



Bridges to Excellence

A publication for nurses and healthcare professionals

SPRING/SUMMER 2007



This year's Nurse Excellence Award Winners are:

(Clockwise from back row standing) Linda Gazzerro, RN, CWOCN; Diane Floyd, RN, BSN, CCRN, CNA; Adrienne Fowler, RN; Elizabeth Bobulski, RN, Senior Vice President of Patient Care Services and Chief Nursing Officer; George Norcross III, Chairman, Board of Trustees; Patricia Budic, RN, CGRN; Sara Dwyer, RN, BSN; Tabitha Leonard, ORT; Susan Chico, CST; Henry Muzones, RN; Tracy Green, RN, BSN; Veronica Still, Unit Secretary; Terry Deubler-DePasquale, RN, CCRN; Kiesha Shields, RN, BSN; Michael Lindsay Tronco, RN, BSN; Diane Yerkes, RN; Cheryl-Anne Kullman, RN BSN.

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Kathy Devine, RN, Trauma Coordinator (center, right), winner of the title contest, is shown with executive editors of *Bridges to Excellence* (from left) Stacey Staman, Kathleen Yhlen and Lynn Ferchau.

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For more information on continuing education courses please contact Cooper University Hospital, Patient Care Services-Education Department at **856-342-2459**; or log onto **www.cooperhealth.org**

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Dear Colleagues,

It is my pleasure to welcome you to this inaugural issue of the Cooper Health System's *Bridges to Excellence*. Cooper Nursing has a rich history of clinical excellence dating back to 1887 when the hospital began to care for the Camden community. Over the following 120 years Cooper's patient population has grown to include many specialties. Cooper Nurses have developed extraordinary skills through the commitment to life long learning and evidenced based practice.

It is our goal through *Bridges to Excellence* to share Cooper Nursing's practice through educational articles that stimulate thinking and drive research to ever refine patient care excellence. We also take pride in sharing the many accomplishments of our Nursing team.

Thank you in advance for your interest and review. We hope you will enjoy reading and learning.

Sincerely,

Elizabeth Bobulski, RN, BS, MPH
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***Bridges to Excellence* Mission Statement:**

"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 *Bridges to Excellence* may obtain submission guidelines by contacting Yhlen-kathleen@cooperhealth.edu

Artist's rendering of the new
Cooper University Hospital.





COOL AID: Hypothermia after Cardiac Arrest

Lynn Ferchau, RN, MSN, CCRN, APN.C

Despite the rapid activation of the “chain of survival”: immediate call for the code team, early delivery of CPR, defibrillation, and ACLS, survival with a good neurological outcome after cardiac arrest is rare.

History

Bigelow (Bernard, 2006) introduced induced hypothermia (IH) as a means of cerebral protection during cardiac surgery. Subsequently, cooling to mild hypothermic states were used during the 1950's for a range of neurologic indications, including head injury, stroke, and anoxic injury. The first use of IH for neurologic injury after cardiac arrest was in 1956 in four patients with only one surviving and in 1957 another 12 were studied with 6 surviving. Interest in the use of IH after cardiac arrest was revived in 1991, when Sterz and his colleagues demonstrated in a dog that IH induced within 15 minutes of cardiac arrest was associated with significant improvements in neurological outcomes. Similar outcomes in lab studies stimulated interest in evaluating this therapy in humans. Between 1997 and 2000, prospective, randomized, controlled clinical trials were conducted in Australia and Europe. These too were encouraging and demonstrated improved survival without an increase in the incidence of side effects or complications. On the basis of these two studies, the International Liaison Committee on resuscitation endorsed the use of hypothermia for patients who have neurologic injury after ventricular fibrillation cardiac arrest. Since that time, clinical studies have focused on the timing and technique for inducing hypothermia after cardiac arrest, as well as the applicability to patients who arrest from a variety of reasons.

The Research

In 1996, four hospitals in Australia started a wave of excitement about using hypothermia after cardiac arrest. They studied 77 patients who were randomly assigned to treatment with hypothermia for 12 hours. The primary outcome measure was survival to hospital discharge with a positive neurological outcome. Good outcome was defined as discharge from the hospital to either home or to a rehabilitation facility. The results gave encouragement for future studies. In the European study, 273 patients were enrolled; 136 of those were randomized for IH. This study also looked encouraging, with 55% being discharged to home or to a rehab facility.

