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Cooper Bridges

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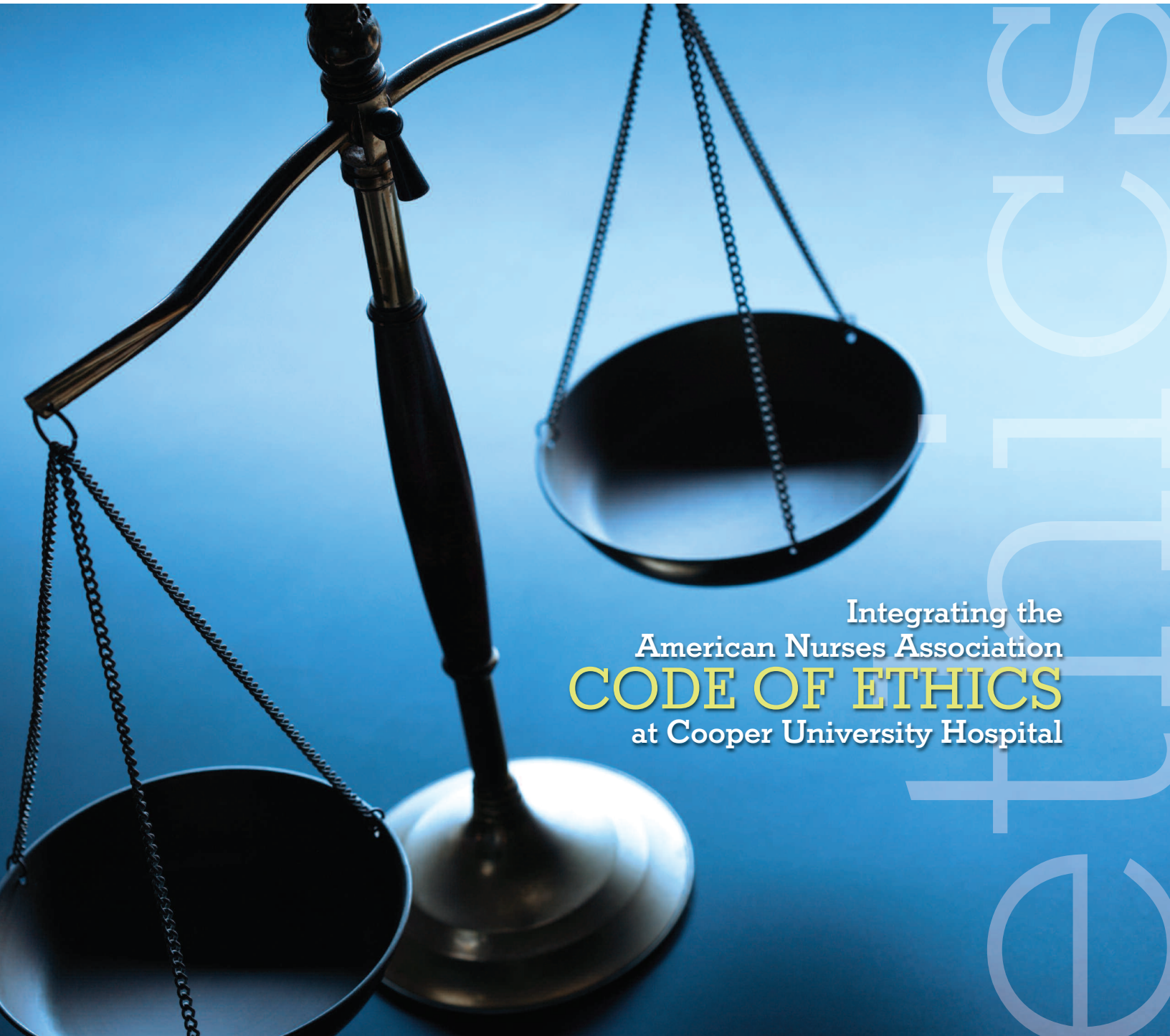

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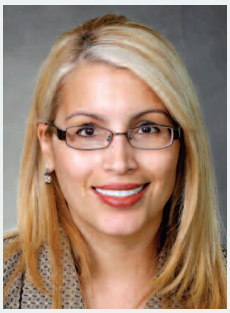


From Nursing Leadership

Ilia Echevarria, MS, MSN, RN, CHES, CCRN, NEA-BC
AVP Professional Development
Patient Care Services

It is an honor to open this edition of *Cooper Bridges* in my new role as Assistant Vice President of Professional Development. In getting to know you and your work, I feel fortunate to have joined a team of such dedicated and accomplished professionals. You have a lot to be proud of as Cooper employees. This past year has been full of great successes that would not have been possible without each of you. These include implementation of medication bar coding, capnography monitoring in the medical/surgical areas, opening of our new state of the art patient care units on Pavilion 8 and 9, and the great improvements in several of our quality metrics in falls, pressure ulcers and catheter-associated urinary infections, just to name a few.

This *Bridges* edition highlights many academic accomplishments of our team members —those who obtained Bachelors or advanced degrees and professional certifications, as well as those who participated in national publications and presentations. As a team, we have much to celebrate.

My role, first and foremost, is to support you in reaching even higher to fulfill your professional potential and to fulfill Cooper's commitment to provide exceptional care and service each day, for each patient. My charge is to make sure that you have meaningful opportunities to continue your professional development and achievements through education, shared governance and nursing research.

As you develop your professional and personal goals for the upcoming year, I urge you to reflect on what's important to you and how you can make a difference each day – at work and at home. I believe that we're each called upon to dream big, while seeing the opportunities right in front of us. As the inspirational writer Orison Sweet Marden put it:

"Don't wait for extraordinary opportunities. Seize common occasions and make them great."

These are extremely exciting times at Cooper and I look forward to partnering with you on this great Cooper journey.

Regards,

Ilia Echevarria

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: **Stauss-mary@cooperhealth.edu**

CARE DELIVERY

Destination Therapy – Left Ventricular Assist Device (DT-LVAD)

Janet A. Tridente, MSN, RN, CCRN

Heart Failure (HF) is a chronic condition associated worldwide with high morbidity and mortality. The incidence of HF is increasing as approximately 6 million Americans have HF (Widmar, Dietrich, & Minnick, 2014). According to Sterling (2013), about half of the population with HF has systolic HF (reduced Ejection Fraction) with the remainder having diastolic HF (normal EF). The New York Heart Association (NYHA) is one system used to classify patients with HF by using the functional status of the patient from Class I (no limitation with regular activities) to Class IV (symptomatic at rest). The NYHA Class III (symptomatic with minimal exertion) is often further classified as IIIa and IIIb (defined as a recent event of dyspnea). Although heart transplantation is the gold standard treatment for patients in the terminal stage of HF, a limited number of donor organs restrict its use (Karapolat et al., 2013).

"Although heart transplantation is the gold standard treatment for patients in the terminal stage of HF, a limited number of donor organs restrict its use."

Evidence has demonstrated survival benefits with permanent pacemakers, implantable defibrillators and the use of medications such as beta-adrenergic blockers, angiotensin-converting enzymes, angiotensin receptor blockers, diuretics, digitalis and IV inotropes. However, prognosis with patients experiencing advanced HF remains grim. According to Khoo (2010), survival for patients in Stage IV HF is 16% at 1 year and decreases to 0% at 5 years.

