field and formal training in clinical trials was minimal (Chester et al, 2007). These nurses learned about clinical trials from a mentor and by self education. Nurses can look to the NIH for clinical trials information; however information is not nursing specific. Non nursing specific certifications and education are available through the Society of Clinical Research Associates (SoCRA) and the Association of Clinical Research Professions (ACRP). The American Nursing Credentialing Center does not currently have a certification for CTN. The Oncology Nursing Society (ONS) has recently published a guide for CTN titled *Oncology Clinical Trials Nurse Competencies*, which defines the CTN's role and responsibilities in cancer clinical trials but can be generalized to other fields (ONS, 2010). This document is an essential step towards obtain recognition of CTN as a nursing specialty. There are some formal education degrees and certificate programs that are available specifically for nurses. For example, Drexel University offers a Master's of Science in Nursing in Clinical Trials Research Nursing as well as a post-Bachelors certificate.

To become a formally recognized nursing specialty CTNs must work together to develop a set of competencies specific to nurses. The societies and colleges mentioned previously can be used as a tool to help clinical trial nurses to become a recognized and integral part of the clinical trials process. "Clinical trials nurses are the trail-blazers, bringing traditional nursing skills into a new and exciting environment, helping to bring cohesion between nursing, science and medicine (Gordon, 2008)."

Email comments to oshea-jonelle@cooperhealth.edu

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Difference in outcome in patients transferred to the ICU after rapid response team intervention compared to standard critical care consult



Mary Jo Anne Cimino, RN • Christa A. Schorr, MSN • Barry Milcarek, PhD
Orlando Luis Debesa, DO • Joseph E. Parrillo, MD • R. Phillip Dellinger, MD

INTRODUCTION: Patients typically show abnormal signs and symptoms within 6 hours prior to an arrest. Failure to recognize these changes in condition have been linked to poor outcomes. Implementation of a rapid response team (RRT) brings critical care expertise to the bedside with the goal of earlier intervention and decreasing morbidity.

HYPOTHESIS: Activating the RRT improves outcomes for patients transferred to the ICU from a general medical surgical or progressive care or stepdown unit compared to those transferred with standard critical care consult.

METHODS: A retrospective review of the Cerner Project IMPACT database for patients admitted to the ICU from a general care floor, general care with telemetry, progressive care unit or stepdown unit during April 2008 – April 2009. Patients were placed in two groups based on activation of the RRT prior to transfer vs. standard ICU consult prior to transfer. Comparisons for demographics, acuity, length of stay, presenting clinical characteristics and outcome were made.

RESULTS: A total of 627 admissions were included: RRT (n=133) and ST (n=494). No significant differences were reported for age, gender, race, CPR within 24 hours of ICU admission, patient type or days on mechanical ventilation in survivors. RRT patients had longer pre-ICU LOS 10+/-12 vs 8+/-9 ($p<0.01$); higher APACHE II score. RRT 20+/-9 vs ST 18+/-6 ($p=0.04$); greater MV within 1 hours of ICU admission. 55% vs 28% ($p<0.01$); lower blood pressure within 1 hour of transfer, RRT 41% vs 26% ($p<0.01$). More RRT patients were transferred from general care floor and progressive care unit. Mortality was higher in RRT transfers, 42.9% vs 21.7% ($p<0.01$).

CONCLUSIONS: Patients transferred to the ICU following RRT are sicker and have an increased mortality. However, the RRT association with greater mortality does not establish cause and effect. Since inception of a RRT at our institution, a 40% decrease in the number of “Code Blue Calls” has been observed over a two year period.





Moral Distress: Have

Don Everly, RN, MSN, MBA, NEA-BC

As you are on your way home from work, do you question whether or not you did everything you wanted to do for the patients you just cared for? Were you not able to give your patients the care that they deserved? Did you feel compelled to provide care that was contrary to your core personal and professional values? Do you feel frustrated, sad, uncertain and maybe a little angry and powerless because what you wanted to do best for your patient was not carried out? Have you ever acted against your conscience by providing aggressive care to prolong life in futile care situations? If you answered “yes” to any of these questions, then you have experienced moral distress.

Moral distress, as defined by Andrew Jameton (1984), is the inability of a moral agent to act according to his or her core values and perceived obligations due to internal and external constraints. This occurs when one knows the right thing to do, but constraints make it nearly impossible to pursue the right course of action. Simply put, it is any situation where you cannot do what you believe you should morally do. Moral distress is not only a major problem in the nursing profession, but it is also a key issue affecting the entire workplace environment.