The Physiologic Mechanisms

The exact effects of hypothermia on the injured brain are uncertain, but there is considerable laboratory evidence that continuing neurological injury occurs in the early post arrest period (Bernard, 2006). The insult to the brain is believed to be caused by several biochemical cascades that are thought to be temperature sensitive, thus providing the rationale for treatment with IH for hours to days after resuscitation. Another proposed mechanism may include improvement in cerebral oxygen delivery. For example, cerebral edema may be present after arrest and hypothermia is known to decrease intracranial pressure.

There is some evidence that IH may be beneficial in the post arrest heart during the reperfusion period. This benefit was seen during interventional cardiology procedures when an intravascular cooling device was used. IH has also been used for the treatment of cardiogenic shock that was not responsive to traditional therapy.

An increase in serum creatinine may be seen after the first 24 hours post cardiac arrest, however, according to references, there is rarely a need for continuous renal replacement therapy (CRRT). The potassium level does decrease during hypothermia as does magnesium and phosphate levels. Additionally, hypothermia does not significantly increase lactate levels or metabolic acidosis.

Decreasing the body temperature does have a small effect on clotting times and platelet counts during prolonged hypothermia of greater than 48 hours.

Hypothermia is known to increase the blood glucose as it decreases insulin release from the pancreas. It has also been established that hyperglycemia is associated with a worsened outcome after anoxic arrest.



Our protocol and order set were developed by a multidisciplinary team and both are considered a “work in progress” as the team continues to seek best practice.

Cooper's Experience

Our protocol and order set were developed by a multidisciplinary team and both are considered a “work in progress” as the team continues to seek best practice. Patients are selected on the basis of the following inclusion criteria: Did the patient have a pulseless cardiac arrest? Does the patient now have a pulse? Is the patient intubated, sedated and paralyzed? Is the systolic blood pressure great than 90 mm Hg? Once these criteria have been determined, the patient is hypothermia induced.

Prior to IH, baseline vital signs are obtained and a foley catheter with a special temperature probe is placed. This probe will monitor the patient's core temperature once attached to the cooling device. Arterial blood gas, lactate level, metabolic panel, PT/INR, PTT, Calcium, Magnesium, Phosphorus, Cardiac enzymes, and CBC are all drawn initially and then at pre-determined intervals thereafter. IH is done by applying an induction device's pads to the patient's torso with the foley catheter probe attached to the machine. This enables the device to self-regulate the temperature of the water that flows through it and ultimately keeps the patient's temperature at the preset temperature of 33 and 34 degrees Celsius (91.4-93.2 degrees F) for 24 hours. Once the patient is at this target temperature for 24 hours, the device is removed and the patient is passively re-warmed over 6 to 12 hours.

During the time that the patient is being cooled, the nurse monitors vital signs via continuous cardiac monitoring, assesses for the presence of shivering, and obtains labs. Patients are also placed on the Insulin Protocol and given anti-ulcer agents to decrease the propensity for stress ulcers. During this critical period, urine output is closely monitored because of the diuresis that occurs during the hypothermic state. Millimeter for millimeter intravenous fluids are utilized to replace the fluid lost during the polyuric phase.

Does It Work?

Cooper has utilized IH on 16 post cardiac arrest patients. IH is a promising method to improve neurologic outcome and given its potential and initial success, nurses will need to stay abreast of the latest research results. After all, you may be asked to “chill your patient” out.

References:

Bernard, S. (2006). Therapeutic hypothermia after cardiac arrest. *Neurologic Clinics of America*, pp. 61- 71.

Bernard, S. et al. (2002). Treatment of comatose survivors of out-of-hospital cardiac arrest with induced hypothermia. *New England Journal of Medicine*, pp. 557-563.

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Ice Cubes?

Aggressive patient cooling should commence immediately after cardiac arrest to decrease the core temperature to 33° C. In practice, initially this was problematic in adults. In the Australian trials, a neuromuscular blocker and surface cooling with ice packs was used, but this method proved to cool the patient too slowly (0.9° C per hour) and was considered to be very inconvenient by the nursing and medical staff. A refrigerated air blanket was utilized in the European trials. This proved to be slow as well, with a decrease in core temperature of only 0.3° C per hour. Additionally, many of the patients required icepacks after 4 hours as this manner of cooling was not always effective.

A study using a simple, inexpensive technique for induction of mild hypothermia used core cooling and the use of a large volume, ice cold intravenous fluid. Along with a large dose of a neuromuscular blocker (to prevent shivering), a large-volume crystalloid was infused rapidly, this cooling method decreased core temperature by 1.6° C per hour and increased blood pressure without causing pulmonary edema in any of the 22 patients.

