



Cooper Bridges

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Baby Friendly Designation:
*A Collaborative
Journey*

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From the Interim Chief Nursing Officer

Gina Marone RN, MSN, NEA-BC

Interim Chief Nursing Officer, Patient Care Services

The foundation of the patient experience is dependent on the culture of the organization. Every employee's beliefs and actions influence and determine the culture. Caregivers comprise a significant workforce who plays an integral role in the patient experience. Nursing care specifically has been identified as one of the most influential and critical components of the patient's positive or negative experience. Nurses are uniquely positioned to develop a special bond with patients which translates to an emotional and compassionate experience for patients and their families.

Nurse communication is also an important component of the patient experience. Hourly rounds are an evidence based method to improve communication and strengthen the nurse patient bond. This interaction provides a purposeful way to ensure that caregivers are attentive while they monitor patient safety, address pain management and deliver basic care. In addition, purposeful hourly rounds have been shown to reduce patient falls and diminish the use of call lights.

As Cooper continues towards achieving a culture of service, I believe each caregiver holds the keys to drive the change to excellence in the patient experience. I hope you are inspired to make a difference with your patients as we hold each other accountable to meet this challenge. I continue to be proud of the great work demonstrated by Cooper staff and look forward to combined efforts to achieve our goals.

Regards,

A handwritten signature in black ink that reads "Gina".

Gina Marone

Email comments to marone-gina@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:

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Baby Friendly Designation: A Collaborative Journey

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The Baby Friendly Hospital Initiative (BFHI) is a global program established in 1991 by the United Nations Children's Fund (UNICEF) and the World Health Organization that recognizes hospitals and birthing centers for their level of care related to infant feeding and supports the National Healthy People 2020 objective of increasing the proportion of mothers who breastfeed their infants (www.healthypeople.gov/2020, 2012). The BFHI encompasses the Ten Steps to Successful Breastfeeding (Table 1) and has been adopted by over 170 countries and 20,000 hospitals and birthing centers. Understanding the overwhelming evidence supporting breastfeeding as a powerful preventive strategy that reduces many common causes of infant morbidity as well as providing health benefits to the mother (Table 2), Cooper University Health Care decided to pursue the Baby Friendly Hospital Designation utilizing their "4-D" pathway. Even with this evidence, the reality is that the initiation, duration and exclusivity of breastfeeding, particularly among our most vulnerable populations of low income and African American women, lags behind our national objective (Ryan, Zhou, & Gaston, 2004).

The 4 Ds

A "4-D" pathway guides a facility toward the Baby Friendly Hospital designation. In the Discovery phase, a facility engages in a process to understand the benefits and requirements for qualifying for the BFHI. The Development phase allows a facility to devise a plan that moves them toward this designation. The Dissemination phase enables a facility to roll out the plan, and the Designation phase includes the final site visit, review and awarding of Baby Friendly status. Hospitals that are designated "Baby Friendly" empower mothers with education, confidence and skills needed to successfully initiate and continue breastfeeding or safely feed formula (www.babyfriendlyusa.org, 2012). Cooper University Health Care has been in the process of implementing the necessary system changes for achieving the Baby Friendly Hospital designation for the last two years.

Discovery Phase

The Maternal Child Health (MCH) Division of Cooper University Health Care recognized a need to improve support of mothers choosing to breastfeed as 2010 statistics from the





Department of Maternal and Child Health demonstrated rates of 40% for the initiation of any breastfeeding and 28% for exclusive breastfeeding (Department of Maternal Child Health, 2010). A gap analysis, utilizing a multidisciplinary team of nurses and physicians, assessed our current level of practice and made recommendations to enhance mother and infant care practices and infant feeding for the patients we serve. This includes the community of Camden and its vulnerable population of mothers and infants represented by 33% poverty and 16% infant mortality rate (www.state.nj.us/health/chs/dataindex.htm). The gap analysis determined deficits in several areas including staff education and collaboration, skin to skin contact immediately after birth, rooming-in and supplementation of breastfed infants. An interdisciplinary

team representing our Lactation Program, Administration, Human Resources, Marketing, Information Technology (IT), Patient Relations and Nurses and Physicians from Labor and Delivery, Obstetrics, Newborn ICU and Pediatrics formed and meets monthly. This interdisciplinary team is committed to the promotion and development of family-centered care through use of documented evidence which supports closing the gaps from our initial analysis as well as informed choices related to infant nutrition including breastfeeding as the nutrition of choice for all newborns.

Development Phase

It was with the intent to obtain the Baby Friendly Hospital Designation that a corporate policy, as well as Patient Care Service policy and procedure, was developed to assure that our project had a singular direction when it came to informed choices regarding optimal infant nutrition. We utilized internal marketing strategies such as informal education at unit-based and hospital-based staff meetings, education during orientation and fliers to inform the organization of our plan, and provide education on the importance of incorporating the BFHI as a means of providing care that lends toward optimal infant feeding outcomes and patient satisfaction.

After policies were established, the group focused on a formal education process for staff including the physicians. Breastfeeding education has always been part of nursing orientation and professional development in the MCH setting. However, we identified a need to incorporate multidisciplinary didactic education and simulation for all inpatient and outpatient MCH staff to enable them to understand the skills and management of lactation based on their job description and level of expertise. Required didactic education was completed by all MCH staff and in addition, a four hour simulation experience was provided on five occasions to over 250 participants including physicians, nurses, administrators and technical staff. This experience fostered interdisciplinary collaboration, and allowed staff to understand each other's role when supporting women before, during and after the delivery of their baby.

