



# Cooper Bridges

A publication for nurses and healthcare professionals

FALL/WINTER 2015 ■ VOLUME 9, ISSUE 2



## When Your Patient is Breastfeeding

**Risk Versus Benefit  
of Breastfeeding  
When Hospitalized**

## Table of Contents:

Leadership Letter . . . . .	3
Everything Old is New Again. . . . .	4
When Your Patient Is Breastfeeding . . . . .	5
Patient Safety: Taking the Best Approach to Doing No Harm . . . . .	10
Periop 101: Plan to Improve Patient Outcomes during the Perioperative Experience . . . . .	11
Direct Care Nurses and Their Experiences in Caring for Patients Enrolled in Clinical Research . . . .	14
Reflections . . . . .	15
Professional News . . . . .	16

### EXECUTIVE EDITORS

**Stacey Staman, RN, MSN, CCRN**  
Pediatric Trauma Program Coordinator

**Mary Stauss, RN, MSN, CEN**  
Clinical Educator II, Emergency & CDU

### ASSOCIATE EDITORS

**Robert Strayer, RN, PhD, APN-C, CCRN**  
Department of Surgery: Metabolic & Bariatric Surgery

**Janet Tridente, RN, MSN, CCRN**  
Clinical Educator II, ICU & CCU



E-mail comments about Cooper Bridges to:  
[Staman-stacey@cooperhealth.edu](mailto:Staman-stacey@cooperhealth.edu)

To add someone to this mailing list, or to correct your address please email:  
[Staman-stacey@cooperhealth.edu](mailto:Staman-stacey@cooperhealth.edu)



**World Class Care. Right Here. Right Now.**

George E. Norcross, III  
Chairman  
Board of Trustees

Adrienne Kirby, PhD, FACHE  
President and CEO  
Cooper University Health Care



## From the Senior Nursing Leadership

**Stephanie D. Conners**  
Senior Executive Vice President,  
Hospital Chief Operating Officer  
and Chief Nursing Officer

**Lisa Laphan-Morad**  
Vice President, Patient Care  
Services and Assistant  
Chief Nursing Officer



Enhancing the experience of every patient with whom we come in contact should be an easy challenge since we work in healthcare and caring for patients is ‘what we do.’ However, as our patients become better educated on healthcare services and more engaged in their plan of care, there is an expectation that the care we provide is with a higher level of service that is inclusive of the patient in the decisions and supported by compassion and commitment to improving the person’s well-being. It is also imperative to recognize that patients have better outcomes when they have a positive patient experience. We are committed to delivering such nursing care at Cooper University Hospital.

This year we have embarked on a journey to enhance our engagement with the patient, their families and each other to provide excellent service and outstanding care. Different than other initiatives where we immediately engage the frontline staff and change processes, our plan has been to educate our nursing leaders to build supportive relationships with the patients and staff. Nursing leaders have been rounding on our patients every day to make a connection with the patient and family; and assist the staff with any barriers they may be having in providing an excellent patient experience. This is also an opportunity for the patients to share their positive experiences and for us to recognize our staff for their efforts.

Literature supports the concept that engaged, happy employees provide outstanding care that will improve patient outcomes. You should be seeing your leaders rounding on you. Why? Because we really care about what is important to you as you are caring for our patients. Your participation has provided ideas for improvement and removing obstacles in our delivery of healthcare. We appreciate your involvement and look forward to many innovative ideas!

“People don’t care how much you know until they know how much you care,” John C. Maxwell. This statement is very poignant. We may have the most knowledgeable clinicians and the most advanced technology and still miss an opportunity to provide an excellent patient experience. Your nursing leadership team is committed to providing you with the resources you need and recognizing your best practice so we can lead the region in providing an outstanding experience for all we serve.

### **Stephanie Conners and Lisa Laphan-Morad**

Email comments to [conners-stephanie@cooperhealth.edu](mailto:conners-stephanie@cooperhealth.edu)

#### **Cooper Bridges Mission:**

*“To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care.”*

Cooper Nurses interested in authoring an article for a future edition of *Cooper Bridges* may obtain submission guidelines by contacting: [Staman-stacey@cooperhealth.edu](mailto:Staman-stacey@cooperhealth.edu)



# Everything Old is New Again

Margo Wallace, RN, MSN

The adage “everything that is old is new again” certainly rings true when discussing vaccine-preventable diseases. Many of these diseases are incorrectly considered eradicated, when in fact they are emerging. “Emergence is in fact regression, a return to the standard that prevailed universally in the previous century” (Lederberg, 1996).

The United States was able to eliminate many vaccine preventable diseases because it had a strong vaccination program with high rates of vaccine coverage in children and a strong public health system for detecting and responding to cases and outbreaks. Two reasons for the increase in cases of vaccine preventable diseases are that vaccination rates have dropped globally and unvaccinated persons are traveling into areas of the world where these diseases are more prevalent and often bringing the virus home with them.

Measles is no longer endemic in the United States, but it is starting to re-emerge. Measles was declared eliminated from the U.S. in 2000 (elimination is defined as the absence of continuous disease transmission for 12 months or more in a specific geographic area). From December 28, 2014 to March 6, 2015, 142 people from 7 states were reported to have contracted measles and are considered to be part of a large outbreak that was linked to an amusement park in California (Zipprich, Winter, Hacker, Xia, Watt, Harriman, 2015).

The first-hand devastating consequences that vaccine-preventable diseases can have on a family or community have not been seen by people alive today. It is possible that measles could become endemic (constant presence of a disease in an area) in the United States again, especially if vaccine coverage levels continue to drop. This can happen when people forget to get vaccinated on time, are not aware that they need a vaccine dose (this is most common among adults) or refuse vaccines for religious, philosophical or personal reasons. Often, people who refuse to get vaccines congregate together. If measles infects a group of people who are unvaccinated it can start an outbreak. This eliminates the protection known as “herd immunity”. When a critical portion of a community is immunized against a contagious disease, most members of the community are protected against that disease because there is little

opportunity for an outbreak. Even those who are not eligible for certain vaccines such as infants, pregnant women or immunocompromised individuals get some protection because the spread of contagious disease is contained.

Measles starts with fever, runny nose, cough, red eyes and sore throat. It is followed by a rash that spreads over the entire body. The average incubation period for measles is 14 days, with a range of 7-21 days (Miller, 2003). Persons with measles are usually considered infectious from 4 days before until 4 days after onset of rash with the rash onset considered day zero.

According to the CDC, you are considered protected from measles if you have at least one of the following:

- written documentation of adequate vaccination defined as:
  - one or more doses of a measles-containing vaccine administered on or after the first birthday for preschool-age children and adults not at high risk
  - two doses of measles-containing vaccine for school-age children and adults at high risk, including college students, healthcare personnel and international travelers
- laboratory evidence of immunity
- laboratory confirmation of measles
- birth in the United States before 1957

All countries that are members in the six World Health Organization regions have committed to eliminating measles by the year 2020. Once a disease has been eliminated from every country, it is considered “eradicated” from the world.