Domingo Liotta and Michael DeBakey developed the left ventricular assist device system to support patients with systolic HF in the early 1960's. In 1963, Liotta and Stanley Crawford implanted the first ventricular assist device into a patient experiencing cardiogenic shock. Ventricular assist devices include left ventricular assist devices (LVADs), right ventricular assist devices (RVADs) and biventricular assist devices (BiVADs) which are two separate pumps. The left ventricular assist devices are the most common (Mechem, 2013).

Three significant advances have marked the evolution of device technology over the past fifty years: the transition to an internal device from an external device, changing to an electrical power source from pneumatic and the conversion to a continuous flow device from a pulsatile device (Khoo, 2010).

TABLE 1 Overview of research relative to destination therapy with a left ventricular assist device (LVAD)

Reference	Sample	Setting	Design	Purpose	Findings
Lietz[10] Rematch trial (2010)	New York Heart Association class IV heart failure symptoms; (n=129); mean age, 68 y; left ventricular ejection fraction, 17%	20 US hospitals from May 1998–July 2001	61 patients randomized to medical therapy; 68 patients randomized for LVAD implantation	Determine if the LVAD population increased their 1-year survival compared with medical therapy only	Percentage of 1-year survival rate of LVAD population compared with medical therapy only 52% vs 25% (relative risk, 0.52; 95% CI, 0.34-0.78; *P*=.001)
Slaughter et al,[5] Fang[11] Heartmate II Destination Therapy Trial (2009)	Patients with end-stage heart failure ineligible for heart transplant; (n=200); mean age, 63 y; left ventricular ejection fraction, 17%	38 US hospitals from March 2005–May 2007	200 patients randomized in a 2:1 fashion; 134 patients received a continuous flow axial flow device Heartmate II LVAD; 66 patients received the Heartmate XVE LVAD	Determine if the second-generation destination therapy LVAD had overall survival improvement compared with the first-generation XVE LVAD	Patients with the Heartmate II LVAD had significantly improved 2-year survival compared with Heartmate XVE recipients (58% vs 24%; *P*=.008)

O'Neill BJ, Kazer MW. Destination to nowhere: a new look at aggressive treatment for heart failure—a case study. *CritCareNurs*.2014;34(2):47-56. Table1. ©2014 AmericanAssociationofCritical Care Nurses. Used with permission.

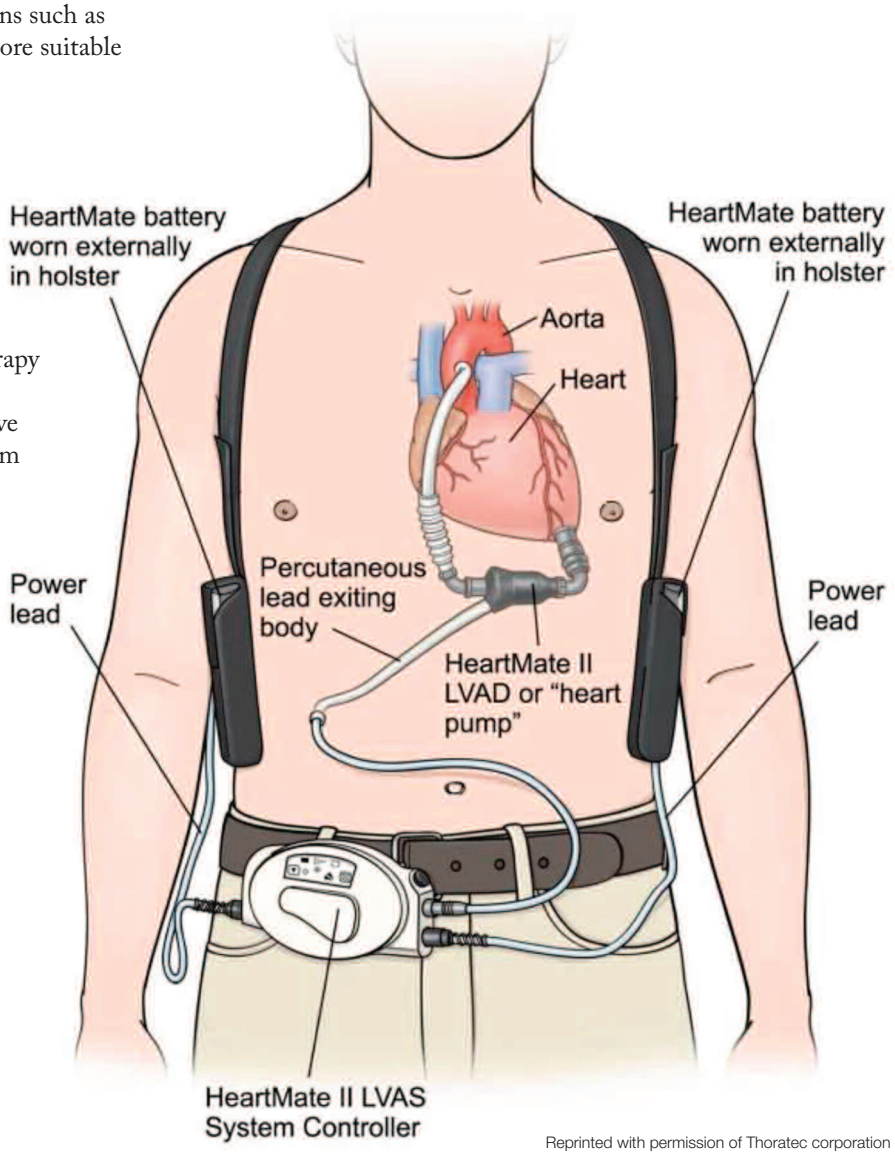
These improvements have resulted in quieter, smaller devices with fewer moving parts, therefore less complications such as stroke, infection and pump failure. Also, they are more suitable for smaller body sizes (Loughran, Kealy, Shook, & Kaan, 2012).

Typically, patients fall into one of three categories:

A. Bridge to transplant (BTT) – a temporary therapy for approved candidates waiting for a transplant.

B. Bridge to recovery (BTR) – a temporary therapy that is discontinued when the native heart recovers from an acute insult such as a massive heart attack. LVADs can alter the myocardium and decrease the size of myocytes helping to improve myocardial function and thereby reducing cell death (Khoo, 2010).

C. Destination Therapy –(DT-LVAD) a permanent therapy for patients to live out the remainder of their lives when recovery of the native heart is not expected or when they do not meet the stringent criteria for heart transplantation (Rowland, 2012).



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One type of LVAD is the HeartMate II, a mechanical circulatory support device that assists the failing heart to deliver blood throughout the body. In January 2010, the Food and Drug Administration's (FDA) approval of the HeartMate II was extended beyond use as a bridge to transplant, to include use as destination therapy (DT-LVAD) for people with severe heart failure who are not candidates for heart transplantation. This device can be used in patients with NYHA class IIIb or IV end stage left ventricular failure, who have received optimal medical therapy for at least 45 of the last 60 days (FDA, 2010). Implantation of an LVAD is standard of care for patients with advanced HF who may benefit from prolonged survival with improved quality of life. This elective, definitive therapy serves as a viable alternative to transplantation (Rame, Alturi, & Acker, 2014). Cooper University Healthcare under the guidance of the Cooper Heart Institute is embarking on a ventricular assist device program to manage advanced HF. Physicians from the Cooper Heart Institute are in partnership with Abington Hospital for program development assistance in the use of the HeartMate II LVAD.