Moral distress is a common ethical conflict that is nonetheless poorly understood and rarely discussed, not only for nurses, but also for physicians and all members of the healthcare team. Unfortunately, too often nurses suffer in silence. Many feel that raising questions or speaking out when in moral distress is risky and it arouses fears of criticism or negative sanction. Such cases include:

- 1) end-of-life decisions and prolonging life by not obtaining “Do Not Resuscitate” orders;
- 2) families indecisiveness about terminating treatments
- 3) situations involving lying to patients or inadequate informed consents;
- 4) ineffective pain control orders
- 5) incompetent or inadequate treatment by a physician; or
- 6) performing unnecessary tests and treatments, especially on terminally ill patients.

Recognizing moral distress is an important step toward resolution, yet many nurses are unaware of how it may be manifested. Such distress may adversely lead to burnout, job dissatisfaction, and leaving the work environment. In one study, nurses reported



You Experienced This?

that moral distress affected their job satisfaction, physical and psychological well-being, self-image, spirituality, and decisions about their own health (Elpern, 2005). Elpern stated that a major consequence of moral distress is suffering that occurs when a person's integrity and sense of self are threatened. This can affect relationships with patients, their family members and other members of the healthcare team. Further, it threatens the quality of patient care and can contribute to medical errors, ineffective delivery of care, and conflict and stress among healthcare providers. In fact, studies suggest that 15-25% of nurses have resigned or left a nursing position due to moral distress (Pendry, 2007).

Nurses can have many different responses to moral distress.

According to Judith Wilkinson (1988), the pain and psychological disequilibrium of moral distress have been found to be manifested as anger, frustration, guilt, loss of self-worth, depression and nightmares. Prolonged or unrecognized suffering due to moral distress can be detrimental to one's personal and professional life. Identifying the signs and symptoms of moral distress is the first step to implementing a positive change (Unruh, 2010).

One strategy to deal with moral distress is to identify it and provide support and resources to anyone who is feeling any of the painful symptoms. Healthcare professionals need to start recognizing and deliberately talk about moral distress in the healthcare setting. Although recognition of the warning signs may be apparent, acting on them may feel like an overwhelming task. Identify a leader or fellow staff member to inform him or her of your situation. By doing so, you may even learn that others have also been bothered by a similar situation and were afraid to speak up. Active listening can also help staff through morally distressing times. Healthcare providers at Cooper University Hospital (CUH) have additional resources available to seek support in reducing moral distress including: an Ethics Committee, Pastoral Care Department, Social Services, Patient Relations, Critical Incident Response Team (CIRT) and an Employee Assistance Program (EAP).

Moral distress is not only a major problem in the nursing profession, but it is also a key issue affecting the entire workplace environment. Moral distress is a common ethical conflict that is nonetheless poorly understood and rarely discussed, not only for nurses, but also for physicians and all members of the healthcare team.



Recognizing, addressing, and tackling this threat of moral distress is necessary in creating a healthy work environment.

The American Association of Critical-Care Nurses (AACN) has issued a position statement recognizing moral distress as a serious, but often ignored problem in nursing. Resources are available from AACN and individuals may download a free handbook about moral distress at www.aacn.org. The AACN has developed a toolkit called “The 4A’s to Rise Above Moral Distress.” These 4 A’s stand for: Ask, Affirm, Assess, and Act. The purpose of the 4 A’s model is to provide a process tool that assists healthcare professionals to identify, assess, and take action when situations that cause moral distress (see figure 1) arise in the workplace. Nurses are individually challenged to recognize and name the experience of moral distress and to commit to addressing this very important issue.

Recognizing, addressing, and tackling this threat of moral distress is necessary in creating a healthy work environment. Nurses need to feel better in order for patients to feel better. Nurses need to educate and provide support systems to each