Email comments to [Wallace-margo@cooperhealth.edu](mailto:Wallace-margo@cooperhealth.edu)

## References:

<http://www.cdc.gov/measles/about/faqs.html#if>.

Zipprich J, Winter K, Hacker J, Xia D, Watt J, Harriman L. (2015). Measles outbreak—California, December 2014–February 2015. *MMWR*. 64, 1-2.

Lederberg J. (1996) Infection emergent (editorial). *JAMA* 1996;275 (3): 243-245.

Miller D.L. (1964). Frequency of complications of measles, 1963. *Report on a national inquiry by the Public Health Laboratory Service in collaboration with the Society of Medical Officers of Health*. *Br Med J*, 2, 75-8.

Miller C, Farrington CP, Harbert K. The epidemiology of subacute sclerosing panencephalitis in England and Wales 1970-1989. *Int J Epidemiol* 1992; 21:998-1006.





# When Your Patient is Breastfeeding

Deborah E. Schoch PhD, RNC, IBCLC, CCE, CPST

**B**reastmilk has long been accepted as the ideal nutrition for infants. The specificity of breastmilk not only provides nutrition and health benefits for infants, but also for mothers (Table 1). The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the first six months of an infant's life, followed by breastfeeding in combination with the introduction of complementary foods until at least 12 months of age, and continuation of breastfeeding for as long as mutually desired by mother and baby (Eidelman, Schanler, et al, 2012).

Breastfeeding rates in the United States continue to rise. The Centers for Disease Control (CDC), in their Breastfeeding Report Cards from 1994 - 2014, reports the initiation rate of any breastfeeding growing from 60% to 79.2% among post-partum women. In addition, from 2007 to 2014, the exclusive breastfeeding rate at 3 months post-partum has risen from 30% to 40% (CDC, 2015). Although slightly lower than the national percentages, Cooper University Health Care's (CUH) Division of Maternal Child Health currently reports a breastfeeding initiation rate of 64.8% and an exclusive breastfeeding rate of 40.0% at discharge from the Mother Infant Unit during the post-partum stay (Department of Maternal Child Health, CUH, 2015). As breastfeeding rates continue to grow so does the distinct possibility that a woman who is providing breastmilk to her infant may be admitted to CUH for a medical or surgical indication.

## **Risk Versus Benefit Of Breastfeeding When Hospitalized**

A maternal illness or surgery creates a unique set of circumstances for both health care professionals and the breastfeeding mother. Therefore an informed discussion among all should take place. The woman may present to a hospital unit with anxiety and stress, not only due to her diagnosis but also due to mother/infant separation and the inability to directly breastfeed or maintain her breastmilk supply. The impact of medications, diagnostic tests, required procedures and her needs regarding lactation should be closely assessed. Outdated thinking suggests that the mother should wean the infant from breastmilk when she is hospitalized due to a medical or surgical implication. However in most cases and using current research and resources hospitalized mothers can continue to provide and feed breastmilk to their infants.

## **Mother Infant Separation**

The anxiety of mother infant separation can be alleviated by allowing the infant to room-in or visit. In both cases the infant should have a separate care-giver and if possible the mother a private room. "Rooming-in" offers the mother direct access to the infant for breastfeeding while recovering from her admission diagnosis. Contact between mothers and infants have positive

effects in reducing anxiety and pain through the release of endorphins during skin to skin contact and breastfeeding (Adedinsowo, D., Fleming, A., et al., 2014; Kendall-Tackett, 2014).

The care-giver for the infant provides basic infant care, and is also available to support the mother during breastfeeding and her hospitalization. The primary nurse caring for the patient, enhances this support by providing privacy and assisting the mother in being comfortable during breastfeeding despite the medical or surgical complication. These measures include the use of pillows and blankets that encourage optimal comfort, positioning and latching instruction during any breastfeeding opportunity, as well as cushioning to protect the mother who may have pain, an operative incision or similar diagnosis.

When a mother becomes ill at home, exposure to the infant has already occurred. A mother admitted to the hospital with an infectious process such as a cold, fever, virus or more serious illness can, in most cases, still provide breastmilk to her infant (Hanson, 2007). Although some viruses are transmitted through breastmilk, the mother's body creates antibodies which are passed to the infant through her milk and provide protection.

A more likely mode of transmission for infections or viruses is through touching or close mouth and nose contact. Therefore, diligent hand-washing, use of hand sanitizer, personal self-hygiene and cleaning of breastmilk expression equipment is important. If the infant is visiting and breastfeeds, the mother should avoid coughing or sneezing in the baby's face and only family members who are healthy should care for the infant. In some cases, it may be advisable for the mother to wear a face-mask when directly breastfeeding (CDC, 2015).

Minimizing mother/infant separation is important when a mother is hospitalized. Stress can not only inhibit her milk production, but may also hinder her care and recovery. When a mother is hospitalized, an assessment regarding the risk/benefit of directly breastfeeding versus expressing breastmilk should be initiated on admission. The mother's prescribed plan of care can ensure rest, treatment for her illness, maintenance of breastmilk production by directly breastfeeding or expressing, and optimally a quick discharge so she can resume her role of mother and care-provider to her infant.

### **Maintaining Milk Production**

When a mother cannot directly breastfeed and desires to maintain her breastmilk supply she must express the milk. Breastmilk production is dependent on emptying the breast as many as 12 times per day in order to provide enough supply to meet the nutritional and developmental needs of her infant. Prolactin, the hormone that predominantly produces breastmilk,

is higher during the night hours. Therefore it is important for the mother to express at least once between the hours of midnight and 6am. The hormones prolactin and oxytocin, when adequately stimulated, will continue to provide breastmilk in optimal amounts for the infant.

A mother can express breastmilk in several ways. Hand or manual expression has long been used to not only express breastmilk for storage or feeding to the infant, but also when softening a slightly over-full breast before direct latching or until an electric breast pump is available. Dr. Jane Morton, from Stanford University, has provided written and visual education on this method of milk expression. Her video "Making More Milk, The Keys to Successful Breastfeeding" can be viewed on the CUH Demand Video System, or via the internet, and is a useful adjunct for staff and mothers (Morton, 2015).

Expression using a hand breast pump is another method of expressing breast milk. This type of pump is easily portable for the mother; however in most cases the use of hand power is not strong enough to adequately drain the breast. Also, depending on the medical or surgical condition of the

mother, she may not have the stamina to use this type of pump in a way that meets her needs and/or the nutritional and developmental needs of her infant.

An electric personal use pump is another option for maintaining a breast milk supply during hospitalization. This pump is brought in from home by the patient. The mother may be more comfortable using her own pump, if she has already been utilizing it at home. However if she has never utilized her personal pump prior to her admission to the hospital it may not be a good time to begin. The anxiety of the hospitalization coupled with learning how to use the pump and maintaining a breastmilk supply may increase her stress. This may also lead to a decreased milk production.