TABLE 1 Ten Steps to Successful Breastfeeding

Step 1: Have a written breastfeeding policy that is routinely communicated to all health care staff
Step 2: Train all health care staff in the skills necessary to implement this policy
Step 3: Inform all pregnant women about the benefits and management of breastfeeding
Step 4: Help mothers initiate breastfeeding within one hour of birth. Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breast-feed, offering help if needed. This step applies to all babies, regardless of feeding method
Step 5: Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants
Step 6: Give infants no food or drink other than breast milk unless medically indicated
Step 7: Practice rooming-in, allow mothers and infants to remain together 24 hours a day. This step applies to all babies, regardless of feeding method
Step 8: Encourage breastfeeding on "cue." This step applies to all babies, regardless of feeding method.
Step 9: Give no pacifiers or artificial nipples to breastfeeding infants
Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center

TABLE 2 Benefits of Breastfeeding

BABY	MOTHER
Enhances maturation of GI tract	Stimulation of oxytocin
Protects against GI problems such as infantile diarrhea and NEC	Decreases in risk for breast Ca
Provides protective antibodies	Decreases in risk for ovarian Ca
Gives cell mediated immunological factors	Increased metabolism with a decrease chance of Adult Type II DM
Decrease in atopic disease such as eczema	Assists with bone density lessening chances of osteoporosis later in life
Some protective benefits against childhood cancers	Increase in metabolism that may assist with post partum weight loss
Decreases chances of Type II DM	Improved bonding
Healthier jaw development	Convenience and money saving
Decrease in childhood obesity	
Analgesic effects	
Stimulates peristalsis	

Five simulation stations were created and included breast milk expression and storage, skin to skin contact after delivery, mother infant coupling and breastfeeding challenges. The skin to skin component utilized two stations, the first in which staff discussed the process of skin to skin contact after delivery and the second where they viewed a video entitled “Skin to Skin in the First Hour after Birth.” The visuals of this film beautifully displayed an infant moving naturally through various transitional stages after birth, initiating breastfeeding and then peacefully falling asleep. For staff who did not regularly attend deliveries, this video was a powerful learning tool, and for staff that did, it provided reinforcement of the evidence related to infant transition from intrauterine to extrauterine life. The third station on mother infant coupling reviewed rooming-in, admission to the mother infant unit, supplementation and pacifier use. The fourth station on breast milk expression and storage reviewed all equipment, supplies and educational tools related to hand expression, use of manual and electric breast pumps and the storing, thawing, preparation, handling and use of mothers’ milk. The final station on breastfeeding challenges after delivery allowed staff to collaborate on common issues such as engorgement, sore nipples and mastitis. This provided each staff member with a deeper understanding on the importance of education, as well as inpatient and outpatient support in creating optimal outcomes related to breastfeeding. Participants had hands-on experience with all equipment and supplies that facilitated breastfeeding and breast milk expression allowing for interactive discussion and education in a comfortable and confidential setting. The evaluations were extremely positive and all staff appreciated the hands-on simulation as a more valuable learning experience as opposed to a classroom lecture.

Dissemination Phase

One major challenge was establishing continuity of care for the new family beginning prenatally through discharge. Recognizing that there isn’t a uniform education approach in the prenatal offices, standardized teaching sheets were developed on the benefits of breastfeeding, skin to skin after delivery, management and skills related to breastfeeding as well as safe handling and preparation of formula. Teaching sheets are presented to expectant mothers during each prenatal visit beginning around 28 weeks gestation.

Labor and Delivery nurses now facilitate skin to skin after delivery with more than 60% of our patients utilizing the mother as the locus of care rather than their traditional practice of using the warmer bed. Admissions and assessments integrated with rooming-in are now done with more than 75% of our postpartum patients and demonstrate positive practice changes by all physicians, nurses and technical staff. Our newborn nursery is now called the Newborn Observation Unit being used most often when an infant had a medical problem or emergency. Our pediatricians have equipment carts and lighting to perform assessments in mothers’ rooms, and staff now has discussions with parents on the benefits of rooming in, infant care and feeding. Newborn Intensive Care staff, understanding the benefits of breast milk including the high yield of antibodies during the first two to five days, now encourages the expression of colostrum for oral care even when an infant is not being fed.

Initiation of any breastfeeding and exclusive breastfeeding has risen dramatically and are now at 65% and 40% respectively (Department of Maternal Child Health, 2013). Further quality indicators including staff and patient interviews are providing the Baby Friendly Steering committee with data that will assist all units in preparation for the final site visit and designation process.

The Baby Friendly Steering committee has also assisted 54 nurses in becoming certified as Breastfeeding Counselors. This group of nurses who work throughout our MCH units will not only assist patients, but also support staff that may need additional information or collaboration when working with breastfeeding mothers. This team of nurses will also work as a unit-based committee to continue improving practice related to breastfeeding.

Our team has not only addressed education and support of mother/infant dyads who are breastfeeding, but also hospital staff through the development and opening of our Employee Lactation Lounge sponsored by a grant from the Cooper Foundation. This new employee benefit has helped to assure the direction of our organization in supporting breastfeeding as the optimal nutrition source for infants.

Designation Phase

As we begin 2013, the BFHI committee looks forward to the Designation Phase by facilitating a site visit in the fourth quarter, and continuing to improve care and practices that revolve around infant feeding. We continue to look at practices that facilitate informed choices by recognizing the MCH staff’s participation and improvement in using evidence-based research that enhances care related to infant feeding and improves patient outcomes and satisfaction. The commitment to patient care and satisfaction is always our primary goal. The BFHI has allowed us the opportunity to enhance that commitment. The ability to improve the lives of our patients and the communities in which they reside is important when considering the benefits of breastfeeding and the use of breast milk. Providing optimal outcomes for some of our most vulnerable populations of patients has given us the opportunity to foster relationships that will allow patients to adopt Cooper University Health Care as the care provider of choice for all their health care needs.