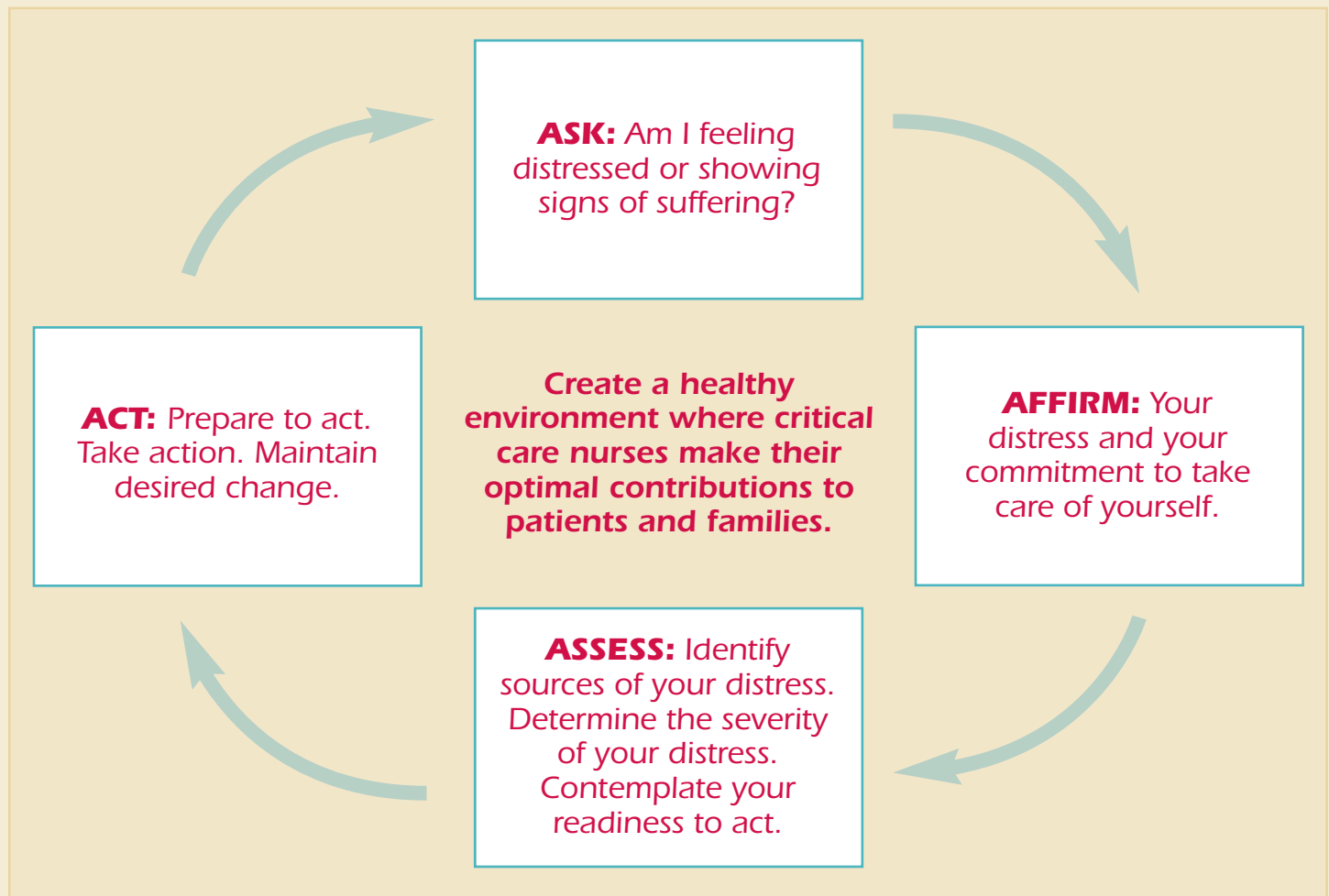
other in order to cope with moral distress. Alleviating or decreasing moral distress, can lead to increased nurse and patient satisfaction, employee retention, and ultimately improved patient-family centered care.

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Figure 1 The 4 A's to Rise Above Moral Distress



Importance of Providing Oral Hygiene in Hospitalized Patients



Kate Wood RN-BC, BSN

All hospitalized patients, whether ambulatory or non-ambulatory, conscious or unconscious, need oral mouth care (Stout, Goulding, & Powell, 2009). This patient population is often unable to provide self mouth care due to physical, cognitive, and emotional disorders. Research has proven that routine oral hygiene has reduced the risk of infections (Stout, Goulding, & Powell, 2009). Oral care was part of a protocol that resulted in a 60% reduction of ventilator associated pneumonia (VAP) (Schleder, et al., 2002). Another study has shown oral care as part of a protocol that resulted in a 42% reduction in VAP and avoiding \$722,975 in health care costs (Vollman, Garcia, & Miller, 2005). Oral hygiene study performed at 11 nursing homes showed patients receiving oral hygiene had half the mortality due to pneumonia of patient's who did not (Yoneyama, et al., 2002). Nurses are the first-line of defense to ensure mouth care is part of the patient's activities of daily living while hospitalized.

How do infections from poor oral hygiene occur in hospitalized patients?