The best option for breastmilk expression during hospitalization is a hospital-grade double electric breast pump. This pump has a motor system that can best duplicate the infant's latch when draining the breast. The ability to pump both breasts at the

same time allows the mother to empty the breast in approximately 15 to 20 minutes and conserves her energy during hospitalization. At CUH, a hospital-grade pump can be obtained from the supply department. When ordering the pump, a dual-hygienic pump kit should also be ordered. This kit contains the flanges that go over the nipple/areola complex, collection bottles and the tubing that connects the entire system to the electric pump. The electric part of the pump is reusable and terminally cleaned by the supply department after a patient is finished with its use, but the dual-hygienic pump kit belongs to the mother. The mother may have storage bags or bottles that can be used for collecting the



**The best option for breastmilk expression during hospitalization is a hospital-grade double electric breast pump. This pump has a motor system that can best duplicate the infant's latch when draining the breast.**





An informed discussion between the mother, physician, primary nurse, lactation consultant and family can assist in allaying fears and ensuring the safe use of breastmilk as well as the best health outcome for the mother while she continues to support her breastmilk supply.

breastmilk. If she has not bought any storage equipment with her to the hospital, a box of breastmilk storage bags should also be ordered from the supply department. Education for use of the pump can be obtained through a consult with the hospital's lactation consultant or by calling one of the maternal child health units in the Dorrance building and asking for one of our certified breastfeeding counselors.

Breastmilk that is collected should be kept cold, frozen or sent home to the infant for feeding. Breastmilk is not considered biohazardous; however it is generally stored separately to maintain it at a temperature that assists in preserving its unique properties (Human Milk Banking Association of North America, 2011). Some suggestions for storage include a cooler with ice at the bedside, or storage in a refrigerator or freezer. The maternal child health units in the Dorrance Building and pediatric units in the Kelemen Building all maintain breastmilk refrigerators and/or freezers that can be used for short-term storage. All milk is labeled with the mother's hospital information along with the date and time of expression. Staff on the unit in which the mother is expressing can contact the unit in which the milk will be stored, take the milk to the unit for storage, and then retrieve it when the mother is ready to feed it to the infant or send it home.

The flanges and bottles from the dual-hygienic pump kit are washed in between milk expressions with hot soapy water, rinsed well and air-dried. Soap in the hand dispensers located in the bathrooms of the patient's room is not appropriate for washing pump equipment as it may contain lotions or other additives. Soap to wash the pump equipment can be obtained from the

mother infant unit or neonatal intensive care unit. The patient is encouraged to invert the flanges and bottles on paper towels for optimal drainage and drying. This ensures the equipment remains as clean as possible and decreases the chance of contamination of the expressed breastmilk. The tubing that connects the flanges and bottles to the electric pump does not need to be washed. In fact, if fluid gets into the tubing the equipment may not function properly.

The ability to assist a mother who is expressing breastmilk while hospitalized for a medical or surgical reason is not easy. All patients who are supplying breastmilk for their infants should receive a lactation consult. This consult enhances:

- support provided by the bedside nurse
- discussions with the health care team related to any concerns regarding milk expression, infant feeding of the expressed milk, and the mother's hospitalization
- reinforcement of education related to the chosen method for milk expression
- assessment of milk expression
- maintenance of a mother's breast milk supply by providing milk expression suggestions

### Medications

Past research trended toward the use of formula feeding or weaning if a mother who wished to provide breastmilk needed medication. Current research has changed this opinion. Few medications are actually contraindicated while a mother is providing breastmilk or breastfeeding her infant (Hale, 2014). An informed decision regarding medications can be obtained by using several resources. These resources allow the health care professional and mother to research medications that may pose a question or doubt and review the degree to which it enters the milk compartment, and affects the infant. These resources include the text "Medications and Mothers' Milk" by Dr. Thomas Hale which is updated every two years and located on all units in the Dorrance Building, the web-site "Lactmed" which is managed by the National Institutes of Health and the United States National Library of Medicine <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>, and the American Academy of Pediatrics Policy Statement on the "Transfer of Drugs and Therapeutics Into Human Breast Milk: an Update of Selected Topics" (Sachs, et al, 2013).

Some questions that should be considered include the following:

- How much or how little does the medication transfer into the breastmilk of the mother?
- What is the risk/benefit ratio of continuing expression and use of breastmilk while using the medication?
- Is the medication being used short term or long term?
- If the medication poses a risk to the infant is there an alternative medication or course that could be followed?

An informed discussion between the mother, physician, primary nurse, lactation consultant and family can assist in allaying fears and ensuring the safe use of breastmilk as well as the best health outcome for the mother while she continues to support her breastmilk supply.

### Surgical Procedures

Surgery is stressful for any patient. For the breastfeeding

mother, there are several considerations including when breastmilk expression or feeding can resume, controlling pain after the procedure and how that may affect breastmilk expression and feeding, and the impact of anesthetic medications on breastmilk and breastfeeding. When the procedure is elective, a mother can plan ahead and express her breastmilk prior to surgery and as soon as she is awake and alert after surgery. When a mother is not able to plan, the bedside nurse can ensure that she expresses appropriately for her comfort and the maintenance of a milk supply as part of the plan of care. All mothers undergoing a surgical procedure should be reminded that surgery is a stressor, and a decrease in milk production may be experienced for several days after surgery (Lawers & Swisher, 2011). However, upon resuming breastfeeding or breastmilk expression, her supply should return within two to five days.

The implications of surgery as well as the drugs and anesthetics used during a surgical procedure for a mother who is providing breastmilk depends on several factors, including the age of the infant, the stability of the infant, the length of lactation and the ability of the infant to clear small quantities of anesthetic medications. Medications used during surgery will have little or no effect on an older infant but may potentially cause problems in newborn infants, particularly those who are premature or suffer from apnea. Mothers with healthy term or older infants can usually resume breastfeeding as soon as awake, stable, and alert. A mother who is awake, alert, and oriented is an indication that any medications used during surgery have redistributed from the circulatory system (and thus generally the milk compartment) and entered adipose and muscle tissue where they are slowly released and excreted from the body. One exception might be a drug that is highly lipid soluble, in which breast tissue may function as a fat compartment, acting as a drug reservoir. Utilizing the resources mentioned above, can help with an informed decision regarding the need for a mother to express and discard her milk for a period of time (Hale, 2007). (Table 2) Support during any surgical procedure is imperative. Enacting a plan of care that includes the lactation consultant will help everyone understand any implications that may arise for the breastfeeding mother.