How Do We Measure Core Temperature?

It is essential that the core temperature be monitored continuously during IH, and of course, accurately. There is a minimal temperature gradient among the brain, esophagus and bladder, therefore it is recommended that esophageal or bladder temperature be utilized. (Bernard, 2006)



Questioning the Status Quo: Research at the Bedside

Stacey Staman, RN, MSN, CCRN
Jennifer Hosking, RN, BSN

Mention the term “research” and the image that frequently comes to mind is that of the stereotypical white lab jacket clad individual working alone in a laboratory. But this isn’t what is happening at Cooper University Hospital (CUH). With the support of research consultant Marianne Chulay and the clinical educators, many of the professional nursing staff are developing and performing their own research studies. Direct patient care providers in the Progressive Care Unit, Intensive Care Unit, Neonatal Intensive Care Unit, Emergency Department, 9th floor Medical-Surgical Unit, 7th floor Medical-Surgical Unit, Psychiatric Unit, and Trauma Units have recently developed research teams.



The Trauma Research focus group (left to right) are Debbie Cannon, Adrienne Bell, Jen Hosking, Mary Lachant, Sue Hoffman, and Stacey Staman. (Not pictured: Ali Mimm, Edna Goodman, Pat Osterheldt, Jamie Eisele, Chris Scharle)

Involving the staff nurse in this process will generate benefits that reach far beyond the walls of our institution.

These 8 groups are following a unit based model of nursing research, which brings clinical research to the level of the action – the bedside, and puts it into the hands of our expert practitioners – our staff nurses (Kacuba, 1993). For many of these individuals, this is the first time they have actively participated in research development and data collection. This process assists in the professional growth of staff and the application of evidence based practice to patients, thus exhibiting research's role in clinical excellence

For these first time researchers, it is important to select a patient focused, staff driven question. The careful selection of a project is the first step to insuring success (Chulay, 2001). Guiding principles in this selection process include building on current clinical expertise, performing a replication study, and identifying a question that is important to patient care and outcomes. Studies that do not require additional funding and which avoid politically charged areas of practice are also identified as ideal.

Guided by the research consultant and research mentors, the staff nurses take the first step: identifying a research question. This brainstorming process begins with the identification of high volume patient care situations that occur within their units on a daily basis. Next, clinical questions about these high volume situations are discussed. Once a complete list is generated, an evaluation process utilizing 12 criteria assists the researchers in narrowing down their options for study. The final research question is selected via majority vote by the research team. The following is a first hand description of a research team member's experience:

Stacey Staman, Nurse Educator for Trauma, discussed the possibility of doing a research project with nurses in Trauma ICU and the Trauma Stepdown Unit. A time and place was posted for those that were interested, and the first meeting was held. Using a brainstorming technique, we categorized our ideas and questions about improving patient care. Believe it or not, we generated a substantial list of topics of interest.

In the next few meetings, we narrowed down our list of potential research questions, eliminating research ideas that involved other departments or were not patient care issues which occurred frequently

At this point in the process, Stacey Staman consulted with our research consultant and discussed the remaining topics of interest. The research consultant provided information and requirements for remaining topic, such as how many patients would be needed for the study. The unit research team discussed each research question, which involved what the research would entail and how long the data collection would take. Some of our topics were then eliminated based on availability of patient population and the time commitment it would take to properly perform the study.

Thirteen research questions remained on the list and we posted the questions on the wall during our next meeting. In this meeting, every nurse marked the six topics that were least appealing to them. After tallying up the results, eight topics were voted off the list and six research questions remained.

At our last meeting, a scoring system to rate each questions and whether it met important criteria for project success was put in place to assist us in the final selection of our research topic. The scoring system used was "0" for "not present" through a "5" for "highly present". A few of the topics that were used in this criteria and scoring tool were: area of staff interest, financial impact on the hospital, importance to clinical practice and patient outcomes, no additional funds required, large number of patients on unit eligible for the study, and staff have clinical expertise in topic.

By using this scoring system, we narrowed our focus to three topics: improving compliance with policies for central venous catheter insertions; family education before transferring a patient from Trauma ICU to Trauma Stepdown or Trauma floor; and ways to decrease family stress during visiting. At our next meeting, we will narrow down the three topics to one research question.