Local tissue inflammation can occur because of increased plaque deposition, decreased saliva production, and decreased clearance of

Oral hygiene study performed at 11 nursing homes showed patients receiving oral hygiene had half the mortality due to pneumonia of patient's who did not. Nurses are the first-line of defense to ensure mouth care is part of the patient's activities of daily living while hospitalized.



mouth debris (Cohn & Fulton, 2006). When tissues become inflamed, the mucosal lining becomes weakened and causes a break in the mucosal lining allowing the entry of bacteria into surrounding tissues. This can lead to local or systemic infections (Cohn & Fulton, 2006).

What types of complications and infections are caused from poor mouth care?

The most common complications due to poor mouth care are hospital acquired pneumonia, aspiration pneumonia, and lower respiratory tract infections in both non-ventilated and ventilated patients. Patients can also experience fungal infections and bacterial infections (Stout, Goulding, & Powell, 2009).

If mouth care is not performed for 3 days, plaque may be host for hundreds of bacterial species which are predominately gram-negative bacteria (Stout, Goulding, & Powell, 2009). Nursing intervention is fundamental to reduce these adverse reactions. Oral hygiene should be considered not only as an integral and vital aspect of

patient care but also as an important element in minimizing the development of pneumonia in patients (McFetridge, 2009, Huskinson & Lloyd, 2009). Research has proven enhanced oral hygiene prevents respiratory infections in hospitalized clients whether they are medical-surgical or critically-ill patients. Guidelines for preventing health-care associated pneumonia recommended a comprehensive oral hygiene program and category II was recommended (Centers for Disease and Control (CDC), 2003).

Self-care deficits that prevent patients from performing their own oral hygiene.

A patient's disease process can prevent them from performing oral hygiene which is an essential part of activities of daily living. Stroke, Alzheimer's disease, Parkinson's disease, spinal cord injury, traumatic brain injury, Multiple Sclerosis, decreased motor coordination, and cognitive impairment (Cohn & Fulton, 2006) also contribute to the inability to perform activities of daily living. Critically ill patients in cardiac, intensive care, intermediate



Nurses are the first-line of defense, therefore; nurses need to ensure patients receive appropriate oral hygiene every day.

and promotes comfort along with a therapeutic benefit of preventing plaque. Toothbrush and toothpaste are used by healthy individuals in providing oral hygiene for the conscious and ambulatory patients. Remember, documentation of oral care is essential. The CDC suggests including the use of an antiseptic agent, chlorhexidine gluconate (0.12%) rinse (CDC, 2004).

Oral hygiene is an important nursing intervention in patient care.

Nurses are the first-line of defense, therefore; nurses need to ensure patients receive appropriate oral hygiene every day. This can be accomplished when nurses assess their patient's ability to perform oral self-care.

Patients with diminished oral self-care need nursing interventions to provide oral hygiene in an effort to decrease plaque buildup. Health promotion implemented by nurses demonstrates the importance of evidence-based practice interventions that can prevent complications and improve patient outcomes and quality of life.

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care, and trauma units may be unable to perform oral hygiene due to multiple co-morbidities (Cohn & Fulton, 2006). Therefore, these patients depend on nurses to provide oral mouth care. Research results estimated 44%–65% patients receive inadequate oral care (Cohn & Fulton, 2006).

Prevention of health care associated bacterial pneumonia.

CDC recommends prevention or modulation of oropharyngeal colonization in the mouth that could lead to health care associated bacterial pneumonia (CDC, 2004). Institutions can develop and implement a comprehensive oral-hygiene program for patients in acute care settings, critical care settings, and medical-surgical areas for all patients whom can develop health care associated pneumonia (CDC, 2004). The program would stem from evidence based practice research.

Tools used in oral care can be performed by nurses, nurse associates, and critical care technicians.

Studies have shown that toothbrushes are more effective than sponges in cleaning a patient's mouth (Huskinson & Lloyd, 2009). It has been recommended that a soft bristle toothbrush with a pea size amount of fluoride toothpaste to brush the teeth of patients is the best way to prevent plaque buildup. In between mouth care for conscious and unconscious ventilated patients, you can use the sponge toothettes (Huskinson & Lloyd, 2009). Fluoride toothpaste has a cleaning value



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What is the Penalty For Dropping the Ball During Patient Hand Off?