### Diagnostic And Radiologic Tests

The American College of Radiology recommends that breastfeeding mothers be given information that allows them to make informed decisions on the use of breastmilk and breastfeeding after receiving contrast media. Research and data suggest that it is safe to continue breastfeeding after receiving iodinated and gadolinium-based agents; however caution should

be used with the MRI contrast agent, Teslascan. Complete information on the use of diagnostic and radiologic contrast media can be obtained by going on CUH's intranet, clicking on Departments, the Department of OB/GYN and then opening the breastfeeding folder. There is a flyer that can be downloaded and used by both staff and mothers in making an informed decision on contrast media and the use of breastmilk. This information is supported by the American College of Radiology, Committee on Drugs and Contrast Media (2013) as well as by the resources above that discusses medications and the breastfeeding mother. Even if the contrast media is safe for use, it is ultimately the mother who must be comfortable when providing the breastmilk or breastfeeding. If she is uncomfortable providing her milk to the infant then expressing and discarding the milk for 12-24 hours is appropriate.

### Contraindications To Breastfeeding

Contraindications related to breastfeeding or the expressing of breastmilk are few but still warrant a short discussion on three of

the more common situations health care professionals may encounter. In the industrialized world, it is not recognized that a mother with positive Human Immunodeficiency Virus breastfeed because there are other alternatives for infant feeding. In developing countries where water sources are poor or nutrition for infants is lacking, exclusive breastfeeding is supported. Research continues to look at the variables related to breastfeeding in this population of patients due to newer medication regimens and treatment (Lauwers & Swisher, 2011).

Mothers who were substance abusers are not typically exempt from breastfeeding or expressing breastmilk because those taking

methadone, suboxone or a similar medication for prior substance abuse, and who are followed by a health care practitioner may breastfeed. Research demonstrates that the amount of medication in the milk compartment is small and does not affect the infant (McAfee, 2007). Those mothers who are using street drugs including but not limited to marijuana, heroin, phencyclidine (PCP) or cocaine should not breastfeed. These drugs of abuse are released into a mother's system in varying amounts, may linger there for unpredictable lengths of time, and may cause neurological, cardiac, respiratory or developmental problems in the infant. Many of these drugs of abuse may also decrease an actual breastmilk supply, limiting nutrition to the infant (Hale, 2014; McAfee, 2007).

Women who present with a diagnosis of cancer should be assessed on an individual basis constructed upon the diagnosis, aggressiveness of the disease process and the treatment. Plans of care should be enacted that allow for some breastfeeding or for





expressing and discarding breastmilk until the treatment is completed. Women who have been treated for cancer in the past and are of child-bearing age may become pregnant. Breastfeeding can be established in this population of patients. A consult with the patient, her primary obstetrical physician, primary oncologist and lactation consultant should occur before delivery to provide optimal support and guidance.

Conclusion

Breastfeeding an infant is intrinsic to our class as mammals. However breastfeeding over time has had peaks and valleys depending on public opinion, women's place in the workforce, lifestyles, sexuality and media coverage. More and more women

are coming into the health care setting well educated on the benefits of breastmilk and breastfeeding, and have chosen this method of nutrition for their infants. All health care professionals have the distinct possibility of caring for a breastfeeding mother in the hospital setting. Knowing how to assist, support and find resources for this population of patients establishes a high standard of care, one that promotes not only healthy outcomes for the mother, but patient satisfaction in meeting her needs and personal infant care goals.

Email comments to [Schoch-Deborah@CooperHealth.edu](mailto:Schoch-Deborah@CooperHealth.edu)

TABLE 1 Benefits of Breastfeeding and Breastmilk for Mothers and Infants	
MOTHER	BABY
<ul style="list-style-type: none"><li>• Stimulation of oxytocin</li><li>• Decreased risk of breast Ca</li><li>• Decreased risk of ovarian Ca</li><li>• Increased metabolism with a decreased chance of adult onset DM</li><li>• Assists with bone density lessening chances of osteoporosis later in life</li><li>• Increase in metabolism that may assist with post-partum weight loss</li><li>• Bonding</li><li>• Convenience and money saving</li></ul>	<ul style="list-style-type: none"><li>• Enhances maturation of GI tract</li><li>• Protects against GI problems such as infantile diarrhea and NEC</li><li>• Gives protective antibodies</li><li>• Gives cell mediated immunological factors</li><li>• Decrease in atopic disease such as eczema</li><li>• Some protective benefits against childhood cancers such as leukemia</li><li>• Decrease in chances of childhood IDDM</li><li>• Jaw development</li><li>• Decrease in childhood obesity</li><li>• Analgesic effects</li><li>• Stimulates peristalsis</li></ul>
<p>Eidelman, A., &amp; Schanler, R. (2012). Policy statement: Breastfeeding and the use of human milk. <i>Pediatrics</i>, 129, e827-e841 Reprinted with permission</p>	

TABLE 2 Special Considerations Regarding Surgical Procedures
<p>Mothers having plastic surgery, such as liposuction, where large doses of local anesthetics (lidocaine/xylocaine or lignocaine) may be used should probably pump and discard their milk for 12 hours prior to resuming breastfeeding (Hale, 2007).</p>
<p>Women having bariatric surgery need clear instruction on diet, and the need for a Vitamin B12 supplement. This vitamin tends to be poorly absorbed through daily dietary intake and may affect the nutritional values of breastmilk (Hale, 2007).</p>
<p>The maternal dose and the ability of the infant to systemically clear small amounts of medications that can cause cardiorespiratory effects is the primary concern before returning to exclusive breastfeeding. Infants who may be predisposed to apnea, hypotension, or hypotonia should probably be protected by a few more hours of interrupted breastfeeding (12–24 hours) prior to resuming (Hale, 2007).</p>
<p>A mother who presents with a breast abscess may breastfeed. Breastfeeding does depend on the location of the abscess, the pain associated with the abscess, and the medications used to treat the abscess. If the mother continues to breastfeed, it is important for routine emptying of the breast. Routine emptying will assist with comfort and maintain her milk supply. A method of expression comfortable for the mother should be utilized (Hale, 2007; Lauwers &amp; Swisher, 2011).</p>
<p>Most medications provided for pain are safe when used in a breastfeeding mother. These medications are traditionally short term, and the amount the infant receives is miniscule (Hale, 2014).</p>

References

Adedinsewo, D., Fleming, A, Steiner, M., Meaney, M., and Girard, A. (2014). Maternal anxiety and breastfeeding: Findings from the MAVAN (Maternal Adversity, Vulnerability, and Neurodevelopment) study. *Journal of Human Lactation*. 30, 102-109

American College of Radiology, Committee on Drugs and Contrast Media. (2013). *Administration of Contrast Media to Breastfeeding Mothers, ACR Manual on Contrast Media, Version 8*. Retrieved from <http://www.acr.org/Quality-Safety/Resources/Contrast-Manual>

Centers for Disease Control and Prevention. (2015). *Breastfeeding Report Card – United States*. Retrieved from <http://www.cdc.gov/breastfeeding/data/reportcard.htm>

Centers for Disease Control and Prevention. (2015). Diseases and conditions: When should a mother avoid breastfeeding? Retrieved from <http://www.cdc.gov/breastfeeding/disease/>

Department of Maternal Child Health. (2015). Breastfeeding Statistics from the Electronic Medical Record. Cooper University Health Care, Camden, N.J.