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Improving the Patient Care Experience through Nurse Navigation



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The nurse navigator (NN) role has evolved from its origin in oncology to the primary care setting for the Human Immunodeficiency Virus (HIV) infected patient. The strong correlation between health care disparities and those with HIV disease has been the root cause of barriers to care for the patients in need of multiple services for their co-occurring disorders (Bradford, Coleman, and Cunningham, 2007). Continuity of care is not a new concept and the need for navigation through the health care continuum has been instrumental in the creation of the concept of the nurse navigator. According to Shockney (2010), the nurse navigator originated from the nursing case management model that kept patients accurately on track with clinical pathways.

Role of the HIV Nurse Navigator

In this emerging patient care model within HIV care, the nurse navigator assists HIV patients beginning with the needs assessment. From a holistic perspective, a determination of the patient's previous health care experiences and their current knowledge of their diagnosis and treatment plan provide the theoretical framework for the journey (Brown, 2012). The professional registered nurse guides the HIV patient through better use of resources, effective communication with providers and the complexity of the multidisciplinary team for the best possible outcomes and treatment adherence (Bradford, et al, 2007). The newly diagnosed HIV patient experiences significant anxiety and stress. For most people, this overwhelming experience can become incapacitating. The NN is able to reduce anxiety through communication, support, education, identification of service resources and facilitation. Creation of the patient navigation program accomplishes most of these needs in the following ways:

- *Determination of potential barriers to delivery of cost-effective and high quality care*
- *Immediate access to provider and services*
- *Provide information and treatment options*
- *Re-engagement of patients out of care greater than 12 months*
- *Treatment adherence and prevention*
- *Partner testing services*

The ultimate goal of navigation is removal of potential barriers such as communication, psycho-social dilemmas, fiscal and any other logistics which can disrupt the continuum of care (Retkin, Antoniadis, Pepitone and Duval, 2013). The success of the NN concept is the provision of support and advocacy from diagnosis to survivorship by providing education, guidance and reassurance (Wilcox & Bruce, 2010).

HIV Treatment Adherence

The difference between long term survival versus illness and death of the HIV infected or Acquired Immune Deficiency Syndrome (AIDS) patient undoubtedly is determined by compliance

with the treatment plan. Chronic AIDS patients who have remained well with limited or no complications from the disease report compliance with the treatment regime determined by their health care provider. Earvin "Magic" Johnson publically speaks about how he has remained strong and feeling well, since the shocking announcement in 1991 of his positive HIV status, because of his committed adherence to his treatment protocol. In the report of their research study, Bradford, et al (2007) was able to illustrate how the conceptual framework for adaptation of a patient navigation process has made a significantly positive influence on engagement and retention in HIV primary care.

Communication with Nurses

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) have been instrumental in creating the environment of accountability and transparency in healthcare. Further, within the contents of the HCAHPS survey is an illustration of patient's perceptions of their care delivery. The NN has a direct impact on the "communication with nurses" domain of the HCAHPS survey since they keep the patient continuously informed and interact with them during their personal journey. Patients feel a remarkable sense of security and contentment along with validation that the nurse is knowledgeable and competent (Robinson & Watters, 2010). The NN is instrumental in the development of the trusting bond between patient and nurse which is arguably a staple and unique to nursing compared to other health care professions.

Cooper University Health Care's Early Intervention Program (EIP) has a NN that is available to newly identified HIV patients or HIV patients lost to care Monday through Friday 9am to 5pm. Cooper's EIP is a state and federally funded practice located at Three Cooper Plaza in Camden New Jersey. The mission of EIP is to improve the health and well-being of those infected/affected with HIV through high quality medical care and support services, community education and early detection regardless of ability to pay. The NN is an exceptional addition to this well-established program and the model was commended by the Centers for Disease Control and the New Jersey State Department of Health.

Case Study

Jane Doe is a 27 year old female with a history of commercial sex worker and polysubstance abuse. She presented to the emergency department with sore throat, fevers and leukopenia. The presentation and history of this patient was concerning for acute HIV infection, despite frequent negative HIV antibody testing in the past. On this visit, the HIV antibody screening was non-reactive. HIV viral load performed revealed over 500,000 copies/ml indicating acute HIV infection. A general rule is the higher the viral load, the more contagious an HIV patient is and consequently is a public health hazard.

(continued on page 13)



A Culture of Always: Venous Thromboembolism (VTE) – An Important Patient Safety Issue

Maryann Powell, RN, MSN; Julie Smith, RN, BA, CCM

A professional nurse's concern is to provide excellent and safe care for patients while they are hospitalized. Venous thromboembolism (VTE) is not a new concern, but it is one that healthcare providers are trying to concentrate on much more closely. Evidence found in several patient studies, multiple clinical outcome trials and clearly defined evidence-based standards of care built on scientific data and research studies are available to guide current nursing practice (Cohen et al., 2008 & Heit et al., 2000). At Cooper University Hospital (CUH) nursing's goal is to develop and maintain a culture where every nurse takes responsibility for their actions also known as "a culture of always" related to VTE prophylaxis.