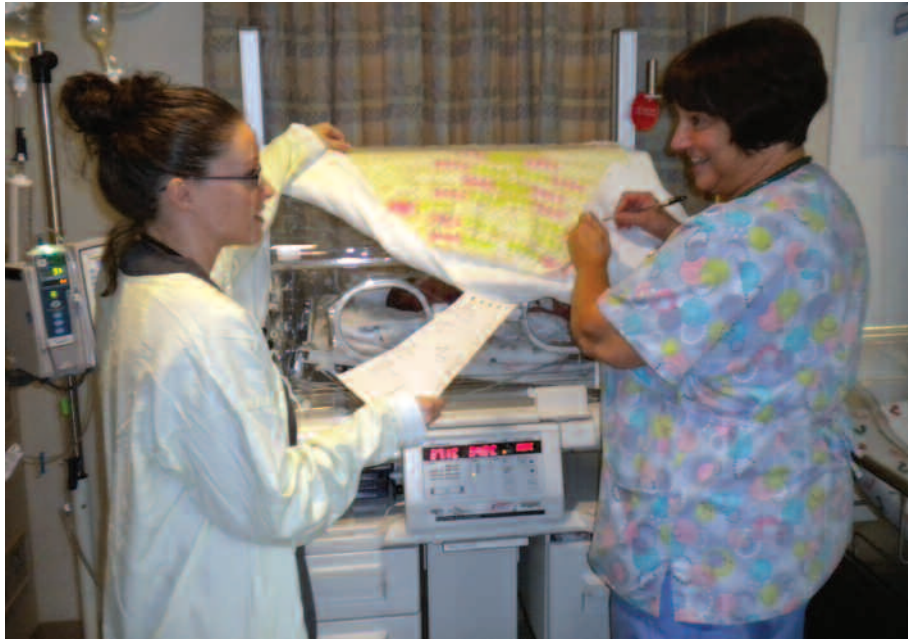


Christina Smith RN MSN, CPN, NE-BC

“Patient Hand-Off” may sound like a game but dropping the ball during a change of shift report can result in much more serious consequences for patients. The importance of an informative and effective nurse-to-nurse report has been highlighted in The Joint Commission National Patient Safety Goals (NPSGs) and most recently has been incorporated into the Provision of Care Standards. The Joint Commission recommends that organizations implement a standardized approach to hand off communications, including an opportunity to ask and respond to questions. In an effort to reduce “dropping the ball” during one of the most critical patient care intervals, many organizations are moving toward standardizing change of shift procedures which include bedside reporting. Conducting nurse-to-nurse shift report at the bedside in the presence of the patient and/or family includes them in all care information and increases patient safety, improves quality of care, increases accountability, and strengthens teamwork. Bedside reporting makes it possible for nurses starting their shift to obtain significant data to prioritize patient care and manage their workload effectively (Anderson, 2007). This important change has been received positively by today’s more informed and engaged consumers.

Change of shift signifies a time of careful communication in order to promote patient safety and best practices (Caruso, 2007). Nurses know their hand off reports are important. Most develop a system and even forms for taking report. It is vital to pass on all important but not superfluous information because timeliness is a vital aspect of their jobs (Wilson, 2007). Nursing has become more complex and time-pressed. At the same time, patient acuity has increased dramatically. Simply put, there is more information to provide in a shorter time period. This is a fine balancing act.

Traditional methods of verbal shift report tend to be lengthy,



Left to right: Heather Comparri, RN; Dale Beloff, RNC

inconsistent, and have missing or incorrect elements of patient information. The risk exists for this critical opportunity of relaying important information to become muddled by irrelevant information instead of focusing on the needs of the patient. The content sometimes degenerates into irrelevant and outdated statements, unrelated to the patient progress and often judgmental in nature, increasing the likelihood of omissions in care and a negative preconception of the patient by the receiving nurse (Anderson, 2007). In addition, the person at the center of the communication—the patient—is seldom part of this process.

Bedside shift report reassures the patient that the staff works as a team and all participants know the plan of care. Evidence suggests that active patient participation in care produces better outcomes (Caruso, 2007). Evidence also suggests that patients in-

Thoughts from a Staff Nurse:

“I find bedside report to be an extremely valuable tool that is utilized in our NICU. Nurse to nurse communication is most often seamless when reporting off on a patient’s status and family dynamics. While verbal report is invaluable, visual comparison from one RN to the next is extremely important. For example, if wound care is involved, the reporting RN can show the next shift any redness, drainage, edema, and any other characteristics he/she may have noted during their shift. This allows for the next shift to have a comparative and hopefully eliminates any overlook of subtle changes in the patient’s condition. This example can be easily substituted with a patient’s respiratory status, color, edema, fontanel status, and a plethora of other possible patient conditions. I also find that a bedside report allows for a smoother transition from one shift to the next for the parents of our infants. Bedside time with the parents allows for introductions of RN to the family and any other healthcare providers that may be involved in the patient’s care. It seems that this eases the overly stressed mind of our parents. Being at the bedside on a continued basis also allows for constant monitoring of vital signs. In the event that an alarm was to occur, nursing staff is at arms length away from their patient to intervene. No time is wasted in becoming accessible to the patient.” Heather Comparri, RN, NICU, Cooper University Hospital