Eidelman, A., Schanler, R., et al (2012). Policy statement: Breastfeeding and the use of human milk. *Pediatrics*. 129, e827 – e841. Doi: 10.1542/peds.2011-3552

Hale, T., (2014). *Medications and Mothers’ Milk*. Amarillo, Tx.: Hale Publishing.

Hale, T. (2007). Anesthetic and analgesic medications: Implications for breastfeeding. In Hale & Hartmann (Eds.) *Textbook of Human Lactation*. Amarillo, Tx: Hale Publishing

Hanson, L. (2007). The role of breastfeeding in the defense of he infant. In Hale and Hartman Hale & Hartmann (Eds.) *Textbook of Human Lactation*. Amarillo, Tx: Hale Publishing.

Human Milk Banking Association of North America. (2011). *Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes, and Child Care Settings*.© HMBANA. 3rd Edition.

Kendall-Tackett, K. (2014). Childbirth related posttraumatic stress disorder: Symptoms and impact on breastfeeding. *Clinical Lactation*. 5, 51 – 55

Lauwers, J., & Swisher, A. (2011). *Counseling the nursing mother: A lactation consultants guide (4th ed.)*. Sudbury, MA: Jones & Bartlett Publishing.

McAfee, G. (2007). Drugs of abuse and breastfeeding. In Hale & Hartmann (Eds.) *Textbook of Human Lactation*. (pp. 575 – 609). Amarillo, Tx: Hale Publishing.

Morton, J. (2015). Making more milk, the key to successful breastfeeding. Retrieved from <http://newborns.stanford.edu/Breastfeeding/HandExpression.html>

Sachs, H., et al. (2013). Transfer of drugs and therapeutics into human milk: an update on selected topics. *Pediatrics*. 132, e796 – e809.

# Patient Safety: Taking the Best Approach in Doing No Harm

Donna O'Shea, RN-BC, MSN

In healthcare organizations it is unfortunate that medication errors, wrong site surgery, falls, fractures and unanticipated deaths occur. Organizations may not always meet national averages; benchmarks identified and set by regulatory entities or those established by their independent organization. Often this is a result of competing priorities related to patient volume, productivity, finances, patient satisfaction initiatives and communication breakdown. The reality is that many of these incidents are preventable.

While such occurrences are not purposeful or deliberate in nature, the implication of what has occurred results in blame, untoward feelings and adverse outcomes. Health care providers often fear or believe negative consequences will result following the reporting of an occurrence.

This is in part due to the verbiage linked to these circumstances: mistake, incident report, retaliation, termination and so forth. In a 2013 survey conducted by the Institute for Safe

Medication Practices (ISMP), nearly 50% of the over 4800 respondents those of which included nurses, pharmacists, physicians and risk management staff indicated that negative, intimidating and disrespectful behaviors from co-workers affected how medication clarification questions were handled, or not, as to avoid confrontation (ISMP, 2013). In addition, only half of the respondents believed they would be supported by their organization if these behaviors were reported (ISMP, 2013). This mindset, even with promised anonymity, may lead to under-reporting and missed opportunities for process improvement.

Regulatory agencies partner with health care organizations to develop, implement, evaluate and foster a culture of safety for patients, visitors and healthcare providers. Adopting a proactive and open culture of safety is not only the right thing to do for patients, families and colleagues; it is a focal point for regulatory agencies including; The Joint Commission, Centers for Medicare and Medicaid Services, Department of Health, and Occupational Safety and Health Administration. The Joint Commission purports a model of trust where report and improve is essential in health care in order to provide a safe culture as an ongoing focus and review of systems, processes and outcomes supports quality care and safety (The Joint Commission, 2015).

In 2003, the Joint Commission developed National Patient Safety Goals (NPSG) to assist accredited organizations with identifying and addressing patient safety concerns. The 2015 NPSG include:

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers
- Improve the safety of using medications

- Reduce the risk of health care – associated infections
- Identify safety risks inherent in its patient population
- Utilize the Universal Protocol for preventing wrong site, wrong procedure and wrong person surgery
- Reduce the risk of patient harm resulting from falls
- Prevent health care-associated pressure ulcers

Developing and sustaining a complete culture of safety is prudent and feasible. One approach that promotes safety is changing the way organizations and its employees think, perceive and act regarding the structures, processes and outcomes designed and in place to ensure patient safety. Organizations that implore efforts to continually move toward a highly reliable, consistent

and safe culture use many methods to ensure safety including standards, policy development, safety councils/committees, staff/patient surveys, incident reporting, good catch reporting, intensive case

reviews, root cause analysis evaluations and partnering with a Patient Safety Organization.

Cooper University Health Care is committed to a goal of zero harm and encourages employees to notify the appropriate resources within the organization who are equipped to support and sustain a safe environment. A multidisciplinary patient safety team comprised of Risk Management, Regulatory and Patient Safety, Patient Relations and Quality and Operational Excellence recognizes success is achieved when every employee is part of the process. As safety advocates, the team promotes early identification and reporting of actual or potential threats to safety.

Venues are available to employees to inform the organization about actual events or opportunities including Cooper's Event and Activity Reporting System (EARS), the Compliance hotline (1-800-500-0333), the Quality and Patient Safety Committee and a variety of councils and committees where staff involvement is welcomed. In a health care organization with a fully functional safety culture, everyone in the organization is engaged. The shift from a passive to proactive approach will cultivate a process where safety, do no harm, and the good catch — an opportunity to thwart an event before it occurs — is natural and embraced. Challenges that impede an individual's ability to speak up when safety concerns are recognized must be eliminated. Developing a true culture of safety involves transforming people and processes. With each spoke of the safety wheel in place and functional, the journey toward a culture of safety is well underway.

Email comments to [O'Shea-Donna@cooperhealth.edu](mailto:O'Shea-Donna@cooperhealth.edu)

## References:

Institute for Safe Medication Practices (ISMP). *Intimidation Still a Problem in Hospital Workplace, ISMP Survey Shows*, October 3, 2013 [www.ismp.org](http://www.ismp.org)  
The Joint Commission (2015). *Comprehensive Accreditation Manual (CAMH)*.



# An Innovative Educational Plan to Improve Patient Outcomes during the Perioperative Experience at Cooper University Hospital

Kathleen M. Williams RN, MSN, CNOR

For the past few decades, the need for perioperative nurses has grown exponentially. The average age of an operating room (OR) nurse is 53 years old (Sederstrom, 2013). It is estimated that in the next five years, 20% of currently employed perioperative nurses will retire while the demand continues to increase (Messina, Ianniciello & Escallier, 2011). Therefore, perioperative nursing continues to be a highly needed specialty area of nursing expertise. Cooper University Hospital (CUH) is no exception to this trend. Over the past year, there has been an increase in the number of retirements, pregnancies, relocations and a projected physical expansion that will place an all-time high demand for perioperative nurses. CUH will be building five new operating rooms over the next 12-18 months, which will also increase our need for highly educated full time perioperative nurses. CUH had to develop a creative way to recruit perioperative nurses. By instituting an educational training program called "Periop 101", we will be able to meet the demands of staffing and plan for our ever changing future.