"Three significant advances have marked the evolution of device technology over the past fifty years: the transition to an internal device from an external device, changing to an electrical power source from pneumatic and the conversion to a continuous flow device from a pulsatile device."

Contraindications

Implantation of a DT-LVAD should not be considered for patients with severe hemodynamic instability, irreversible major organ failure, uncertain neurological status, coagulopathy issues, prolonged mechanical ventilation, sepsis or right HF. Psychosocial issues may preclude implantation as well.

Indications

Once a patient's functional HF status meets criteria for an LVAD, the patient's ability to survive the implant must be thoroughly assessed. It is clear that patient selection is the primary factor determining success for patients with LVADs (Boyle, 2010). Other considerations include timing through pre-operative assessment and optimization of the patient's condition including nutritional support. According to Slaughter (2010), when possible, LVAD implantation should be elective and not emergent, especially in candidates for destination therapy. In addition, patients need a strong support system that is willing to assume the caregiver role and attend the training necessary to respond in the event of an emergency. It is also imperative that community EMS systems develop training and protocols in the care of the patient with an LVAD so they are able to adequately manage these patients during transport.

Implantation of the Device

The HeartMate II is surgically implanted through a sternotomy and placed below the heart with the entrance (inflow cannula) connected to the apex of the left ventricle and its exit (outflow cannula) placed in the ascending aorta. Blood flows from the heart into an electric motor in the pump and drives a rotor that pushes blood into the aorta and out to the entire body. A driveline (flexible tube) extends from the pump, through the skin and connects to a controller outside of the body. Batteries or a standard electrical outlet supply the power to the controller. Intra-operative management includes echocardiography to assess valvular function and intracardiac thrombi. Post-operative management includes right ventricular function and blood pressure management (Slaughter, 2010).

Care of the Patient

The use of an LVAD presents complex challenges that require an intense and sustained effort from the interdisciplinary team. Care for these patients requires an understanding of the components and function of different devices, as well as their complications. Because of the unique skill set necessary to manage the patient with an LVAD, an interdisciplinary HF team is required to provide comprehensive care from initial referral until support is terminated. Effective education for the patient and caregiver is the key to outpatient success. All team members must learn the system operation, maintenance, troubleshooting and how to respond in an emergency. Competency must be demonstrated prior to discharge and periodically reassessed.

Infection is the most common complication encountered. It can occur in the blood stream, in the device pocket or where the driveline exits the skin. Meticulous aseptic care for the exit site is critical to long term survival and proper site care includes a securement device for the percutaneous driveline. Stroke rates continue to improve, although they remain a major concern. Bleeding may occur from the direct effects of the device, acquired von Willebrand's coagulopathy, or from therapeutic anticoagulation. The gastrointestinal system is the most frequent site of bleeding. Lifelong anticoagulation is required to avoid thrombosis. However, device thrombosis occurs rarely (2%–3%) but is very serious and may require pump exchange. Mechanical malfunction, such as broken wires or short circuits are increasing with aging devices. However, new-generation pumps have markedly improved durability and reliability (Sterling, 2013). The highest risk of death after LVAD implant is before hospital discharge (Slaughter, 2010). Right ventricular failure is a leading cause of morbidity and death after LVAD implantation due to the failure of the right ventricle to pump enough blood through the pulmonary circuit to adequately fill the left heart (Slaughter, 2010).

Since The HeartMate II is a continuous flow device that pumps throughout the cardiac cycle with aortic flow present

In light of the growing population of patients with HF, the strict criteria for transplantation candidacy and evolving technology, mechanical circulatory support devices will play a significant role in the care of patients with advanced heart disease.

during diastole, it is often difficult to palpate a pulse and measure a blood pressure by auscultation. In the early post-op period, an arterial catheter for blood pressure measurement is required. Once removed, a Doppler with sphygmomanometer is the most reliable method of blood pressure auscultation. The goal is a mean arterial pressure (MAP) of 70-80mmHg. The MAP is a combination of the patient's own cardiac output and pump output. Auscultation over the heart reveals a mechanical humming. Pulse oximetry readings may be unreliable because of the low pulse pressure from the pump therefore cerebral oximetry may be indicated (Slaughter, 2010).

Evidence

Several studies have addressed the implementation of LVADs. Outcomes of the REMATCH (Randomized Evaluation of Mechanical Assistance for Treatment of Congestive Heart Failure) trial in 2001 and the HeartMate II Destination Therapy Trial in 2009 demonstrate the DT-LVAD increases 1-year survival compared with medical treatment alone and the HeartMate II improved 2-year survival rates compared to the older model HeartMate XVE (O'Neill & Kazer, 2014). In 2009, the American College of Cardiology updated their 2005 guidelines for the management of HF to support the consideration of a DT-LVAD for patients with refractory HF and estimated 1-year mortality with medical therapy to exceed 50 percent (O'Neill & Kazar, 2014).

The Post FDA Approval Study analyzed 247 HeartMate II patients who were identified as destination therapy in the national database, Interagency for Mechanically Assisted Circulatory Support (INTERMACS). The studies confirmed the clinical trial results with good quality of life and greater outcomes. The primary endpoint of the study was a 2-year survival rate without disabling stroke or need device replacement. The initial clinical trial was 58% and the post FDA approval study revealed 62% with some centers reporting 74% (Ulrich, 2014). To date, over 14, 000 patients have been implanted with the HeartMate II (Thoratec, 2014).

In light of the growing population of patients with HF, the strict criteria for transplantation candidacy and evolving technology, mechanical circulatory support devices will play a significant role in the care of patients with advanced heart disease. The REVIVE-IT (Randomized Evaluation of VAD Intervention before Inotropic Therapy) clinical trial is sponsored by the National Heart, Lung and Blood Institute, to study if advanced HF patients have a better quality of life and live longer when they receive an LVAD at an earlier period of disease progression, rather than waiting until they are at a more advanced stage of HF as is currently required to be a candidate for an LVAD (Kirkendoll, 2014). Hopefully, this study will advance scientific knowledge and change the patient population to include patients with less severity of illness that are most likely to achieve the greatest outcome with mechanical circulatory support.

Email comments to **tridente-janet@cooperhealth.edu**

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Anchoring a Pediatric IV: A Comparative Study of Peripheral IV Securement Devices in Pediatric Patients ages 2 months through 36 months old

Sue Butler RN, BSN, CPN, CCRN; Dominic A. Parone RN, BSN, CEN, CFRN; Tania Berghaier RN, BSN, CPN; Michele Doyle RN, BSN, CPN; Nicole Luedtke RN, BSN; Kerri Myers RN, CPN; Krystal Hunter MBA; Jane Greene Ryan PhD, CNM

Purpose: Children between the ages of 2 - 36 months go through several stages of mobility, and transition from complete physical dependence to independence. This puts them at a much higher risk for dislodging a patent intact IV increasing the risk of IV complications and unnecessary multiple IV restarts. A randomized control group study was done on this age group, comparing both the effectiveness and the cost of 2 peripheral IV securement devices, Statlock® and standard (bio-occlusive dressing and tape) in 128 pediatric patients admitted to a 500 bed, urban, tertiary care hospital.