volved in their care are more satisfied and less litigious (Anderson, 2006). Benefits of bedside reporting for staff nurses include the oncoming nurse's ability to visualize patients during the report and prioritize care for the shift. Experiential learning also occurs at the bedside when nurses can demonstrate equipment use and share information related to individualized patient care needs. Accountability between shifts is promoted by immediate visualization of patient needs by both shifts. Staff relationships are improved as communication is now face-to-face thus building teamwork and decreasing blame.

Reporting that follows the trend of charting by exception will be most time effective. Stating every normal assessment finding and listing every lab value is time consuming and may prompt the

Table 1 Tips for an Effective Bedside Report

- Organize your time so you are ready to give report when the oncoming shift arrives.
- If you did not receive complete information from the previous shift, search for pertinent details in the patient's medical record and include them in your report.
- Review the data you have entered on your formal report sheet and take the sheet with you when you give report.
- Be brief and direct. You do not have much time to exchange information.
- If you began a task that someone on the next shift needs to complete, point out what must be done and when. For example, if a patient received pain medication just before the end of your shift, mention that pain evaluation is due and indicate the time (Wilson, 2007).

listener to miss important information. Normal findings are pertinent and should be stated when they indicate change, recovery, or response to treatment (McLaughlin, 2004). If the nurse feels additional information is needed, it is the nurse's responsibility to refer to the medical record.

The key to organizing your report is to make it effective while minimizing duplication and missed information (Table 1). Instead of repeating information already on the report sheet, use your "face" time to answer questions and clear up any confusion. Regardless of the approach used, the end-of-shift report is more than passing on information already written on the report sheet. Properly planned and effectively delivered, it is a polished skill of which you can be proud. You can review all the profiles you want to describe skin integrity, IV sites, or mental status, but until you physically assess the patient in person, you do not have a clear, real-time picture of the patient's status."

Email comments to smith-christina@cooperhealth.edu

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REFLECTIONS: (continued from page 15)

sources to keep up and prevent further complications was taxing and difficult for all the clinical leaders on this case.

Thanksgiving came and went. Christmas and New Year's celebrations all took place in the room around the patient. Her family and the dedicated ICU nursing staff decorated her room. The staff talked to her and told her all about her baby girl. New baby pictures were constantly popping up all around the bedside, as well as throughout the ICU. Donations of money and new baby clothes were presented to the family from the nursing staff. This patient's family became our family. The patient's Mom moved to South Jersey, while her Dad and her only brother traveled back and forth from the south and mid-west to be at her bedside as much as possible. Her fiancé would come in the evening after working all day. One family member usually kept vigil at this bedside almost every night during the course of her stay at CUH.

At one point, the patient's condition had deteriorated to the possibility of considering a lung transplant. However, the attending pulmonologist called three area transplant centers, and all three refused this patient. That same day the pulmonologist consulted cardiothoracic surgery to consider putting the patient on extracorporeal membrane oxygenation or ECMO, which is similar to the "heart-lung bypass" machine used in open heart surgery. The machine essentially would take over the work of breathing, but the patient was too unstable and the cardiothoracic surgeons considered the procedure too risky.

The patient's father, a minister, would not give up on his only

daughter. He could not bring himself to sign a Do Not Resuscitate (DNR) order. He prayed and continued his vigil with his wife, son and future son in law at his daughter's bedside. Their prayers were answered. The patient made it through the night on the oscillator, with seven chest tubes; all trying to keep her lungs functioning enough to receive oxygen. She made it through the next shift, the next day and the next week; with many bumps in the road, but that had to be the darkest day.

"Our girl" experienced empyema, and lung abscesses from fungal infections, sepsis, spontaneous pneumothorax (multiple times), ventilator associated pneumonia, anemia, and deep vein thrombosis. She also had a seizure while being weaned from her benzodiazepines and developed neuromyopathy in all four extremities. She was finally given a tracheostomy and weaned from the ventilator in the ICU. In all the time that she was too unstable to move or be turned, she did not develop any skin breakdown! Finally, the day came for discharge to the long term acute care facility, however, first there had to be an appropriate send off. The ICU nurses had a baby shower, complete with cake, decorations and of course more baby clothes and toys, to try to make up for lost time.