This experience impacts both our units and our hospital as we demonstrate support for the professional growth of our direct care providers. Unit-based research can improve morale by empowering professional practice models. As these teams proceed through the next steps, education and support will be provided by the mentors. Each of these 8 teams will then subsequently develop the research proposal, submit the project proposal to the Institutional Review Board (IRB) for approval, and begin data collection. Upon completion of the study, teams will then analyze their findings and share associated generalizable knowledge with their peers, through reporting at conferences and publishing. This may also provide the added benefit of promoting staff recruitment and retention. Individually, participation in development of a research study promotes critical thinking skills, teamwork and public speaking skills.

Involving the staff nurse in this process will generate benefits that reach far beyond the walls of our institution. Through scientific study and validation of nursing interventions, professional nurses will provide patients with cost-effective, compassionate and appropriate care that result in improved outcomes and development of evidence-based practice.

References:

- Chulay, M. (2001). Clinician involvement in critical care research. *Critical Care Nursing Clinics of North America*. 13(1), pp-53-61.
- Kacuba, A. (1993). Turning tradition upside down: Staff nurses and clinical research. *AJN / Supplement-November*, pp5-10.



FALLS: Framing A Landscape Leading to Safety

Donna O'Shea, RN, BC, BSN
Danielle Majuri, RN, MSN, APN-C

Falls affect all age groups from birth to death, there are no age restrictions. Tinetti, Speechley, and Ginter defined falls as “an event which results in a person coming to rest unintentionally on the ground or other lower level, not as a result of a major intrinsic event (such as a stroke) or overwhelming hazard” (as quoted in Masud and Morris, 2001, p.3). Several factors contribute to falls including a) intrinsic factors like age, diagnosis, and the increasing complexity of patients with co-morbidities, b) extrinsic factors such as environmental or equipment (e.g., slipping, tripping, and poor lighting), and c) medication related causes (e.g., narcotics, sedatives, and diuretics).

When a patient falls, the consequences can be complicated

and costly. The resulting injury can leave the patient at increased risk of morbidity and mortality as well as a decreased sense of safety. Psychological events such as fear of falling again, can lead to a reduction in the activities of daily living resulting in decreased quality of life.

As predicted by a group of financial and economic experts, by the year 2020, the total number of falls resulting in injury in the United States will be 17,293,000 at a projected cost of \$85.37 billion (Englander, Hodson, and Terregrossa, 1996). These estimates include falls in both healthcare settings and the community. The associated costs are linked to expenditures of resources, delays in throughput and access, and indemnities incurred.

Table 1 Cooper University Hospital Fall Prevention Program

	CATEGORY 0	CATEGORY 1	CATEGORY 2	CATEGORY 3
RISK	NONE	LOW	MODERATE	HIGH
POINTS	0	1-3	4-7	>7
ASSESSMENT	1. Complete daily fall risk assessment 2. Assess for language barrier	Same as previous category	Same as previous category and also: 1. Assess for need to apply restraint alternative 2. Review medication schedule 3. Assess muscular strength and gait	Same as previous category and also: 1. Assess patient's room assignment 2. Re-assess toileting needs/routine
INTERVENTION	1. Maintain clutter free environment 2. Maintain bed in lowest position, breaks locked. 3. Assist patient with ADLs, if necessary 4. Place call bell within patient's reach 5. Ensure patient has slip-resistant slippers or shoes when ambulating 6. Maintain a night light	Same as previous category and also: 1. Minimize fluid intake at bedtime 2. Offer patient assistance with toileting prior to bed 3. Establish a toileting schedule. 4. Offer patient assistance with ambulation 5. If available, place patient in bed closest to bathroom. If not available to move bed assignment order patient a commode 6. Incorporate patient and family members into fall prevention plan of care 7. Observe patient once an hour; more frequently if necessary	Same as previous category and also: 1. Incorporate patient and family members into fall prevention plan of care 2. Identify patient as a moderate fall risk with a Fall Risk arm band, Fall Risk magnet on the door frame of the patient's room and a Fall Risk sign posted above the patient's bed. Communicate patient's fall risk status to other departments when patient leaves nursing unit. 3. Consider restraint alternative 4. Consider need for physical therapy consult – request consult from physician if needed. 5. Re-adjust medication schedule if needed (ex. Change diuretic time from 8:00pm to 8:00am)	Same as previous category and also: 1. Consider moving patient's room assignment closer to the nursing station, if available 2. Consider use of a 1:1 or 2:1 observation or continuous family presence
EDUCATION	1. Orient patient/Family to environment 2. Instruct patient/family on proper use of call light 3. Encourage patient and family to call for assistance, when transferring the patient in/out of the bed or chair, and when ambulating to the bathroom. 4. Educate patient/family on fall prevention program and plan of care	Same as previous category	Same as previous category	Same as previous category

The potential for falls and fall-related injuries are a matter of public health priority and are an important patient safety consideration. It is imperative that staff become adept at assessing patients for risk, engaging in effective communication with healthcare personnel, and by continually evaluating current fall prevention practices. Nurses play a pivotal role in identifying and reducing a patient's risk for falls by assessing, planning, implementing and evaluating the plan of care for each patient.