VTE is a term that refers to the occlusion (either occlusive or non-occlusive) of a vein by a blood clot that has become dislodged from its original site and has traveled through the blood stream to another location within the body. VTE can manifest as a deep vein thrombosis (DVT) or even a pulmonary embolism (PE); both are exceedingly dangerous to the patient and can cause significant morbidity or even mortality. VTE is a contributory factor in up to 15% of all in-hospital deaths (Dente, 2013). Prophylactic, timely, therapeutic and consistent anticoagulation therapy reduces the incidence of VTE by approximately 50% in acutely ill patients based on findings from multiple research studies and reports

(Amin, 2010; Cohen, 2008; Dharmajaran, 2012; Goldhaber, 2004; Guyatt, 2012; Heit, et al, 2000; 2008; Kakkar, 2010; Kirwan, 2003; Schleyer, 2011; Shojania, 2001; Tapson, 2005; & Tooher, 2005).

Incidence

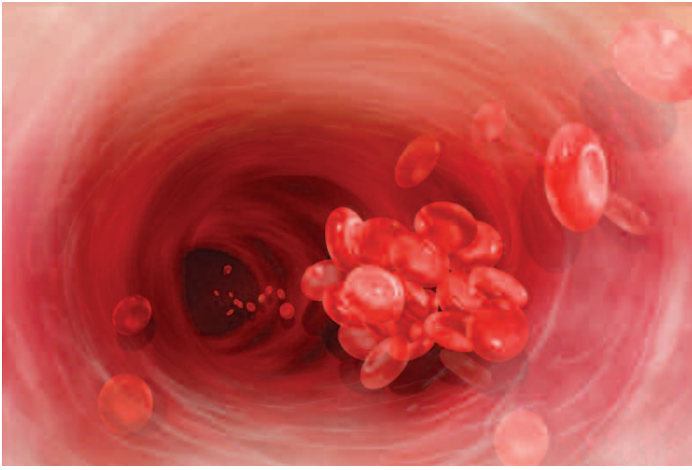
The estimated annual incidence of DVT and PE in the United States, collectively identified as VTE, is approximately 900,000 (Heit, 2008). Two of three identified cases of DVT or PE are associated with recent hospitalization and the immobilization of bed rest, something nurses are familiar with and have some degree of control over. The result of VTE can cause long term disability, chronic ill health and mortality and has been responsible for approximately 300,000 deaths each year in hospitals throughout the United States (Anderson, 2007). The consequences of not preventing VTE are multifold. The presence of a DVT can result in a PE, which can ultimately prove fatal for the patient (Geerts, 2008). PE is still considered by many healthcare providers and researchers as a primary preventable cause of a hospital death (Trujillo, 2010).

Evidence-Based Order Sets

Based on the prevalence and severity of clinical outcomes, a VTE measure set has been developed by the Agency for Healthcare



The primary goal of VTE prophylaxis is to promote both medical and life style changes in order to decrease the risk of VTE for those considered as high-risk patients.



Research and Quality (2001) and further delineated by the National Quality Forum (NQF) (2006) for evaluative use by hospitals throughout the US. The measure set (Core Measure) assesses the volume of patients who actually receive a medically defined VTE prophylaxis or who have a clear cut documentation as to why no VTE prophylaxis was administered/applied (contraindication) on the day of or the day after a hospital admission or on a surgical end date for surgeries that are done on the day of or the day after admission to the hospital. The most current VTE Core Measure Set includes the following:

- VTE-1 Venous thromboembolism prophylaxis
- VTE-2 Intensive Care Unit venous thromboembolism prophylaxis
- VTE-3 Venous thromboembolism patients with anticoagulation overlap therapy
- VTE-4 Venous thromboembolism patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol or nomogram.
- VTE-5 Venous thromboembolism warfarin therapy discharge instructions
- VTE-6 Hospital acquired potentially preventable venous thromboembolism

Therapies

Examples of evidence-based and accepted VTE prophylaxis include: enoxaparin (Lovenox), unfractionated heparin, fondaparinux, warfarin, graduated compression stockings, intermittent pneumatic compression stockings. Aspirin, considered by some providers as an option when anticoagulants cannot be used, is considered ineffective for VTE prophylaxis (Glynn, 2007). Most VTE prophylactic therapies are active until discharge from the hospital setting. Some therapies are carried over to the post-discharge period based on the risk assessment, morbidity and medical history of the patient (Michota, 2004).

Risk Factors

The identified risk factors for developing VTE include extended immobilization, age >60 years, malignancy (especially pancreatic, liver, kidney, stomach and ovarian), cancer therapy, trauma, obesity (BMI >30), recent major surgery (especially CABG, urologic surgery, neurosurgery, and orthopedic surgery), pregnancy, use of oral

contraception, hormone replacement therapy (HRT), cardiac or respiratory failure, smoking, central venous catheterization, hyper-viscosity (e.g., sickle cell disease, polycythemia), acquired thrombophilias (antiphospholipid syndrome, hyperhomocysteinemia) and inherited thrombophilias (e.g., factor V Leiden, antithrombin deficiency) and previous VTE (Dente, 2013).

Nursing Care Plan

The primary goal of VTE prophylaxis is to promote both medical and life style changes in order to decrease the risk of VTE for those considered as high-risk patients. Administer the prescribed prophylactic medications as ordered, on the correct time schedule and in conjunction with lab testing results as indicated. Educate and document the specific instruction provided to the patient regarding the medication the importance of diet, follow-up and any lab testing that may accompany the use of the drug. Implement and document the use of non-pharmacologic VTE prophylaxis such as intermittent compression devices or anti-embolism stockings. Document the intermittent compression device as “ON” during each shift assessment. Inform the patient of the importance of maintaining the therapy for the duration of hospitalization and if prescribed, in the post-discharge period (Caprini, 2005).