Significance to nursing: IV placement among pediatric patients while clinically necessary can be traumatizing to the child and parent. Using the best IV securement device can help decrease the numbers of IVs placed ultimately decreasing patient discomfort, risks for infection from multiple IV placements and hospital costs.

Patient population: Pediatric patients ages 2 months to 36 months.

Methodology: After obtaining parental consent, pediatric patients admitted from November 2012 through January 2014 and aged 2 to 36 months were randomly assigned to either the Statlock® or standard device group. IV lines used for caustic or vasoactive medications, blood products or blood draws were excluded from the study. Of the 128 pediatric patients originally enrolled, 4 were excluded from the study (2 parents withdrew their child before the IV was placed, and 2 children needed emergent blood draws and IV contrast). The IVs of 124 children were monitored for patency every four hours until IV securement failed, IV site complication noted, or securement device removed when child discharged from the hospital.

Data analysis: Independent T Tests, One Way Anova, Mann-Whitney U test, Pearson Chi Square, Log Rank Tests

Results: Analysis of the data from the 124 children found that among the children ages 2 to 12 months, IVs placed in the arm (forearm and antecubital sites) were more stable (defined as patent and intact) compared to hand placement ($p < 0.05$). Five IV complications were tracked: pain, swelling, pulls, redness, leaks and occlusions. Forty percent of the IVs (49/124) were discontinued because of one of these complications. Both types of IV securement were equally likely to result in complications (tape, 48%; Statlock® 46%).

The most common complication among all children was "pulls" (47%). Among those aged 2 to 12 months, IVs secured by standard device were less secure than Statlock® IV's (51% tape pulls; 39% Statlock® pulls). We also examined complications by site of IV placement. Of the 25 "pulled" IVs 19 (76%) of these "pulls" were IVs placed in the hand. When placed in the arm, IVs were more stable and remained patent longer (Statlock®, 47 hours, standard 37 hours).

Evaluation of hospital costs revealed that the Statlock® cost $.60 more than the Standard device.

Conclusion / Recommendations for research and or clinical practice: Nurses observed that the current design of the Statlock® was too large for pediatric patient's hands. It is possible that redesign of the current pediatric Statlock® could increase the utility and stability of this device. While many nurse prefer to place IVs in the hand, the arm area was found to be the most stable and least susceptible to "pulls" in this group of pediatric patients. The cost of the securement devices were about the same, but the increased 10 hour Statlock® dwell time could save a child from having additional IVs inserted. The limitations of our study were the small sample size and age of population. With a much larger sample size, and using pediatric & neonatal Statlocks®, we may be able to get more definitive results as to which IV securement device would be the most secure in this age group. Due to the low sample size and age restrictions further research needs to be conducted.

We would like to acknowledge the following nurses without whom this research project would not have been possible: Robert Lawston, Lynn Pyle, Tammy A. Beringer, Regina Callahan, Hannah Birch, Traci Kramer, Kathryn McCurley, Brenda Brown, and Joan Madara.

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CARE DELIVERY / EBP

Integrating the American Nurses Association Code of Ethics at Cooper University Hospital

Barbara J. Sproge, MSN, RN, OCN, CHPN

During the past year, nurses at Cooper University Hospital (CUH) have been increasing their awareness of the American Nurses Association (ANA) Code of Ethics and the functions of the Bioethics Committee within Cooper. In May 2013, the Clinical Educators at CUH hosted an educational seminar on the ANA Code of Ethics for nursing council members. This author had the privilege of presenting information on the topic along with Vicki D. Lachman, PhD, MBE, APRN, Associate Professor at Drexel University, and a member of the ANA task force charged with updating the ANA Code of Ethics in the coming year. Dr Lachman provided valuable and timely information on how nurses should utilize the code in their daily clinical practice. The following is a description of the code, and its importance to the profession of nursing.

The American Nurses Association's (ANA) Code for Nurses with Interpretive Statements (Code for Nurses) explicates the goals, values and ethical precepts that direct the profession of nursing. The ANA believes the Code for Nurses is nonnegotiable and that each nurse has an obligation to uphold and adhere to the code of ethics (ANA, 2001).

Lachman contends that the ANA Code of Ethics instills nurses with a sense of pride and confidence, and supports nurses through many challenges. It provides a social contract with society, as well as ethical and legal guidance to all members of the profession. In addition, the code outlines a framework within which nurses can make ethical decisions and discharge their professional responsibilities to the public, to other members of the health team and to the profession (ANA, 2001a).

Significance to Nursing

Every day, nurses care for patients and families who are facing life-changing physical, psycho-social, spiritual, emotional and financial problems. Advances in medical technology, changes in social and family systems, cultural and religious diversity and an unlimited array of health care choices have added to the complexity of the current health care landscape (Calman, 2010; Kinlaw, 2005). Therefore, ethical issues are inherent in the nursing care provided to patients and families throughout the life span and particularly during end-of-life (EOL). Some current ethical conflicts include: the right to refuse or discontinue treatment, the right to die, resuscitation status, organ transplantation, perinatal issues, disenfranchised and/or vulnerable populations, genetic engineering, patient autonomy and healthcare costs (Alichnie, 2012). Modern medical technology can lead to unrealistic expectations of medical care, generating disagreements between the patient, family members and the healthcare team.

Often, nurses are called upon to participate in family meetings in order to clarify goals of care for a particular patient. During these difficult discussions, it is evident nurses have the privilege of interacting with people at one of the most vulnerable times in their lives. According to the Gallup poll, for the past 10 years, nursing has been recognized by the public as the most trusted profession. In fact, this past year, 84% of respondents noted that nurses' ethical standards are high or very high (Thompson, et al., 2013). In order to continue to earn that level of public trust, it is our professional duty to take a look at some of the ethical dilemmas that occur in our institutions and examine how we can continue to integrate the ANA Code of Ethics into our nursing practice.

Role of Bioethics Committee

CUH has a multidisciplinary Bioethics Committee that meets on a monthly basis. The committee's purpose is to provide a forum for ethical reflection and discussion of values, and attempt to meet the needs of our patients and other affected individuals through group processes and consensus-building (Jonsen et al., 2006).

Ethics is a philosophical discipline pertaining to notions of good and bad, right and wrong—our moral life in community. Bioethics is the application of ethics to the field of medicine and healthcare. Ethicists and bioethicists ask relevant questions more than provide sure and certain answers (Center for Practical Bioethics, 2014).

In addition, ethics consultative services (ECS) are used by multidisciplinary committee members when requested. ECS is a set of services provided by an individual or group in response to questions from patients, families, surrogates, healthcare professionals or other involved parties who seek to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care (American Society for Bioethics and Humanities, 2011). The goals of ECS at CUH include protecting patients' rights, diffusing con-

flict, changing medical and nursing plans-of-care to promote quality and reducing the use of non-beneficial treatments.