Process improvement activities foster continual identification and solutions to problems affecting a healthcare organization. Cooper University Hospital identified a patient safety concern in 2003, when a medical surgical unit noticed an increase in their fall rates. After examining the incidences, a performance improvement team developed and implemented a mechanism for documenting a falls risk assessment. This project initially reduced the number of fall occurrences and led to the development of a multidisciplinary team to research, organize, and initiate a hospital-wide fall prevention program. The team members consisted of nurse educators, nurse managers, nurse associates, and critical care technicians

After several months of research, a fall prevention program was developed. All patients were assessed for their risk for falling at the time of admission and daily thereafter. The risk assessment was added to all admission databases and daily assessment flow sheets to be completed by the nurse (see Table 1 and 2). Education regarding the new fall prevention program was provided to the patient care services department in an effort to provide a holistic approach to patient safety.

Efforts to continually improve practice led three nurses to a workshop sponsored by the New Jersey Department of Health and Senior Services during the summer of 2006. Nurse educators Danielle Majuri, RN, MSN, Donna O'Shea, RN, BSN, and Joanne Porter, RN, BSN, manager of regulatory affairs participated in a 2-day collaborative fall workshop. The focus for Day 1 was to meet with other hospitals to discuss information and research, discuss fall theory, share knowledge about best practices used in healthcare organizations, formulate a collaborative project for preventing falls, and develop a best practice model. Day 2, held in the fall of 2006, commenced with a ten minute presentation from each of the participating organizations, summarizing the results of their project and relative findings.

Prior to the workshop, Cooper University Hospital utilized a brief post-fall nursing assessment as part of the hospital incident report. As a result of the workshop the Cooper nurses decided to modify the current post fall assessment after analyzing best practices because the current assessment did not collect adequate data concerning the nature of the fall. The nurses believed that new information about falls could assist them in making decisions regarding changes in the current fall prevention program. In addition products and equipment were evaluated to assist front-line staff in preventing falls.

A pilot project was initiated on a 48-bed medical-surgical unit using the revised post fall assessment. This particular unit had the highest fall rate in the hospital and was consequently, the pilot unit during the implementation of the fall risk assessment program in 2003. The goal of the project was to decrease patient falls by understanding the most common causes for patient falls, and implement changes to the fall program that would increase patient safety. The staff was invited to the first team meeting to discuss

Table 2 Cooper University Hospital Fall Prevention Risk Assessment

Risk Factors:	Points
Age greater than 75	1
Incontinent of bowel or bladder/urgency	1
Generalized weakness	1
Complaint of dizziness (with or without position change)	1
Diuretic use	1
Documented orthostatic hypotension	1
Recent fall, or a fall within the past 3 months	7
Agitation/Restlessness	1
Narcotic /sedative use (PO, IV, or PCA)	1
Change in mental status	1
Impaired judgment (lack of safety awareness/confusion)	1
Assistive devices (cane / walker)	1
Visual/Auditory Deficits	1
Seizure Disorders	1
Total Points	

Patient's category classification:

Category 0 (0 pts.)	No risk
Category 1 (1–3 pts.)	Low risk
Category 2 (4–7 pts.)	Moderate risk
Category 3 (> 7 pts.)	High risk

and give input on re-creating the post-fall assessment. The team agreed that the best plan would be to revise the hospital incident report. The new post-fall assessment included detailed information about the nature of the fall, fall history, fall risk factors, and medications that can contribute to falls. The staff was educated on the new incident report and the reasons for the changes. The pilot began in July 2006. The feedback from the staff was positive. The form was found to be user-friendly and easy to complete.