Patient/Family Education

Assess and document patient/family understanding of prescribed anticoagulant medications, including dosage, timing and possible side effects (Wittkowsky, 2004). Review laboratory blood draw requirements, if any. Discuss the importance of having blood testing as ordered by the provider, within the time frame specified, and what the results mean specific to unusual bleeding signs and symptoms. Instruct patient what to do if side effects are noted, including who to call and the importance of calling promptly upon discovery of an adverse effect. Educate patient/family specific to modifiable risk factors for VTE: oral contraception, HRT, obesity, smoking, protracted long immobilization periods and sedentary lifestyle.

Failure to Prevent

Significant difficulties in both detection and treatment of major thrombotic events and the subsequent high rate of mortality attributed to VTE, make prevention of VTE the most effective safeguard for patients. In order to effectively and efficiently prevent hospital-acquired VTE, every single patient must be assessed for VTE risk factors at the time of their admission to the hospital; otherwise known as the Culture of Always. Following this careful risk assessment and barring specific contraindications, appropriate VTE prophylaxis is to be initiated that will decrease the mortality and morbidity associated with DVT or PE.

“Failure to prevent” is a relatively new concept that is attributable to 6 factors related to VTE screening and patient assessment (Duff, 2011):

1. Incomplete risk factor assessment
2. Lack of timeliness specific to risk factor assessment for VTE (not done at the time of admission to the hospital or at the time of surgery).
3. Lack of initiation of VTE prophylaxis when risk level is identified

Nurses play a major role in the assessment of risk factors and implementation, adherence and education of the patient/family related to prophylactic treatment for VTE.

4. Inadequate duration of VTE prophylaxis
5. Incorrect type of prophylaxis is selected not specific to the level of risk or in accordance with any specifically documented contraindications.

Summary

Despite its proven effectiveness, rates of appropriate thromboprophylaxis remain low in both medical and surgical patients. In a review of evidence-based patient safety practices, thromboprophylaxis against VTE is the number one safety practice that should be implemented for hospitalized patients. Safe practices published by the NQF recommend routine evaluation of all hospitalized patients for the risk of VTE and the subsequent

use of appropriate prophylaxis (NQF, National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism, 2006).

VTE is a significant cause of long-term disability, chronic ill health and mortality (Gillies, 1996). Improving adherence to best practice guidelines for risk assessment and prevention of VTE is the role of all health care providers. Nurses play a major role in the assessment of risk factors and implementation, adherence and education of the patient/family related to prophylactic treatment for VTE. It is an important patient safety issue, one that readily falls into "The Culture of Always."

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Capnography (EtCO₂): The Sixth VITAL Sign

Lois Scipione, RN, MSN, PCCN

Your patient is a 40 year old woman who had a bilateral mastectomy. Upon admission to the unit, the nurse obtains the history on the patient: she is a non-smoker, no previous surgeries with medications including only a multi-vitamin daily. Vital signs are: blood pressure 118/72, and heart rate 68. Lungs are clear to auscultation with a rate of 18 breaths per minute and oxygen saturation by pulse oximetry is 98% on 2 liters nasal cannula. You implement her post-operative analgesia order for hydromorphone via patient controlled analgesia (PCA). The patient is stable, responsive with vital signs within normal limits during several periodic checks. However, several hours later you find the patient breathing at a rate of 9 per minute and difficult to arouse. For many of us, this sounds all too familiar, doesn't it?

One of the most common forms of pain control in the post surgery period is PCA with opioids such as morphine or hydromorphone. PCA delivery of opioid medications can create the potential for over sedation and respiratory depression. Opioid naïve patients who have never been exposed to opioid therapy are at risk for respiratory depression (Darcy, 2008). Fortunately, nurses can prevent negative outcomes from respiratory depression with the use of End Tidal Carbon Dioxide (EtCO₂) monitoring with waveform capnography.

The history of capnography dates back to 1970 when it was first used by anesthesiologists. During that time, EtCO₂ monitoring required patients to be intubated which limited use to critical care units and the operating room (OR) (Maddox & Williams, 2012). Capnography monitoring has been the standard of care in the OR since 1991. With the addition of improved technology in 2004, new recommendations and standards of care have allowed application and expansion of capnography monitoring to units outside of the OR. Capnography monitoring is non-invasive and easy to use in non-critical care areas such as medical-surgical units.

At Cooper University Hospital, the EtCO₂ monitoring device attaches to the Alaris IV pump. The patient is required to wear a special nasal cannula with or without oxygen delivery that measures exhaled carbon dioxide. The EtCO₂ numeric measurement along with the capnography waveform appears on the screen of the Alaris module. The pump alarms when the patient's readings exceed the preset parameter limits alerting the nurse that the patient's respiratory drive is compromised.