## Solution to Our Problem

Perioperative leaders struggle with creative efficient methods of recruiting, educating and retaining new nurses into the OR. The OR is often a foreign place to most nurses because nursing schools have eliminated perioperative didactic content and clinical experiences from their curriculums. "Although nursing students often accompany patients to the OR and stay to observe the

surgery, passive observation does not provide the student with an in-depth understanding of the role of the perioperative nurse" (Messina, Ianniciello, & Escallier, 2011, p. 180-181). This is detrimental to perioperative nursing, as a specialty, because it never showcases or exposes these areas. Therefore graduate nurses do not graduate from school planning to be OR nurses. The current solution is to entice seasoned nurses from other specialty areas or general nursing areas to make professional changes to the OR. This in itself is not an easy task because it requires extensive training and orientation. OR nursing is very different than any other area of nursing; therefore selection of candidates is vital because turnover is common. Training OR nurses creates a financial burden on the health care facility because orienting a nurse to the perioperative environment can cost upward from \$59,000 (D. Doyle, RN, MS, CNOR, NE-BC; in-person communication; December 12, 2013) (in Ball, Doyle, & Occumma, 2015, p. 116). The cost is not restricted to financial costs alone. Utilizing the current clinical staff to repeatedly train new perioperative students creates additional stress and potential burn out.

## Defining the Periop 101 Program

The perioperative environment is a difficult place for novice nurses to fit in, unless there is a concerted effort from both staff members and leaders to embrace the novice nurse's desire to learn (Wilson, 2012). Success is achievable through structured programs



and planning. Many institutions have instituted a perioperative training program called “Periop 101” which can be implemented several different ways. Through the use of a combination of video modules, PowerPoint presentations, and reading materials, a nurse learns the theory supporting perioperative nursing. In addition, there is usually a laboratory component, in which the student is able to practice skills learned in the classroom. The nurse educator is vital to the success of the Periop 101 program and ensures that the students are paired with effective preceptors who will advocate for them. The perioperative environment is full of surgeons, residents, medical students, physician assistants and product vendors all of whom can have strong personalities. This can be intimidating to Periop 101 students attempting to acclimate to a new environment. With a carefully planned and structured program, success is achievable because the students are afforded a learning environment that allows them to be exposed to every aspect of an OR in a systematic, logical plan.

Cooper University Hospital has undergone its own growth and changes. To meet the rapid expansion, we were forced to develop a creative way to fill our staffing needs. The author partook in a highly structured program from her previous place of employment called “Perioperative 101”.

### **Cooper's Periop 101 Student Selection**

The goal of CUH's Periop 101 course is to train, educate and prepare nurses who have been carefully selected to partake in the program. Finding appropriate registered nurses (RN's) for the Periop 101 course is not an easy task. The leadership team had to

assess each applicant, not only for clinical competence and desire to work in the perioperative area, but also the RN's social skills. Novice nurses entering the perioperative environment feel the effects of not being readily accepted into the social culture, perhaps because of their lack of perioperative knowledge (Wilson, 2012). A timid or shy RN may not be as successful as an outgoing or boisterous RN, as they may not fit this type of environment well, and selection is key. The author, in collaboration with the clinical director of the OR, carefully selected 4 nurses from all of the applicants that displayed the qualities necessary for success in the CUH operating room. For the first pilot, only experienced nurses and those who were currently employed by CUH were considered for the course. For the next cohort, new graduates and nurses who do not work for CUH will be considered.

### **Didactic Training**

The CUH Periop 101 program was carefully developed to include the model of hiring the RN into a permanent staff position, which is a fully paid experience. This model is different from the author's previous place of employment, therefore a great deal of the curriculum and schedules needed revision. After rewriting the curriculum and schedules, the Periop 101 program was implemented over a total of one year. Prior to starting in the operating room, the students rotate through the Central Sterile Supply department. The philosophy behind going to this department is for learning to assemble the surgical instrument sets. This gives the students an opportunity to learn the different surgical sets and instruments, and also to learn the work flow of



Cooper University Hospital has undergone its own growth and changes. To meet the rapid expansion, we were forced to develop a creative way to fill our staffing needs.



the central supply area. In addition, this provides a name to a face of the central supply staff so when the new perioperative nurses call down for an item; they know to whom they are speaking. The perioperative students are scheduled to spend four weeks in Central Supply. The first six months of Periop 101 includes a didactic element in which lectures are delivered to the students one day per week. The lectures give the students the theory, historical perspective, evidence and rationale for why they do what they do in the OR. Instead of just placing them in an OR and assigning tasks, the student can understand why the task is

CUH has proactively planned for its growing future. By implementing a solid, organized and evidence-based perioperative educational program, the goal and intent is to train, educate and retain high-performing OR nurses.



performed. In addition to the lectures, the students were required to write papers on pertinent topics which encouraged them to research perioperative topics and review current literature and trends. Lastly, as a learning assessment tool, the author administered a midterm examination and final examination to gauge the students' comprehension of information delivered.

### Clinical Training

On days not in lecture, the students are in the clinical setting with a preceptor learning each specialty area of perioperative nursing. After the first six months is complete, the students transition to a full-time RN orientation to each surgical specialty. They will formally rotate through each specialty area for three weeks, including a rotation to night shift. This is more intensive than a general orientation for a regular RN staff position. "When new nurses feel encouraged and supported, and do not feel abandoned or set up to fail, they will persevere through struggles, obstacles, mistakes, and fears and become more self-sufficient" (Morgenthaler, 2008, p.99). This orientation process is extensive to ensure our Periop 101 nurses are fully supported and have the requisite knowledge needed to fully succeed in a high paced environment. The author historically has noticed that turnover happens when perioperative nurses are not fully trained and supported. CUH's goal is to retain our Periop 101 nurses, not only after the initial training is complete but for many years to come.

### Conclusion

Although the current national trend looks dismal for OR nurses (as a whole), CUH has proactively planned for its growing future. By implementing a solid, organized and evidence-based perioperative educational program, the goal and intent is to train, educate and retain high-performing OR nurses. The Cooper leaders, in conjunction with the current literature and trends, created the best curriculum to meet the needs of CUH while recognizing varied learning styles of individual students. The end product is CUH's Periop 101 program. The pilot cohort is currently in progress and thus far has been a success. The next class of approximately eight students is scheduled to start in September, and the goal for this class is to include a larger number of students and allow new graduates to partake as well. Periop 101 has truly helped prepare us for the future growth and expansion of Cooper University Hospital's operating rooms. As we look to the future and build bigger and better operating rooms, we strive to live the mission of one team, one purpose.