After ten days and decannulation of her tracheostomy tube, it was off to inpatient rehabilitation (rehab) to start strength training. Inpatient rehab soon became outpatient rehab. Today the patient is walking with a walker and gaining strength. She will need it to keep up with her thriving toddler and her new husband. They were married here at CUH, in the Margaret L. Isaac Memorial Chapel this past spring.

A Miraculous Recovery

Suzanne M. Gould, RN, MHA, CCRN



In the fall of 2009, a 25 year old female who was 36 weeks pregnant with her first child presented to a community hospital. The patient was short of breath, complained of chest pain and had a cough that was ongoing for a week. In addition, she was tachycardic, tachypneic and her pulse oximeter was 80% on room air. Her chest x-ray showed diffuse alveolar infiltrates. She was intubated, given Tamiflu and Vancomycin and transferred to Cooper University Hospital's (CUH) Intensive Care Unit (ICU). This would be her home for more than 100 days. She had H1N1 and was in Acute Respiratory Distress Syndrome (ARDS).

The patient delivered a healthy baby girl by cesarean section the evening of her admission to CUH. Sadly, she would not see her daughter, hold her or even take part in naming her. Her respiratory condition continued to deteriorate and she remained sedated and on a ventilator for the next three months.

The ICU staff had seen about a dozen or so cases of H1N1 this past flu season, all young adults and primarily young pregnant women. This was going to be the most challenging case the team would manage and successfully treat to discharge. The patient experienced a myriad of complications and her lung tissue was extremely damaged. Her condition changed hour to hour many days.

This required an almost constant vigil by the entire ICU multidisciplinary team; to adapt her therapy to meet her oxygenation requirements. The dedicated team rose to the challenge and attacked the aggressive H1N1 with every weapon in their arsenal. Many "rescue" ventilatory methods were attempted. A special ventilator called an oscillator would blast short bursts of oxygen through the ventilator into the patient's lungs to open small air sacs called alveoli. The patient was also turned onto her stomach (this technique is called proning) for hours in order to allow collapsed alveoli to reinflate. This went on day after day, week after week. While it was important to provide consistent care, the staff was often mentally and physically exhausted after a couple of shifts caring for this patient. Over time, it became difficult for the leadership team to assign "fresh" legs and eyes to this situation.

The patient had declined to the point of respiratory failure and her lung tissue was so damaged that she developed a bronchopleural fistula; an opening between the bronchial tree and the pleural space. The fistula was a new challenge and created yet another obstacle against our efforts toward oxygenation and ventilation. There were many days when the patient had to be "singled"—meaning one nurse took care of just her; she was that fragile. Allocating the re-

(continued on page 14)





Professional News

DEGREES:

Jonelle A. O'Shea, RN-BC, MSN Drexel University
Susan Maltman RN MSN Immaculata University
Wendy Topeka RN MSN Immaculata University
Dianne Hyman RN MSN Immaculata University
Jackie Tubens RN MSN Immaculata University
Barbara Sproge RN MSN Immaculata University
Jan McFetridge, RN MSN Immaculata University
Stacy Carr, RN BSN Immaculata University
Edna Parker RN BSN Rutgers University
Michelle Hailey RN BSN University of Delaware

CERTIFICATIONS:

Victoria Johnson, RN, BSN, CCRN
certified Critical Care Nurse
Jodie Szalma, BSN, RN-BC, PCCN
certified Progressive Care Nurse
Thomas Repici, RN, PCCN certified Progressive Care Nurse
Grace Mansilla, RN-BC certified Medical Surgical Nurse
Chris Sipala RN PCCN certified Progressive Care Nurse
Jean Williams RN CCRN certified Progressive Care Nurse
Tammy Beringer RN BSN CPST certified National Child Passenger Safety Technician

AWARDS:

Joan Watt, RN, from Division of Hematology and Oncology was recognized as part of the Pennsylvania Real Estate Investment Trust's (PREIT) Tribute to Nurses. This program recognizes areas nurses for their dedication to the healthcare profession. She was nominated by a patient that she had been treating since 2008.

PRESENTATIONS:

Carole-Rae Reed, PhD, RN, APN, BC and **Cheryl Koehl, RN, MSN, APN**, "Developing & Coaching Staff Excellence in Nursing Research Through a Mentor Program" poster presented at the National Conference for NNSDO in San Diego CA July 10, 2010.
Chaudron Carter, Ed.D, MHE.d, MHA, RN, NE-BC, "A Collaboration in Student Nurse Hospital Orientation" Poster Presentation at the PNEG Conference – Innovation and Creativity in Nursing Education, October 2010

PUBLICATIONS:

Davies-Hathen, N. & Korner, K. (2010). Opening a new medical-surgical unit the right way. *Pennsylvania Nurse*, 65(2), 11-14.
Pugh, L., Duffy, & L., Stauss, M. (2010) Patient care plans: an innovative approach to superusers in the emergency department. *JEN*, 36(4).