Potential concerns with the use of capnography in non-intubated patients include compliance with use, dislodgement of the nasal cannula, false or nuisance alarms and patient mobility. Nevertheless,

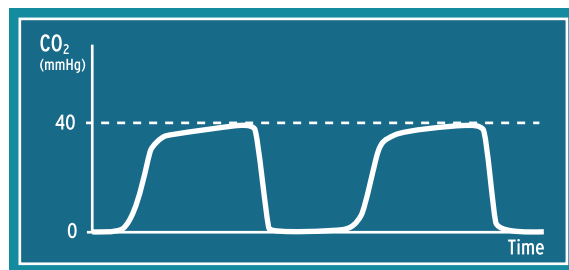
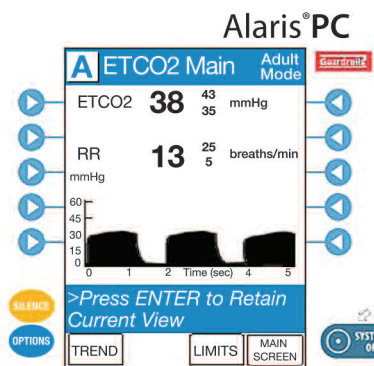
many of these issues are preventable by providing education to the patient and clinician. For instance, a thorough explanation provided to the patient about the necessity of its use in relation to their own safety helps to reduce and or eliminate noncompliance or patient refusal. If patients are ambulating on the unit, they do not need to use the monitoring device because they are breathing and awake during ambulation.

How does capnography work? First, one needs to understand oxygenation and ventilation and the difference between pulse oximetry and capnography. Oxygenation is the process of getting oxygen into the body, while ventilation encompasses inhalation and exhalation. Carbon dioxide is eliminated during exhalation. Pulse oximetry reflects oxygenation by measuring SpO₂ but changes in oxygen levels will lag with hypoventilation and apnea. Capnography (EtCO₂) measures ventilation and immediately detects hypoventilation and apnea. Supplemental oxygen does not treat desaturation due to hypoventilation, but instead postpones the patient's insidious progress to apnea (Darcy, 2007). Slow

shallow breaths cause the elimination of carbon dioxide to fall behind. Relying solely on oxygen saturation is a deceiving and dangerous practice because supplemental oxygen can skew results and gives inaccurate pulse oximetry readings (Spratt, 2010). EtCO₂ capnography monitoring is more reliable. In addition, monitoring respiratory rate is an unreliable method because it does not reflect whether effective ventilation or gas exchange is taking place. A patient may have a normal respiratory rate but could be on the verge of respiratory failure (Spratt, 2010).

The unique features of the Alaris Capnography module include (Care Fusion.com):

- Clinicians can view the EtCO₂ numeric measurement on the module
- Clinicians are able to view the continuous capnography waveform on the screen along with the respiratory rate and EtCO₂ level
- Clinicians are able to trend data and see how often the alarm have been triggered and why
- The Alaris pump audibly alarms and the PCA pump pauses when the EtCO₂ level is too high and/or the respiratory rate is too low
- Alarms are triggered based on the predetermined preset limits which are programmed into the data profile on the pumps



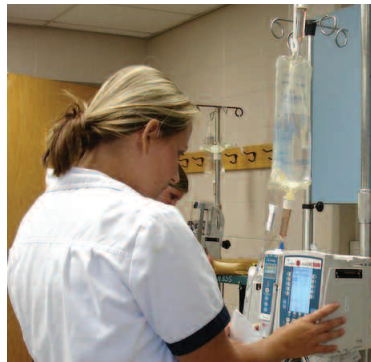


Capnography monitoring is the wave of the future. Used in conjunction with PCA administration for pain management postoperatively, capnography provides an additional level of safety for the patient because it allows for early recognition of hypoventilation and can prevent adverse events from happening.

The limits of the monitors at Cooper are determined by an interdisciplinary group including respiratory, anesthesia, pharmacy, nursing and palliative care. When an alarm triggers, the nurse must assess the patient. Often the patient will hear the alarm which causes them to initiate a spontaneous deep breath which will then cancel the alarm. However, if the respiratory rate drops below the preset parameters or the EtCO₂ level exceeds the parameters, the PCA pump will alarm and stop infusing. It is important that the nurse check the patient's EtCO₂ level in conjunction with the every four hour assessment of the PCA infusion. This assessment also includes vital signs, assessment of pain, validation of the pump settings and the correct medication infusing in the pump. The nurse needs to document the assessment on the patient's PCA flowsheet.

The use of capnography monitoring is increasing because of its reliability and safety. Capnography is now part of the American Heart Association recommendations in American Cardiac Life Support protocols to confirm correct placement of an endotracheal tube (American Heart Association, 2011). In addition, capnography monitors the quality and effectiveness of cardiopulmonary resuscitation (CPR). A quantitative waveform capnography of less than 10 mm Hg indicates that the quality of CPR has declined. This can usually be improved by implementing a new chest compressor (American Heart Association, 2011).

Capnography monitoring is the wave of the future. Used in conjunction with PCA administration for pain management post-



operatively, capnography provides an additional level of safety for the patient because it allows for early recognition of hypoventilation and can prevent adverse events from happening. EtCO₂ with waveform capnography monitoring alerts the clinician to assess the patient and determine if adjustments need to be made in medication, dosage or discontinuation of the pain medication as the nurse can monitor trends. This promotes timely interventions based on earlier assessments preventing a sentinel event from occurring. Capnography is an effective tool that can improve patient outcomes.

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Breast, Cervical, and Colorectal Cancer Related Health Disparities: Cancer Education and Screening in Underserved Asian Indian Women within Southern New Jersey



Sharon K. Byrne, DrNP, APN, AOCNP; Evelyn Robles-Rodriguez, MSN, APN, AOCN; Yogini Patel, BA

According to the National Action Plan for Cancer Survivorship, culturally competent patient education and care is a priority. The Camden County Cancer Screening Project (CCCSP) through the Department of Medicine, Hematology/Oncology seeks to provide culturally and linguistically appropriate cancer education and screening to underserved Asian Indian (Hindu) women through the use of a dedicated outreach worker and advanced practice nurse run clinic.