Email comments to [williams-kathleen1@CooperHealth.edu](mailto:williams-kathleen1@CooperHealth.edu)

### References:

- Ball, K., Doyle, D., & Oocumma, N.I. (2015). Nursing shortages in the OR: Solutions for new models of education. *AORN Journal*, 101(1), 115-136.
- Messina, B.A.M., Ianniciello, J.M., & Escallier, L.A. (2011). Opening the doors to the OR: Providing students with perioperative clinical experiences. *AORN Journal*, 94(2), 180-188.
- Morgenthaler, L. (2008). Leaving the nest and joining the flock: OR residency programs and team mentoring. *AORN Journal*, 88(1), 97-101.
- Sederstrom, J. (2013). 7 specialties lead demand for nurses. *Healthcare Traveler*. Retrieved from <http://healthcaretraveler.modernmedicine.com/healthcare-traveler/content/tags/american-association-critical-care-nurses/7-specialties-lead-demand?page=full>
- Wilson, G. (2012). Redesigning OR orientation. *AORN Journal*, 95(4), 453-462.



# Direct Care Nurses and Their Experiences in Caring for Patients Enrolled in Clinical Research

Jonelle O'Shea, RN, MSN; Jacqueline Bockarie, RN; Roslyn, Moses, RN; Kevin O'Brien, RN; Lindsay Ott, RN; Dominic Parone, RN; Linda Smith, RN; Mary Stauss, RN, MSN; Nora Vizzachero, DNP, APN; Rosemarie White, RN; Mary Francis, PhD, APN; Margot Wallace, RN; Jane Greene-Ryan, PhD, CNM

## Purpose:

Nurses are responsible for many aspects of their patients' bedside care, including those related to research protocols. Little has been published examining the role of the hospital nurse in caring for research subjects. The purpose of this study was to determine what information is given to nurses who are caring for patients in a clinical research study and what information nurses would like to receive. Our hypothesis was nurses desire more information than they receive when participating in patient research.

## Methods:

An invitation to an electronic anonymous 12 item survey was e-mailed to 1050 nurses in a 500 bed urban Level I trauma center for this IRB approved exempt study. Study inclusion criteria were: 1 year experience as an RN, current practice as a direct care staff nurse, and must remember recently caring for patient in a clinical research study at this hospital. Informed consent was implied by response to the survey. Emails, flyers and verbal encouragement were used for recruitment.

## Results:

Sixty five nurses started the survey (6% response rate) and 45 completed the survey in its entirety. Nursing units with the highest response rate were; Medical/Surgical (n=12), Critical Care (n=10), ED/Urgent Care (n= 9), Outpatient/Other (n=8). Of the respondents, 93% felt it was very important or important to be informed about the research study in which their patients are enrolled. When caring for a research subject, 31% of nurses felt

very prepared or prepared, 37% somewhat prepared, and 31% somewhat unprepared or very unprepared. Nurses chose up to 5 ways they were informed from a list of 16 options. The top four responses were: Research Nurse/Coordinator (67%), Nurse Handoff Report (40%), Primary Investigator (20%), and Attending Physician (20%). Nurses chose up to 5 ways they preferred to be informed. The top responses were: Research Coordinator (51%), In-Service (49%), and Nurse Handoff Report (40%). No statistical significance was found in comparing preference or methods of becoming informed vs. years of experience or type of nursing unit. Comparing preferences vs. methods of informed revealed significant differences in In-service ( $p<0.001$ ), Study Summary Sheet ( $p=0.001$ ), Resident/Fellow ( $p=0.003$ ), Nurse Handoff Report ( $p=0.006$ ), Info in EMR ( $p=0.021$ ) and PI ( $p=0.039$ ) with all significant methods having a higher preference than ways the nurse was informed.

## Conclusion:

The methods in which nurses prefer to be informed are similar across units well represented in the study. Research Coordinator was selected most often in both preference and method of information. When looking at preference vs method of information ( $p=0.302$ ) it is not significant which means nurses are getting and desire information from the Research Coordinator. Our study confirms that nurses desire more information than they receive about their patients which are enrolled in clinical research.

Email comments to [O'Shea-jonelle@cooperhealth.edu](mailto:O'Shea-jonelle@cooperhealth.edu)





# A Celebration of Life

Sue Butler, RN, BSN, CPN, CCRN

Our first Pediatric Trauma Celebration of Life Task Force came together on July 25, 2014. In just 6 meetings, and in over 2 months, our hard working, multidisciplinary, dynamic task force was able to carry out our 1st annual Celebration of Life Picnic at the Camden Adventure Aquarium on Saturday, 20 September 2014 for pediatric trauma survivors and their families.

Here they come. 11 year old T. walked in smiling with his family. I immediately wrapped my arms around him. He looked amazing. He had sustained a traumatic brain injury after a fall at school and spent about 2 weeks at Cooper. His mom said, "We call him our Christmas miracle." Five year old A. came running in with his family, wearing his Captain America costume. He was still in outpatient rehab and is now able to run and talk after his accident. Fourteen year old S. who sustained a splenic laceration from a longboard accident, came in smiling, showing me his dimples. We talked about his love for riding his long board and surfing. Eight year old T. is an inspiration to us all. She was involved in a terrible car accident; in a coma, with severe head injuries. She spent many weeks in the PICU before heading to rehab. After several months of rehab, T. arrived in a wheelchair smiling, talking, and even took a few steps. Hugs were exchanged and stories were shared.

This is the best medicine any PICU nurse, physician or medical staff could ask for; watching these now healthy children running around, playing, looking at the fish in the shark tank, joining in at the hands-on table, eating and exploring the Aquarium. During lunch, we raffled off several gift baskets.

Eleven year old T. drew the first raffle ticket, and it happened to be his own name, for the one basket he was hoping to win. We couldn't believe it! T. was beaming ear to ear as he claimed his winning basket. Dad came

up to me afterwards, and told me with tears in his eyes how grateful he was to me and Cooper for giving him his son back.

Now this is when I almost lost it. None of T's successes, as with all our other pediatric trauma survivors, could have happened without



his parents' perseverance, determination, love and strength. I will always be truly grateful to them and all the other parents for entrusting me to take care of their precious child.

I have been a PICU nurse at Cooper for the last 18 years, caring for a variety of sick pediatric trauma patients from the ages of 1 day to 18 years old. These children have a variety of traumatic injuries resulting from near drownings, falls, motor vehicle crashes, bike accidents, gunshot wounds, stabbings and hangings. Frequently, this is the first hospitalization for these pediatric patients. The families are distraught and worried and often in shock because their lives have changed in a split second. Now their child is extremely ill with medical staff performing life-saving care; often doing all this quickly to stabilize their child before giving the family much information. Parents now have to entrust their child to us, strangers to them. Bonds are formed and we become partners in caring for their child. While in the PICU, we address their needs, communicate, educate, collaborate their plan of care and give them both emotional and physical support. We have become their hospital family.