Nursing Role in Bioethics

Nurses have long used ethical principles such as autonomy, beneficence, nonmaleficence and justice, which are grounded in respect for individuals, in the delivery of healthcare to meet clients' needs. The following is a review of these important concepts:

- **Autonomy:** agreement to respect another's right to self-determine a course of action; support for independent decision making
- **Beneficence:** compassion; taking positive action to help others; desire to do good; the core principle of nursing advocacy
- **Nonmaleficence:** avoidance of harm or hurt; the core of medical oath and nursing ethics
- **Justice:** equal and fair distribution of resources, based on analysis of benefits and burdens (ANA, 2001)

Often, nurses at the bedside are asked to help explain complex medical facts and sort through feelings associated with ethical dilemmas and healthcare decisions. As such, nurses frequently have a more intimate understanding of client preferences and concerns. During discussions in the Bioethics Committee meetings, nurses use their patient advocacy role to create a context for, and the promotion of, consensus-building. Beyond the role of participant in the meditative process, nurses on the committee play a key role in defining appropriate care for clients caught in clinical ethical dilemmas.

As medical advances continue to emerge, there is a need for nurses to continue to familiarize themselves with the ANA's Code of Ethics. Nurses must also continue to educate themselves on the meditative process and the work of the multidisciplinary Bioethics committee. One cannot understate the importance of a nurse's voice to insure better moral and humanistic outcomes for the patients and families we serve.

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CARE DELIVERY / EBP

Professional Certification: What Does It Really Mean?

Jean M. Zoll, MSN, MA, RN, CCRN, CGRN

In the professional world of health care, there has been much discussion about education and certification and how these factors directly affect the ever changing environment of health care delivery. Professional certification in one's area of practice demonstrates dedication to professional excellence. Health care clients look for physicians who are 'board certified' to care for their families and themselves. The public may not be aware that many other health care providers, who they come in contact with regularly, are also eligible to become board certified. The process of becoming certified in your area of practice tells a story of commitment and dedication about the individual who has obtained this milestone.

Certification is a voluntary process of validating knowledge, skills and abilities beyond the scope of daily practice. This statement is true for the Registered Nurse (RN), as it goes beyond the scope of basic licensure. But this is also true for other members of the health care team as well. The process of obtaining and maintaining certification demonstrates desire to improve the quality of patient care and the delivery of services. The certified staff is striving for certain expectations. They have a passion for the delivery of the highest quality of care from everyone on the health care delivery team.

Certification of health care professionals helps build an evidence based relationship to health care practice. Nursing certification fosters a relationship of collegiality and respect with other health care providers. Professional certification provides multiple benefits. It validates competence, qualifications and advanced knowledge in an area of practice. This accomplishment is associated with the attitudes of self-regulation, self-determination and independence. The process influences accountability, accomplishment growth and specialized knowledge. Ultimately, certification provides a higher level of recognition among employers, peers and clients.

Any professional certification demonstrates a commitment to a particular practice specialty. This validates the professional's competence in the specialty. At the Cooper Digestive Health Institute (CDHI) Endoscopy Center, the entire care team believes in the power of obtaining certification(s) related to their roles within the team. Seventy five percent of the RNs at the center are certified in GI nursing practice as CGRN. This certification is granted by the Society of Gastroenterology Nurses and Associates. One hundred percent of the GI technicians that are eligible in the center are also certified. The tech certification title is 'Flexible Endoscopy Preprocessors' certified. The coder for the center already possesses one certification in her field and is currently studying to obtain a second certification.

The staff of the CDHI endoscopy center has embraced the opportunity to validate their expertise and skills through certification. The team's vision is to 'do the right thing' in the delivery of the best standard of care for our clients. The goal is to build a healthcare team of excellence to serve the people of the Delaware Valley.

Email comments to **zoll-jean@cooperhealth.edu**

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Certification of health care professionals helps build an evidence based relationship to health care practice. Nursing certification fosters a relationship of collegiality and respect with other health care providers.

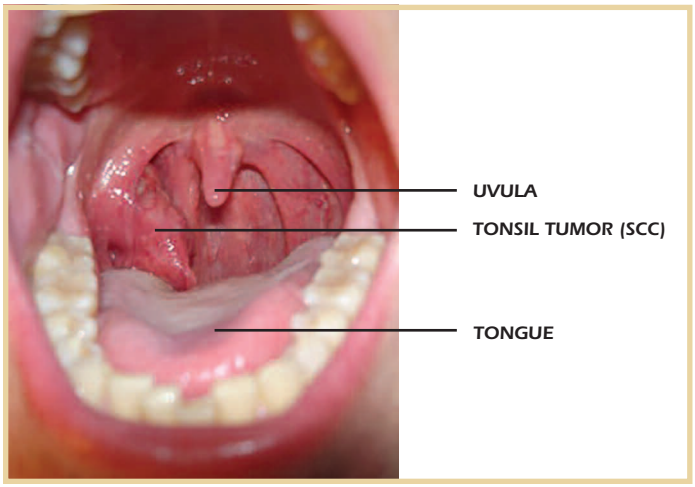
PATIENTS / FAMILIES / COMMUNITIES

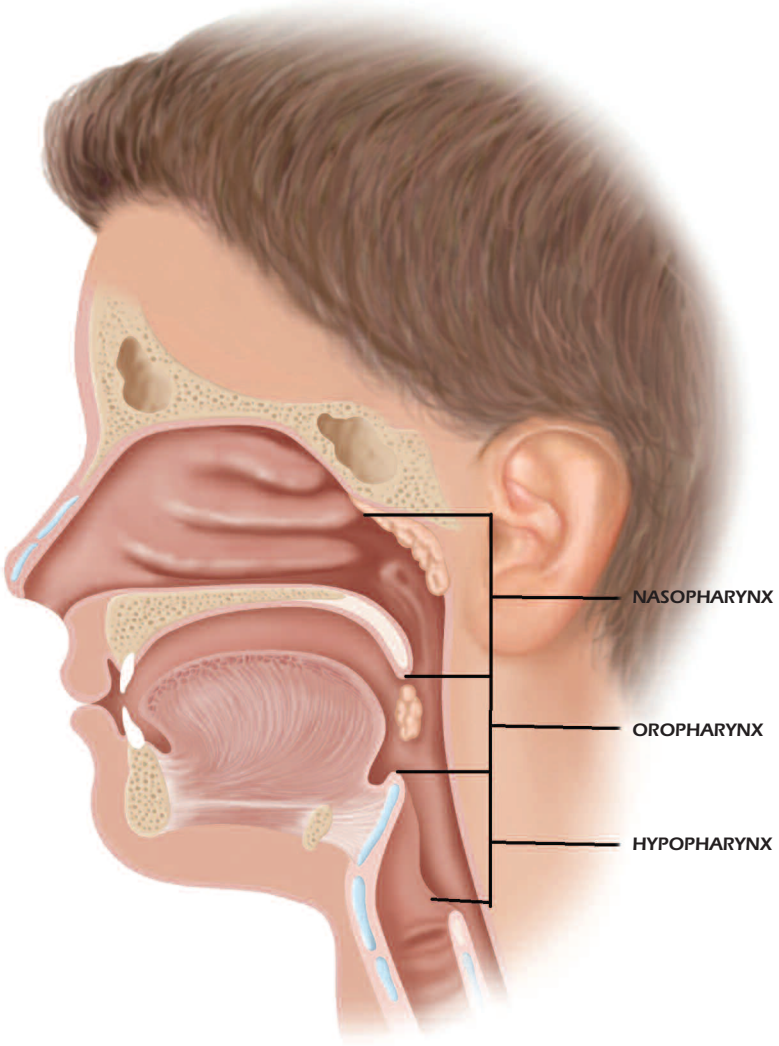
The Changing Face of Head and Neck Cancer

Molly Hammond, CORLN, MSN, APN

Head and Neck cancer is the sixth most common cancer worldwide. These tumors originate from the oral cavity, oropharynx, hypopharynx and larynx with squamous cell carcinoma (SCC) histology being the most prevalent (Langendijk & Psyrri, 2010). Traditionally, long-term exposure to tobacco and alcohol has been identified as the main risk factors. These patients often have a great deal of challenging social dilemmas and medical comorbidities which result in extensive neglected disease. Subsequently, major radical resections with reconstruction along with chemotherapy and radiation become the only options of cure or palliation.