LADDER APPOINTMENTS:

Level 3

Elizabeth Alonzo, RN, BSN PCU
Ryan Allison, RN NICU
Heather Budden, RN NICU
Nancy DeBerardinis, RN S7
Jill DeMarco, RN PCU
Nicole Hughes, RN, BSN S7
Correinne McKenna, RN ICU
Diane Molino, RN PCU
Jean Rabbuttino, RN Mt Laurel
Barbara Smith, RN Mt Laurel
Vicky Tubens, RN, BSN ICU
Lynn Marie Yerg, RN S7
Irene Augird, RN CCL
Debra Cosenza, RN SDS/SPU
Tracy Green, RN, BSN NICU
Jamie Jefferson, RN NICU
Andrea Jones, RN NICU
Robert Lawston, RN PICU
Henry Muzones, RN CCL
Lisa Passero, RN SDS/SPU
Donna Tappen, RN, BSN NICU
Jennifer Yoder, RN, BSN POOL

Level 4

Genellen Bona, RN, MSN NICU
Melissa Campbell, RN WCC
Kathy Fee, RN NICU
Marla Janor, RN, BSN Voorhees
Lauren Miller, RN, BSN NICU
Karen Mitchell, RN Mt Laurel
Kerry Myers, RN, BSN PEDS N6
Edward Norton, RN Diagnostic Radiology
Lori Osinski, RN Diagnostic Radiology
Maurine Remaly, RN, BSN BAYLOR
Norma Rowello, RN N/S9
Renee Smith, RN, BSN NICU
Carla Stillwell, RN, BSN SDS/SPU
Linda Sullivan, RN, BSN PACU
Carolyn Ali, RN N/S9
Dale Ann Beloff, RN NICU
Lisa D'Averso, RN, BSN BAYLOR
Doreen DeSimone, RN SDS
Mary DiBenedetto, RN SDS/SPU
Maria Eastlack, RN, BSN SDS/SPU
Cynthia Garretson, RN, BSN NICU
Nancy Gibson, RN, BSN MI
Regina Chavous-Gibson, RN L&D
Amanda Glass, RN, BSN PICU
Catherine Hassinger, RN MT LAUREL
Jane Hasson, RN NICU

Diana Hays, RN NICU
Angela Jones, RN Voorhees
Kay Joseph, RN S7
Kathryn McCurley, RN, BSN PEDS N6
Janine McNamara, RN, BSN Mt Laurel
Barbara Murphy, RN LD
Rachel Neel, RN, BSN N/S8
Debbie Orr, RN, MSN CCL
Kim Potorti, RN, BSN SDS/SPU
Patricia Reitman, RN Voorhees
Lisa Repogle, RN, BSN CCL
Carolyn Scratchard, RN, MSN Voorhees
Kim Serafine, RN Voorhees
Megan Staerk, RN, BSN N10
Caitlin Stevens, RN, BSN NICU
Amy Stevens, RN, BSN NICU
Danielle Tamburino, RN Peds
Diane Wachter, RN, BSN NICU
Christine Wadehn, RN, BSN ENDO
Diane Fletcher, RN L&D

Level 5

Maria Alcontin, RN, BSN S7
Audrey Bennett, RN, BSN LD
Tania Berghaier, RN, BSN Peds
Suzanne Butler, RN, BSN PICU
Elizabeth Canders, RN, BSN NICU
Michelle Doyle, RN, BSN Peds
Mary Jane Durkin, RN, BSN Infusion Center
Valerie Gibson, RN, BSN NICU
Mary Greeley, RN, BSN CCL
Linda Hessler, RN, BSN PACU
Ann McCausland, RN, BSN NICU
Lois Meyer, RN, BSN NICU
Jonelle O'Shea, RN, MSN Cardiology
Janine Rousseau, RN PICU
Jodie Szalma, RN, BSN N10
Michael Tronco, RN, BSN PICU
Jeannette Walton, RN Echo
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Lorene Pugh, RN, BSN ED
Seema Shah, RN, BSN N10
Barbara Wenning, RN, BSN CCL
Donna Wood, RN, BSN NICU

Level 6

Michelle Basile, RN, MSN NICU
Neingull Suokhire, RN, BSN, MHA S5
Kimberly Vaughan, RN, BSN Voorhees