The Pediatric Trauma Survivor Task Force met again in October 2014 to debrief. Based on the success of our first efforts, we unanimously agreed that this event was a huge success and we decided to make this a yearly event.

It's amazing how quickly time flies. We were back at the Camden Aquarium for our Second annual Cooper "Celebration of Life" reunion on Saturday, September 19, 2015. Almost 200 former pediatric trauma patients and families and over thirty of our Cooper trauma and pediatric physicians, nurses, and staff were in attendance. This year we played a very special song, "My fight song" for our pediatric survivors and their families. It said a lot of what we all were feeling that day (staff and families alike) as we looked around the room at all our trauma survivors – they made it! They stayed strong, hit all challenges head on, and made great strides in their recovery.

Another special moment for me occurred when raffling off our last gift basket. I looked over at the 11 year old T. who won the first basket at our 1st event. I saw him standing next to his parents and sister holding his ticket tightly in one hand looking intensely at our last basket. The last ticket was pulled. Yes! It was his ticket. Everyone laughed and cheered as this young man threw his arms up in the air with a big "yes" and proudly went up to claim his winnings. These moments and more remind me of a quote – "When you're a nurse, you know that you will touch a life and a life will touch yours."

[Special Thank you to all of the Task Force Members: Stacey Staman, Nicole Fox, Lori Lodge, Mary LaChant, Patricia Tomlinson, Dave Groves, Rhonda Wexler, Amanda Bednar, Sue Butler, Kasey Massa, Marina Dvortsyn, Adele McCloskey, Greg Staman, Brittany Spaeth, Sherry Schlagle, Joan Madara, Gina Brouster]



## Professional News

### DEGREES:

**Carmen McDonald, RN, PhD, MSN, AHN-BC, NEA-BC**, earned a PhD in Healthcare Administration from Walden University, October 2015.

**Denise Urevick, RN, BSN**, received her BSN from Rowan and graduated summa cum laude.

**Gina Brouster, RN, BSN**, earned her BSN from Rowan University and graduated summa cum laude.

**Janet L. Ulrich, RN, BSN, CBC, CPST**, received her BSN from Rowan University.

**Dana Franklin, RN, MSN**, graduated with an MSN in Clinical Nurse Leadership from Rutgers University.

**Megan Bianchini, RN, MSN, FNP**, graduated from Rutgers Camden in May with a MSN.

**Okon Bassey, RRT, BSc, MHA**, earned a Master's Degree in Health Care Administration from Independence University, Utah.

**Stacey Weber, RN, MSN**, graduated from Rutgers University with a MSN.

**Dorothy Burke, RN, BSN**, received her BSN from Rowan University

**Brittany Butler, RN, BSN**, graduated from Widener University with a BSN.

**Julia Viner Tenthoff, RN, MSN**, graduated with her masters in Pediatric Nursing from the University of Pennsylvania.

**Marie Eagan, RN, BSN**, graduated from University of Phoenix with her BSN.

### CERTIFICATIONS:

**Dianne Hyman, RN, MSN, OCN, CN-BN**, passed the certification exam for Certified Navigator – Breast Nurse

**Rebecca Johnson, RN, BSN, CEN**, passed the certification in emergency nursing exam.

**Miranda Peurala, RN, BSN, CBC, IBCLC**, passed the boards for International Board Certified Lactation Consultant.

**Jessica Soto, RN, BSN, PHRN**, recently obtained her PHRN certification

**Steve Teitelman, RN, TCRN**, recently obtained certification in Trauma Nursing

**Megan Bianchini, RN, MSN, FNP**, became ANCC certified as a Family Nurse Practitioner in September.

**Elizabeth Lee, RN, CNI Nurse Coordinator** – Department of Neurosurgery is now a certified provider and instructor in ASLS (Advanced Stroke Life Support).

**Janet Zerno, RN, CNOR**, received her CNOR certification

**Diane L. Miller, RN, BSN, RNC**, achieved the certification in Maternal Newborn Nursing

**Marc Cucetta, RN, CEN, Michael Piotti, RN, BSN, CEN, Kathleen Koestler, RN, BSN, CEN**, passed the certification in emergency nursing exam

### PRESENTATIONS:

**Carmen McDonald, RN, PhD, MSN, AHN-BC, NEA-BC**, and **Lucy Suokhrie, MSHCA, BSN, RN-BC**, presented "Improving the Patient Care Experience Through Nurse Navigation" at the ANAC Conference in Chicago, Ill. on October 30, 2015.

**Janice Delgiorno, RN, MSN, CCRN, ACNP-BC**, and **Elizabeth Lee, RN**, presented Case Studies in Spine Trauma at the Trends in Critical Care Nursing Conference in Philadelphia, PA in October.

**Janice Delgiorno, RN, MSN, CCRN, ACNP-BC**, presented Dancing With Death: Designer and Club Drugs; Challenges in Managing the Geriatric Trauma Patient; Complications of Blood Transfusions in the ICU; Battlefield to Trauma Center: New Advances in Trauma Resuscitation at the Trends in Critical Care Conference in Philadelphia, PA.

**Jonelle O'Shea, RN, MSN**, Clinical Research Coordinator presented 2 posters at the Society of Clinical Research Associates (SOCRA) 24th Annual Conference in Denver CO: "Implementation strategies to improve the healthcare team's experiences and knowledge in caring for subjects enrolled in clinical research" and "Direct Care Nurses and Their Experiences in Caring for Patients Enrolled in Clinical Research".

**Sue Butler, RN, BSN, CPN, CCRN** presented a poster "Anchoring a Pediatric IV: A Comparative Study of Peripheral IV Securement Devices in Pediatric Patients ages 2 months through 36 months old" at the 2nd Annual Camden Scholars' Forum.

**Sue Butler, RN, BSN, CPN, CCRN** gave oral presentation on "Anchoring a Pediatric IV: A Comparative Study of Peripheral IV Securement Devices in Pediatric Patients ages 2 months through 36 months old"

**Stacey Staman, RN, MSN, CCRN** and **Dr. Nicole Fox** presented a poster "The path to verification as a Level II pediatric trauma center leads to improved patient care" at the 2nd Annual Pediatric Trauma Society Meeting in Scottsdale, AZ in November.

### AWARDS:

**Jennifer Glendening, RN, MSN, CMSRN, RN-BC, CPHQ** – March of Dimes Nurse of the Year for Infection Control & Quality / Risk Management Award.

Congratulations to all of the finalists: **Keith Kline, RN, Angela Spinelli, RN, Adam Thaler, RN, Valerie Gibson, RN, Lynette Jones, RN, Sharon McLean, RN, Laura Profico, RN**, and **Agnes Asamoah, RN**.