In the late 1990s, a different group composed of relatively young, healthy patients began presenting with malignant tumors of the oropharynx (the part of the throat between the soft palate and the epiglottis). Microscopic histologic and molecular analysis was done on tonsil tumors and some fundamental differences were apparent between samples taken from patients with a history of heavy tobacco and alcohol use and those without (Scudellari, 2013). In the second group, the site of the cancer started deep in the tonsil versus more superficially in the former. On a molecular level, the tumors in the healthy group lacked mutation in protein called p53 (a tumor suppressor) that is traditionally associated with oropharyngeal cancers. This prompted a search for further explanation for the etiology of cancer in this newer group of patients. Molecular and epidemiologic studies supported human papillomavirus (HPV) to be the contributing factor to the tumor development in the "healthy" group. HPV type 16, a strain that is common in cervical cancer, was found in 90% of HPV related tumors (Scudellari, 2013). The active HPV 16 DNA appears to lead to malignancy in this subset of patients with head and neck squamous-cell carcinomas (HNSCC) by silencing the tumor suppressor protein, p53 (Mao, Hong; 2004).





The exact mechanism of transmission of oral HPV infection is not entirely clear. In the US, between years 1988 and 2004, the incidence of HPV-negative oropharyngeal squamous cell carcinoma (OPSCC) decreased from 2/100,000 to 1/100,000 and the incidence of HPV-positive OPSCC increased from 0.8/100,000 to 2.6/100,000 (225%). Testing for p16 protein, which was found to be over expressed in HPV-associated OPSCC, has been implemented as a reliable diagnostic tool to identify HPV positive tumors (Langendijk & Psyrri, 2010). Identifying these HPV-related/p16 positive tumors is important for a number of reasons. Patients who have HPV+ tumors are commonly found in young adults (<50 years old), present initially with relatively small tumors, and they are more responsive to treatment which results in a better overall prognosis. Following treatment, these younger patients tend to live longer and are more susceptible to either late adverse effects or need radiation therapy in the future for a second primary tumor. Those with >10 pack-year of tobacco smoking and metastasis to multiple lymph nodes or with a metastatic node >6cm had a significantly worse prognosis even in the setting of p16 positivity (Langendijk & Psyrri, 2010). In other words, patients who do not have a history for significant cigarette smoking who have sought medical attention before metastasis to multiple lymph nodes respond

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The Changing Face of Head and Neck Cancer

(continued from page 13)

better to treatment. However, HPV/p16 positivity is not protective in advanced disease or with a history of smoking.

Current treatment options for p16 positive HNSCC are multidisciplinary, similar to non-p16 positive tumors. Radiation alone or surgery alone for stage I/II cancer are included in the current standards of care. Options for more locally advanced tumors include radiation with concurrent chemotherapy, induction chemotherapy followed by radiation with or without concurrent systemic therapy, and surgery with postoperative radiation with or without concurrent chemotherapy (Sturgis and Ang, 2011). Significant toxicities however, such as swallowing issues and long-term morbidity, are noted with the above treatment modalities. Tumors that are p16 positive responsive have been noted to respond better and be more easily eradicated to treatment. Studies have begun to determine if less toxic treatment modalities will be an option for treatment in these patients who are generally young and otherwise healthy.

Gardasil and Cervarix are two vaccines that have been approved to protect against HPV-16 to prevent cervical cancer. Unlike cervical cancer, there is not currently a screening method for HNSCC. Abnormal cells in HPV-related tumors are typically found deep within tonsil tissues which would require invasive surgical techniques for sampling (Scudellari, 2013). Investigators continue to work on more acceptable tissue sampling to compile evidence that the vaccine also works to prevent HNSCS. The hope is that one day the vaccines that are currently available and effective for preventing cervical cancer from HPV will be able to provide the same protection against HNSCC.

Email comments to **hammond-molly @cooperhealth.edu**

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Langendijk, J., A. & Psyrri, A. (2010). The prognostic significance of p16 overexpression in oropharyngeal squamous cell carcinoma: implications for treatment strategies and future clinical studies. *Annals of Oncology, 21*(10), 1931-1934.

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Mao, L. & Hong, W. K. (2004). How does human papillomavirus contribute to head and neck cancer development? *Journal of the National Cancer Institute, 96*(13), 978-980.

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Professional News

(continued from page 16)

Melissa MacDonald, RN, BSN, Pavilion 6 Surgical Staff Nurse. *Cooper Nursing Alumni Clinical Nurse Excellence Award*

Lois Meyer, RNC, BSN, Neonatal Intensive Care Staff Nurse. *John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing Practice*

Helen Nichter, RN, MSN, APN-C , Breast Surgery Advanced Practice Nurse. *Advanced Practice Nurse Excellence Award*

Rosetta Oliver, RN-BC, BSN, Associate Clinical Director, Pavilion 7 Orthopaedics/ Neurology. *The Selma and Martin Hirsch Family Foundation Clinical Excellence Staff Award*

Erika Orfe, RN, BSN, Trauma/Surgical Intensive Care Staff Nurse. *Excellence in Trauma Nursing Award*

Donna Reamer, RN, Case Manager, Care Coordination Department. *Shaina Horton Memorial Award for Patient Centered Care*

Jamie Sabetta, RN, BSN, Pavilion 7, Orthopaedics/Neurology Staff Nurse. *The Barbara and Jack Tarditi Family Excellence in Nursing Mentorship Award, Cooper Nurse of the Year Award*

Mary Stauss, RN, MSN, APN, CEN, Clinical Educator, Emergency Department and Clinical Decision Unit. *The Lynn Nelson Memorial Award of Excellence*

Mary Thomas, RN-BC, Medical/Surgical/Oncology Unit Nurse. *Sue Zamitis and Rose Smith Memorial Award for Excellence in Oncology Nursing*

Other

MaryAnn Cupta, RN, *received her ACMA Case Management Certification*

Beth Jerome, RN, BSN, *received her Certificate in Nursing Informatics from Pennsylvania State University College of Nursing*

Julie Mesiano, RN, BSN, CNE, *earned a post graduate certificate in Nursing Education and Faculty Role from Drexel University*

Ken Rodenheiser, RN, BSN, *was chosen to be a Certified Diabetes Educator (CDE) mentee at the Cooper Diabetes Education Center/Program with the Camden Coalition Healthcare Providers*

PROFESSIONAL LADDER:

Level 3

Alexandra Chowansky . . . . .ICU
Amanda Tole . . . . . .NS 10
Barbara Smith . . . . . .CDHI
Jacklyn Palmisano . . . . . .PCU
Joanne Moffitt . . . . . .SCU
Julie Mesiano . . . . . .NS 10
Julie Stone . . . . . .PCU
Kimberly Damian . . . . . .ICU
Lauren Blantz . . . . . .PCU
Lynn Pyle . . . . . .Peds
Megan McHugh . . . . . .NS 10
Michelle Perrello P6
Priscilla Hagerty N7
Rebecca Reustle NS10