A relationship was built in 2007 by the CCCSP collaborating with National Indian Cooperative Enterprises, Inc. (NICE) a non-profit organization dedicated to service of the Indian community in South Jersey. The resultant program provides cancer education and early detection to women rarely or never screened. An Indian outreach worker dedicates 10 hours per week to community outreach and serves as the interpreter at a monthly clinic conducted by one of the Departments Advanced Practice Nurses. Services may include clinical breast examination, Pap smear and pelvic exam, digital rectal examination, mammography, and referral for colonoscopy as per American Cancer Society guidelines related to patient age and presentation. Patients with abnormal findings are referred for diagnostic services at no cost through grants from the New Jersey Cancer Early Education and Diagnosis program (NJCEED) or Susan G. Komen for the Cure. The Program also makes referrals to the Charity Care Program, Comprehensive Breast Center, Women's Care Center, and/or Department of Gastroenterology.

From its inception in 2007 through 2011, over 750+ Indian women with a mean age of 47.5 years have been educated through the programs outreach activities. Over 50% of participants have

received breast cancer screening and 59% of participants have returned for yearly cancer screening. To date, one case of invasive breast cancer, one case of ductal carcinoma in situ (DCIS), and 11 benign breast conditions has been diagnosed. Cervical cancer screening in 184 women identified 3 cases of cervical intraepithelial neoplasia (CIN) I-III/dysplasia. Two women participating in colonoscopy screening required follow-up for non-cancerous conditions.

This outreach strategy is a successful approach to increasing the knowledge and access of the underserved Indian (Hindu) women to annual cancer screening. We continue to work closely with NICE, Inc through 2012-2013 to sustain the viability of the program.

Acknowledgement: *This program is supported by grants from the Susan G. Komen for the Cure, Central and South Jersey and NJCEED.*

Email comments to byrne-sharon@cooperhealth.edu

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Improving the Patient Care Experience Through Nurse Navigation *(continued from page 7)*

This patient was visited by the NN while she was an inpatient and Jane was found to be very distraught about this new found condition in her life. She was frightened and stated, "I am only 27 and I guess this means I am going to die?" The NN was able to provide important information about her condition and to forecast what the treatment plan would be like. But what was most notable, was the initial bond created by the rapport the NN developed early in the patient-nurse relationship. Jane Doe is currently in treatment and the latest viral load is 114copies/ml. Viral load levels under 75 copies/ml are considered undetectable by Cooper HIV clinicians, and Jane is close to that status, revealing successful treatment adherence.

Email comments to Suokhrie-lucy@cooperhealth.edu

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Alison Lazzaro, RN, BSN
(September 2013) Nurse's Viewpoint in The Hospital Newspaper http://issuu.com/belsitoinc/docs/hospital_newspaper_nj_september_ebo page 18.

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Mary Stauss, RN, MSN, APN, CEN
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Reflections (continued from page 15)

Due to the highly emotional nature of every aspect of the donation process: a dying or brain dead patient, his/her family and their profound sense of loss, as well as religious and political beliefs, several laws and many guidelines have been put in place. These laws and guidelines have been put in place to limit unethical conduct in the donation process.

All healthcare providers practicing at the bedside in the state of New Jersey need to be aware that it is their legal responsibility to notify The Sharing Network of potential organ donors within 1 hour of the following criteria:

Vented patients who have 1 or more of the following criteria:

1. Glasgow Coma Scale (GCS) of 5 or less
2. Loss of 2 or more cranial nerve reflexes (pupils fixed, no cough, no gag)
3. Beginning discussions of:
 - a. Withdrawal of life support
 - b. End of life prior to extubation

The criteria above have been agreed to by The Sharing Network and Cooper University Hospital (CUH) based on Centers for Medicare and Medicaid (CMS) guidelines; other guidelines by CMS and agreed to by The Sharing Network and CUH include:

1. Hospitals must notify the OPO of every death or imminent death in the hospital. When death is imminent, the hospital must notify the OPO both before a potential donor is removed from a ventilator and while the potential donor's organs are still viable.
2. "Timely notification" means a hospital must contact the OPO by telephone as soon as possible after an individual has died, has been placed on a ventilator due to a severe brain injury, or who has been declared brain dead (ideally within 1 hour). That is, a hospital must notify the OPO while a brain dead or severely brain-injured, ventilator-dependent individual is still attached to the ventilator and as soon as possible after the death of any other individual, including a potential non-heart-beating donor. Even if the hospital does not consider an

individual who is not on a ventilator to be a potential donor, the hospital must call the OPO as soon as possible after the death of that individual has occurred.

New to me in this experience was learning that if a person of legal age has made his/her desire known, possibly on their driver's license, to be an organ donor, it is considered a legally binding agreement/document. Another such document could be an Advanced Directive or Healthcare Proxy. This means that even if the family has objections to organ donation the OPO only has to provide notification, not seek approval for a patient become to become an organ donor. This is backed by New Jersey State and Federal laws.

I found that my belief that organ donation is a good thing was reinforced by my direct participation in this experience, difficult as it was. All of the people I met from The Sharing Network did everything humanly possible to comfort John's family as they moved through the process to eventually help two people live vastly improved lives. Unfortunately, the difficult choice this family made is uncommon which leaves many people needing transplants waiting in vain.

Since being involved in John's donation process I have begun to attend the Donation Champion Clinical Ladder Committee at CUH. This committee meets quarterly and is currently working on several initiatives to encourage donation and recognize those who have already donated or have received organs through the combined efforts of The Sharing Network and CUH, its staff and patients.

Everyone at Cooper University Hospital is focused on better outcomes for our patients. Enhancing the donation process could allow someone's death to have a much greater meaning and for the recipients the organ they receive may allow a return to an active and healthier life.