Five falls on the pilot unit were noted during the one-month trial. The common factors found throughout the trial was patient's were climbing out of bed in an attempt to ambulate. The patients needed to use the bathroom, were agitated and/or restless, or needed assistance but did not use the call bell. As a result of our enhanced knowledge additional interventions were provided which included placement of a patient companion at the bedside of an at risk patient. In addition, staff was encouraged to communicate a patient's fall risk assessment during shift report. Since the inception of the fall prevention program, Cooper's fall rate has been at or below the national average. Cooper continues to implement best practices by monitoring and making improvements to the program. Presently, consideration for the use of different fall prevention products is under review. Ongoing education and research will continue to help nurses provide the best care to their patients. The goal at Cooper is to provide safe quality care to the patients and families they serve.

References:

- Masud, T., & Morris, R.O. (2001). Epidemiology of falls. *Age and Ageing*, 30(S4), 3-7.
- Englander, F., Hodson, T.J., & Terregrossa, R.A. (1996). Economic dimensions of slip and fall injuries. *Journal of Forensic Science*, 41:733-746.

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Recognizing Individual Nurses: Accomplishments and Contributions

Rowena Ripa, RN, PCCN
Kelly Jakubawski, RN

Since the early 1970s, clinical ladder programs have been a method of defining, recognizing, and rewarding nursing practice at various levels of expertise. Nursing's goal of providing quality patient care remains a constant in the midst of change. As clinical practice in hospitals become more complex, clinical ladders can motivate nurses to remain at the bedside, where they are needed, in a time when most healthcare organizations are challenged with a nursing shortage.

At Cooper University Hospital the professional ladder is made up of four levels. (see Table 1). There are a myriad of ways to earn critical points to climb the ladder. Points may be earned by completing continuing education hours, obtaining an advanced degree, becoming certified in an area of expertise, or joining a professional organization. Nurses may also earn points by becoming involved in the community, conducting research, and

providing unit-based activities for staff nurses. In addition, nurses who are mentors or preceptors for new staff nurses, or are involved in the shared governance structure can also earn points towards the ladder.

Professional ladders can motivate nurses to obtain certification. Certification is voluntary and is a process used to validate that registered nurses possess knowledge, skills, and abilities to practice in a defined specialty. Certification in nursing requires passing a comprehensive exam which covers practice standards in a clinical area. Certification also involves a study of evidence-based nursing practice and application of knowledge within the clinical specialty. The value of certification in nursing benefits the patients and families by confirming nursing knowledge, skills, and experience.

Becoming involved in a professional organization or committee provides opportunities for nurses to communicate and network with peers. Professional and personal relationships develop by sharing current knowledge about best practices helps keep nurses current in their practice and ensures the delivery of comprehensive quality care to patients and families. Staff nurses view these individuals as leaders on their unit and consult them to help them problem-solve clinical issues.

Professional ladders promote personal development by encouraging nurses to volunteer in the community or participate in unit-based activities. An example of a community activity is participating in blood pressure screenings or health fairs. Nurses may also feel a sense of pride by engaging in unit-based activities. A unit-based activity might be designing a bulletin board with educational information for either patients or staff. Nurses may also earn points by initiating activities that promote camaraderie on their unit. For example, nurses may organize unit social activities such as celebrating birthdays, showers, or professional achievements. As a result, nurses feel a sense of belonging which creates an environment conducive to providing quality care.

The professional ladder gives nurses the

opportunity to become involved in research projects, which allows them to implement evidence-based practice. The nursing profession gains validity when there is evidence to prove its theories.

Nurses at Cooper are empowered to make decisions that affect their professional practice through a formal shared governance model. Shared governance ensures that nurses have a voice in how patient care is delivered. Our model is built on five councils that have an explicit communication structure to make patient care decisions as well as unit, hospital programs, and nursing policy decisions. Nurses from various units interact with one another, present different perspectives regarding the delivery of care, broaden their knowledge base, and enhance their ability to make decisions. Through this structure, patient care and professional development are advanced.

In addition to personal satisfaction and peer recognition, a monetary reward is given to nurses who successfully achieve ladder requirements. The ladder provides nurses with recognition for their contributions to the profession for going above and beyond minimal requirements.

Cooper staff nurses must have at least one year of clinical experience in order to apply for the ladder. The RN is required to work a minimum of 1,000 hours per year and be supported by the clinical manager for ladder recognition. The completed application contains copies of current certifications, degree attainment, and attendance or participation in all professional activities. The completed application is then submitted to the professional council. As part of the shared governance structure, the professional council reviews all of the applications and appoints candidates to the clinical ladder. The approved applicants are sent a formal letter of appointment by the council. Nurses on the ladder need to re-apply annually.