Level 4

Adisa Kljuo . . . . . .ICU
Adrian Hernandez . . . . . .NICU
Barbara Murphy . . . . . .L&D
Carlisa Brown . . . . . .INCU
Catherine Hassinger . . . . .CDHI
Christie Merget . . . . . .INCU
Christine Albano . . . . . .PACU
Christine Wadehn . . . . . .CDHI
Dale Beloff . . . . . .NICU
Doreen DeSimone . . . . . .SCU
Doris Bell N7
Edward Norton . . . . . .ICU
Ella Hawk . . . . . .ICU
Erin Toal . . . . . .ICU
Grace Baillargeon . . . . . .PACU
Heather Marshall . . . . . .ICU
Henry Muzones CCL
Jaclyn Hayden . . . . . .PICU
Jacqueline Vega . . . . . .ICU
Jamie Sabetta P7
Jane Hassan . . . . . .NICU
Jean Rabbuttino . . . . . .CDHI
Jennifer Nazarethian P7
Jillian Moffitt . . . . . .ICU
Kacey Zorzi . . . . . .INCU
Karen Mitchell . . . . . .CDHI
Kathryn McCurly . . . . . .Pool
Katie Shultz . . . . . .Peds
Kerri Myers . . . . . .Peds
Kristen Donofry . . . . . .L&D
Lara Roseman NS9
Lauren Harris . . . . . .MFCU
Leah Gebhard NS10
Lindsey Ott . . . . . .ICU
Lisa Durso NS10
Lori Osinski . . . . . .ICU
Lynn Jones . . . . . .CSC
Mariecar David . . . . . .OR
Martha Jane Murphy . . . . . .CM
Matthew Lightcap P7
Megan Bianchini . . . . . .ICU
Melissa MacDonald P8
Michelle Ives . . . . . .NICU
Naomi Tilton . . . . . .NICU
Natalia Berrios . . . . . .ICU
Norma Rowello NS9
Patricia Jewell . . . . . .CDU
Renee Smith . . . . . .NICU
Susan Lieberum . . . . . .M/I
Trinh Nguyen N7
Vicki Freiberg . . . . . .OR

Level 5

Abby Holladay . . . . . .Hem/Onc
Allison Stec . . . . . .NICU
Anna McCausland . . . . . .NICU
Betsy Maier NS10
Brenda Brown . . . . . .Peds
Caitlyn Stevens . . . . . .NICU
Carolyn Scratchard . . . . . .VSC
Cheryl Kazmierski . . . . . .Pool
Danielle Baback . . . . . .ICU
Diane Wachter . . . . . .NICU
Dominic Parone . . . . . .Air Med
Donna Wood . . . . . .NICU
Elizabeth Alonso . . . . . .ICU
Eugene McEady . . . . . .ICU
Grace Mansilla N7
Haemin Lee . . . . . .ICU
Jackie Franchetti . . . . . .NICU
Janinie McNamara . . . . . .CDHI
Janine Rousseau . . . . . .PICU
Jeanine Tuzi . . . . . .NICU
Jeannett Walton . . . . . .Echo
Jenieve Thompson . . . . . .ICU
Jodie Szalma . . . . . .INCU
Karen Kimbrough . . . . . .PACU
Kathleen Zimmer . . . . . .PACU
Kimberly Potorti . . . . . .SCU
Linda Hessler . . . . . .PACU
Linda Sullivan . . . . . .PACU
Lisa Replogle CCL
Lois Meyer . . . . . .NICU
Lorene Pugh . . . . . .ED
Lynnette Jones P8
Marcy Chojnacki . . . . . .TSDU
Maria Alcontin P7
Maria Meneses . . . . . .NICU
Marie Eastlack . . . . . .SCU
Marina Dvortsyn . . . . . .Peds
Maryjane Durkin Outpatient Chemo
Michelle Doyle . . . . . .Peds
Paulette Palogruto . . . . . .ICU
Regina Callaghan . . . . . .Peds
Rosa Arroyo . . . . . .L&D
Rosemarie Maitland . . . . . .ICU
Tania Bergahair . . . . . .Peds
Valerie Gibson . . . . . .NICU
Victoria Johnson . . . . . .ICU

Level 6

Audrey Bennett . . . . . .L&D
Debbie Orr CCL
Jean Zoll . . . . . .CDHI
Michelle Basile . . . . . .NICU

PATIENTS / FAMILIES / COMMUNITIES

REFLECTIONS

From Nursing School to Nursing in the Real World

Jamie Sabetta RN-BC, BSN

I became a nurse for many reasons but mainly because I truly love taking care of people. There is no reward greater than receiving a thank you at the end of a day to make me realize that my job is worth every up and down. I've been at Cooper since October 2010 and had my fair share of ups and downs, but it's been the thank yous at the end of my shifts that have made it all worthwhile.

I'll never forget my first code. I was newly off orientation, sitting at the front desk writing my notes and down the hall I heard a co-worker yell "call a code." The voice was calling from my patient's room. My heart sank and I ran into the room. I froze while the other nurses on my floor sprang into action. Then I tried to do everything I could to help and was so thankful for my fellow staff members' assistance at the moment I needed them most.

I realized at that point in time, my co-workers were not just people who work with me but they are my family. It took me a little bit of time to overcome the feelings of fear and wanting to run away from nursing. It wasn't until the time I was assigned a stroke patient and his family all gave me big hugs and thanked me for the care their loved one received that I felt I made the right decision.

Jamie Sabetta RN-BC, BSN

You are there as a shoulder to cry on or as a hand to squeeze when the doctor walks in at that final moment. You become part of that family's life at that moment and that's something I love about being a nurse.

On Pavilion 7, we care for many orthopedic joint revision/replacement patients. On their first post-op day on the floor, I enjoy being there to reassure them that when they get out up bed, stand up and take their first step, I will be there to support them and their new joint will work great. Once I was assigned a patient who had his knee replaced. It was his first surgery and he was experiencing pain since his arrival from PACU. I had to sign off for the night but I told him he was in good hands and that I would see him the next morning. I said to him, "I'll be back in the morning to get you up and get moving." He said "really, tomorrow I'm going to be moving already?" I told him to just relax tonight and that we'll get to work tomorrow. The next morning I walked into his room and he gave me those "panic eyes." I told him not to worry, that he would be alright. Breakfast came and we set his table up, and then explained that it's finally time to stand. The patient stood up and let out such a breath that he began laughing. I didn't think he expected to be standing up the first day after his surgery. The next day I was able to discharge him to his home. He told me he was still in shock about being sent home only a few days after having his knee replaced and that he was walking… with minimal assistance from a walker! It has been a great experience watching patients admitted post-surgery, seeing fear in their eyes and being able to send them home a few days later with confidence, ready to face the next chapter in their lives.