I would encourage every nurse to support this important work to the limits your beliefs will allow. Many more lives could be improved because of your support.

Email comments to Ball-lee@cooperhealth.edu



REFLECTIONS

Practicing Intentional Acts of Kindness

Lee A. Ball, RN, CCRN



Lee Ball

On behalf of New Jersey Sharing Network (NJSN), I would like to thank you for your support of the donation process involving a patient on June 21st. This donor's family made the generous decision to donate his organs to help change the lives of others. Please share this letter with the staff involved.

The following transplants have taken place as a result of your efforts:

One of the donor's kidneys was transplanted into a 41 year-old gentleman from New Jersey. He is single and is disabled due to his kidney disease. He had been on the waiting list for a kidney transplant since January of 2008. His new kidney had immediate function and he is expected to make a full recovery.

The other kidney was transplanted into a 36 year-old gentleman from New Jersey. He is single and is employed as a dealer in Atlantic City. In his spare time, he enjoys playing on-line games and watching TV. He has a very close relationship with his family. He was in need of a kidney transplant due to hypertension. He had been on the waiting list since February of 2008. His new kidney also had immediate function. His creatinine is down to 1.3. These two individuals will now be able to enjoy markedly improved lifestyles, free of dialysis and the many dietary restrictions that previously prevented them from living life to its fullest.

In addition, the family's gracious decision to consent for research gives hope to all of us that many of the diseases we suffer from today will be more easily treated or even eradicated in the future. We were able to recover the donor's liver for this important purpose.

what organs/tissues may be procured for transplantation.

The OPO, in cooperation with the hospital staff, helps guide the patient's family through the process. This process is extensive and includes everything from pastoral care to determining if there are limitations to the donations that are to be procured and gifted. Once all of this has been completed and the patient is ready to go to the OR a comfort care protocol is initiated. Comfort care includes administering morphine to the patient, starting a morphine drip and possibly propofol as well.

Once in the OR, the patient is placed on a monitor and all equipment is made available and properly positioned. The health-care team takes time is taken to pay their respects to the patient, his/her family and for positive outcomes for the people who will receive the donations. Present in the OR during this prep time are the hospital staff and the OPO team who will be performing the procurement of organs.

Next, to eliminate any conflict of interest prior to withdrawal of life sustaining measures, the OPO team leaves the room and waits for notification that the patient has died. All life sustaining medications are then withdrawn, and the patient is removed from his/her ventilator. The responsibility as the nurse who is staying is to advocate for the patient's comfort through their passing.

The OPO will make the family aware that they may go into the OR but once their family member has been pronounced deceased they will need to leave relatively quickly so that team may start the surgery. The procurement process starts within 5 minutes of pronouncement of death.

I recommend that if you are the nurse going to the OR with a patient who is an donor that you take at least one extra bag of each medication, pain medicine and possibly a sedative, that you think you will need; you can always return what has not been used to the pharmacy. My recommendation is based on past experience that end of life care may hold some surprises.

As a registered nurse practicing at the bedside in an intensive care unit caring for patients in John's condition is not uncommon. Also not common was the ability of this family to see beyond their immense grief at the impending loss of their son, grandson and brother and to make a decision that in a very short time greatly improved two other lives.

In over 15 years of practicing I never had an occasion to take an organ donor to the OR. John's circumstances made him what is called a Donor by Cardiac Death (DCD) or what used to be called a non heart beating donor. DCD is becoming more common. Last year was the first year that DCD donations out-numbered donations due to brain death. It is my opinion that only a seasoned nurse accompanies a donor patient to the OR. Novice nurses should be mentored by an experienced nurse in this type of donation.

(continued on page 14)

I recently received this e-mail and realized I wanted to write this article, which seemed so daunting to write until this arrived. As soon as I left this patient (I will call him John Smith in this article) in the operating room (OR), I felt strongly about passing on my experience as the nurse who went with John to procure his healthy organs.

John was a young man in his early twenties who had serious diminished mental capacity due to recent circumstances. He was responsive but continued to require a ventilator and medications to support his blood pressure. His care had progressed to a point where discussions had commenced with his family about how they would like to proceed with care given his compromised state. Several options were discussed and the decision was made by John's family that he would not wish to live in his current state and that his prognosis was poor enough that the likely outcome was John's imminent death.

At this point, The Sharing Network, New Jersey's, Organ Procurement Organization (OPO), had been notified of John's condition and they had become actively involved in discussions with his family. The Sharing Network collaborates with all health-care disciplines in a patient's end of life care with the goals to ease the family's distress over the imminent death of their loved one, answer questions and facilitate the donation process.

Once the decision is made, comprehensive testing is completed to determine what organs and tissues are viable to transplant and who will be the best match to receive them. While all of this is being done every effort is made to maintain the patient in a "normally functioning hemodynamic state" in an effort to maximize



Professional News

PROFESSIONAL LADDER:

Level 3

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Sandy DurlfinglerCCL
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Lindsay OttICU
Jackie VegaIR
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Rebecca ReustleNS10
Lara GrahamNS9
Priscella HagertyN7
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Lisa SineniOR
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Grace MansillaN7
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Mariecar DavidOR
Vickie FreibergOR
Angela PetrongoloOR
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Lourdes San BuenaventuraOR
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Kimberly ZlupkoP6
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Marielyn PowellRad
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Megan StaerkED
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Donna WoodNICU
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Phyllis DiCristoNS9
Sherry WrightN7
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Stacey CarrP6
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Linda SullivanPACU
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