Professional ladders provide nurses with an opportunity to advance in their profession while remaining at the bedside. In addition to the personal rewards of being recognized by your peers; a clinical ladder is an excellent way to increase employee satisfaction, motivate nurses to continue their professional development, and keep expert nurses in direct patient care roles while enhancing quality care for patients and families.

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Table 1 Cooper University Hospital Professional Nursing Ladder

LEVEL 3: Novice

- RN with one year of clinical experience and
- 10 critical points with
- Recommendation by the Clinical Manager.
- Compensation \$1000/year

LEVEL 4: Advanced Beginner

- RN with a minimum of two years experience
- 15 critical points
- Bachelor's degree or Specialty Certification
- Recommendation by the Clinical Manager.
- Compensation \$2000/year

LEVEL 5: Competent Nurse

- RN with a minimum of three years experience
- 20 critical points
- Bachelor's degree and a unit-specific certification completed in order to advance to Level 5
- Recommendation by the Clinical Manager.
- Compensation \$3000/year

LEVEL 6: Proficient Nurse

- RN with a minimum of four years experience
- 25 critical points
- Master's Degree and unit-specific certification
- Recommendation by the Clinical Manager.
- Compensation \$4000/year.



Kamilah Fields, RN, MSN, APN

Reflections: A Nursing Journey



Kamilah Fields, RN, MSN, APN

Obstetrical Triage Nurse Practitioner

As a second-degree student, I entered nursing school at Thomas Jefferson University with some hesitancy and uncertainty after receiving my bachelor's degree in biology at the University of Maryland Eastern Shore. I was proud of my accomplishments, but was faced with planning my future. After researching and seeking the advice of many academic and personal advisors, I was attracted to nursing because it is a well established profession that has so much to offer including flexible career options and endless opportunities.

During the second semester of an accelerated BSN-MSN program, I entertained thoughts of a summer student nurse externship program to gain needed experience, although, after spending days and nights eating, drinking, and living nursing, I could think of many other ways to spend my summer months. After weighing all of my options I decided to apply for an externship position to expose myself to the realities of nursing, not to mention receiving a paycheck, which had become foreign to me.

Cooper University Hospital offered a great nurse externship opportunity for second-year nursing students that met the criteria I was looking for. I accepted a position on the labor and delivery unit at Cooper University Hospital because it offered an opportunity to put into practice the clinical skills and theory learned in school. In addition, Cooper had a positive reputation, diverse patient population, flexible scheduling, and a competitive pay rate. The nursing externship program at Cooper University Hospital bridged the gap from being a student to my professional role as a nurse. The program encouraged me to put knowledge into action, fostered the establishment and development of relationships with peers, and helped me identify my strengths and weaknesses as a nurse. I started the summer externship with many ideas and expectations, and ended with the beginning of a career.

When I completed my BSN and obtained my RN license I took a position at Cooper on the labor and delivery unit where I started as an extern. As planned, I continued in the MSN program at Thomas Jefferson University. During this very challenging time, I was grateful to have developed a rapport with the staff I worked with and to have established my role on the unit.

After completing my Master's degree, I was offered a position as obstetrical (OB) triage physician extender. I have a unique role collaborating with obstetrical residents and attending physicians to establish a plan of care for OB patients who present to triage with complications. Although fairly new to the advanced practice field, I have had the opportunity to lecture at hospital conferences, precept nursing students, and assist in performing initial patient assessments for one of the many maternal fetal medicine research studies. In addition, I have participated on the committee for the South Jersey Chapter of the March of Dimes.

In the community, I have been fortunate to participate as a team leader and teacher in the Wellness Center and Healing School at my church, Living Faith Christian Center. I provide spiritual counseling to young women through a ministry called Government of 12 and participate in the Prayer Ministry. When time allows, I volunteer as a nurse for the students at Living Faith Christian Academy and Living Faith High School.

In my leisure time, I enjoy reading, decorating, landscaping, travel, and spending time with family and friends. Although my roles as a leader and nurse do not afford many opportunities to be idle, it gives me pleasure knowing that I am impacting people's lives.