I've learned through nursing not to take anything for granted. Being in this career as a new nurse, you never realize how many different emotions you will experience. My hardest emotion was dealing with the passing of a patient. You become part of someone's family during that phase of life and being in nursing school you never really know how you're going to react until the situation arises and you are the nurse taking care of not only the patient but the family also. I placed a white rose photo on the patient's door and within a few minutes her family arrived and immediately came to the nurse's station to talk about the white rose. The family told me their mothers favorite flower was a white rose and at that moment when they saw it on her door they knew she would be at ease and comfortable. They thanked me for placing it there and decorating her room with photos of her grandchildren that they had left at the bedside. Sadly the patient passed at the end of my shift, I tried to stay as strong as I could, but also shed a few tears with the family. In the matter of a 12 hour shift, I learned so much about my patient and her life that I felt like I knew her my whole life. At these hard times you share moments of sadness and moments of reflections with the patient's family. You are there as a shoulder to cry on or as a hand to squeeze when the doctor walks in at that final moment. You become part of that family's life at that moment and that's something I love about being a nurse.

Email comments to **Sabetta-jamie@cooperhealth.edu**

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Professional News

DEGREES:

Brittani Abele, RN, BSN
Ohio University
Robert Austin, RN, MSN
University of Pennsylvania
Danielle Baback, RN, MSN
Holy Family University
Diane Ballak, RN-BC, BSN
Rowan University
Natalie Bene, RN, BSN
Rowan University
Lynda Brooks, RN, BSN
Rowan University
Dorothy Burke, RN, BSN
Rowan University
Karen Capone, RN, BSN
Rowan University
Barbara Carroll, RN, BSN
Wilmington University
Lisa Clothier, RN, BSN
Rowan University
Andrew Colligan, RN, BSN
Rowan University
Norma Colwell-Rowello, RN, BSN
Rowan University
Deb Cutrona, RN, MSN
Wilmington University
Debbie Cosenza, RN, BSN
Wilmington University
Stephanie Crumb, RN, BSN
Wilmington University
Kimberly Damian, RN, BSN
Ohio University
Mariko Deal, RN BSN
Rowan University
Lynda DePasquale, RN, MSN
Walden University
Mary DiBenedetto, RN, BSN
Rowan University
Sandy Durflinger, RN, MSN
Walden University
Jamie Eisele, RN, BSN
Rowan University
Mary Francis, PhD, RN, ACNP-BC
Widener University
Lizabeth Gsell, RN, BSN
Rowan University
MaryBeth Harow, RN, BSN
Rowan University
Catherine Hassinger, RN, BSN
Rowan University
Susan Hoffman, RN, BSN
Rowan University
Andrea Jones, RN, BSN
Rowan University
Carol Jones, RN, BSN
Rowan University
Susan Joo, RN, BSN
Rowan University
Timothy Kane, RN, BSN
Rowan University
Patricia Kerfoot, RN, BSN
Rowan University
Mary LaChant, RN, BSN
Rowan University
Susan Lieberum, RN, BSN
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Nicole Luedtke, RN, BSN
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Kassie Mannino, RN, BSN
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Christine Marts, RN, BSN
Rowan University
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Brandi Nice, RN, BSN
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Joanne Olsen, RN, BSN
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Laura Profico, RN, BSN
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Linda Smith, RN, BSN
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Nicholas Stewart, RN BSN
Rowan University
Jacqueline Tedeschi, RN, BSN
Rowan University
Steven Torres, RN, BSN
Rowan University
Lori Tritschler, RN, BSN
Rowan University
Nora Vizzachero, RN, DNP
Thomas Jefferson University

CERTIFICATIONS:

Danielle Dodge, RN-BC, BSN
Mary Anne Figueroa, RN, CNOR
Jamie Sabetta, RN-BC, BSN
Karen Slutsky, RN, BSN, CPPS
Megan Sweeney, RN-BC, BSN
Kim Zlupko, RN-BC, BSN
Jacquelynn White, RN, MSN, APN, AOCNP
Kim Zlupko, RN-BC, BSN

PRESENTATIONS:

Grace Mansilla, RN, BSN, Poster presentation "Pain Assessment of the Critically Ill Patient Unable to Self-Report" presented at the 26th Annual ENRS Scientific Session, Philadelphia, PA April 10, 2014.

Erika Orfe, RN, BSN, Poster presentation "Implementation of a Multidisciplinary Timeout and Checklist for Bronchoscopy-Guided Percutaneous Tracheostomy." Presented at the 17th Annual Society of Trauma Nurses Conference, New Orleans, LA, April 3, 2014.

Barbara Sproge, MSN, RN, OCN, CHPN, is presented a poster at the 8th Annual Hospice & Palliative Nurses' Association Clinical Practice Forum in Pittsburgh, Pa: "Impact of Palliative Medicine Rotation on Resident Education and Patient Care at Cooper University Hospital." Co-authors include: **Huda Sayed, MD, Barbara Sproge, MSN, RN, OCN, CHPN, Mark Angelo, MD FACP.**

PUBLICATIONS:

Sharon K. Byrne, DrNP, APN, NP-C, AOCNP, CNE, a APN in the Cancer Screening Project, MD Anderson Cancer Center at Cooper, had the manuscript "Sustainable Global Health Outreach in Haiti: Service-Learning for Primary Care Nurse Practitioner Students" accepted for publication in The Journal for Nurse Practitioners (JNP). It will appear as a featured article in the on-line faculty section of JNP.

APPOINTMENTS:

Sharon K. Byrne DrNP, APN, NP-C, AOCNP, CNE, a APN in the Cancer Screening Project, MD Anderson Cancer Center at Cooper, has recently been invited to serve as a Peer Reviewer for Nurse Educator and Journal of General Internal Medicine. She has been a Peer Reviewer for Oncology Nursing Forum since 2006.

Rosemary Kates RN, APN, CWOCN, is currently serving a two year term as the President of the Delaware Valley Wound Ostomy and Continence Nurses Society(DVWOCN) and is also the Chair of Public Policy /Advocacy for the National WOCN Society

OUTREACH:

Sharon K. Byrne, DrNP, APN, NP-C, AOCNP, CNE, a APN in the Cancer Screening Project, MD Anderson Cancer Center at Cooper served as a Explorers Sans Frontiers (ESF) volunteer staff leader for June 2014 mission to Haiti. The multidisciplinary team of healthcare providers and volunteers were able to successfully support over 1, 200 persons across the lifespan providing care at 4 different sites in the Port-Au-Prince area.

2014 NURSING EXCELLENCE AWARDS

Leonora Ball, RN, MSN, APN, Cardiothoracic Surgery Advanced Practice Nurse. *The Cooper Heart Institute and The Heart House Award for Excellence in Cardiovascular Nursing*

Ruth Cooper, EMT-B, Emergency Technician, Emergency Department. *The Barbara and Jack Tarditi Award for Excellence in Patient Care (Non-Nurse)*

Deborah Cutrona, RN, MSN, CCRN, Post Anesthesia Care Unit Staff Nurse. *The Barbara and Jack Tarditi Family Excellence Award for Nursing Research*

Joanne Fox, RNC-NIC, BSN, Clinical Director, Neonatal Intensive Care Unit. *The Philip and Carole Norcross Award for Excellence in Nursing Leadership*

Karen Kimbrough, RN, BSN, CCRN, Post Anesthesia Care Unit Staff Nurse. *The Philip and Carole Norcross Award for Excellence in Perioperative Nursing*

Matthew Lightcap, RN, BSN, Pavilion 7, Orthopaedics/ Neurology Staff Nurse. *The Carol G. Tracey Compassion Award*

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