Email comments to fields-kamilah@cooperhealth.edu



Professional News

DEGREES:

Deborah Schoch, RN, MSN
Widener University

CERTIFICATIONS:

Andrew Bergman, RN, CCRN
Laura Decker, RN, CCRN
Diane Floyd, RN, BSN, CCRN, CNA

PRESENTATIONS:

- 4th Annual National Patient Safety Conference: Surveillance Through Nursing's Eyes, Penn Nursing Science, March 2007, Philadelphia, PA

Poster Presentation: Implementing a Rapid Response Team Without a Budget

Mary Jo Cimino, RN, CCRN, Jean Minder, RN, MSN, Lynn Ferchau, MSN, APN, CCRN, Robin Vecchiarelli, RN, BSN

Poster Presentation: Implementing the Surviving Sepsis Campaign (SSC) Performance Improvement Program: Strategic Progress in Patient Care Delivery Using the 6 and 24 Hour Severe Sepsis Bundles
Christa Schorr, RN, BSN

Poster Presentation: Changing ICU Culture to Improve Patient Safety Implementation of "Good Catch" Event Reporting
Janette McFetridge, RN, BSN, Suzanne Gould, RN, MS, CCRN

- Clinical Issues in Anesthesiology Conference, Lake Placid, NY January 16-20, 2007.

Presentation: Adult/Pediatric Simulator Workshop
Amanda Burden, MD, Greg Staman, RN, Charles Blatz, CRNA, MSN, Edward Murphy, CRNA, MSN.

- 7th Annual International Meeting on Simulation in Healthcare, Orlando, FL January 14-16, 2007.

Poster presentation: Assessment of Performance of Senior Residents During a Simulated Respiratory Arrest Simulation in Healthcare
Amanda Burden, MD, Greg Staman, RN, Marc Torjman, PhD, Carolyn Bekes, MD, MHA, Michael Kirchhoff, MD, Charles Blatz, CRNA, MSN

- IARS 81st Clinical and Scientific Congress, Orlando, FL March 26th, 2007.

Poster presentation: Assessment of Clinical Performance of First Responders during a Simulated Respiratory Arrest: a Comparison of Interns to Senior Residents
Amanda Burden, MD, Greg Staman, RN, Marc Torjman PhD, Carolyn Bekes, MD, MHA, Michael Kirchhoff, MD, Charles Blatz, CRNA, MSN.

- 37th annual meeting of the Western Trauma Association, Steamboat Springs, CO, February 25 to March 3, 2007.

Presentation: Outcome of Bowel Anastomoses in Damage Control Laparotomy
Steve Ross, MD, Nina Civil, MBChB, James Eakins, MD, Greg Staman RN, Mary Lachant, RN.

- 29th Annual Emergency Care Conference Atlantic City, NJ; March 14-16, 2007

Poster Presentation Therapeutic Hypothermia Post Cardiac Arrest

Mary Stauss, RN, MSN, APN, CEN

- Trends in Trauma & Cardiovascular Nursing, Valley Forge Convention Center; King of Prussia, PA, April 19 & 20, 2007

Presentation: Temperature Management: The Cold Hard Facts

Mary Stauss, RN, MSN, APN, CEN

Presentation: Maternal Trauma
Stacey Staman, RN, MSN, CCRN

Presentation: Extremes of Ages
Diane Floyd, RN, BSN, CCRN, CNA and Kathy Devine, RN, BSN, CCRN

Presentation: Trauma Case Studies: A Mastery Session

Stacey Staman, RN, MSN, CCRN, Kathy Devine, RN, BSN, CCRN, Diane Floyd, RN, BSN, CCRN, CNA, and Cynthia Santoro, RN, BSN, CCRN

APPOINTMENTS:

Tina (Helene) Herbert, RN, BSN
2007 Member Ambassador American Operating Room Nurses

Emma Brandon, RN, BSN, MHA, CNA
Director of Clinical Information Systems
Cooper University Hospital

PUBLISHED:

Packed Red Blood Cell Transfusion in the Intensive Care Unit: Limitations and Consequences
American Journal of Critical Care. (2007). 16, 39-48.

Mary Jo Cimino, RN, CCRN, Suzanne Gould, RN, MS, CCRN

Assessment of Performance of Senior Residents During a Simulated Respiratory Arrest Simulation in Healthcare
Journal of the Society for Simulation in Healthcare (2007) 2 (1).

Amanda Burden, MD, Greg Staman RN, Marc Torjman, PhD, Carolyn Bekes, MD, MHA, Michael Kirchhoff, MD, Charles Blatz, CRNA, MSN.

Delayed Primary Closure in Damage Control Laparotomy: the Value of the Wittmann Patch™
Am Surg. 2007 Jan; 73(1):10-2.

Josef Hadeed, MD, Greg Staman, RN, Hector Sariol, MD, Sanjay Kumar, MD, Steve Ross, MD.

AWARDS:

Cooper University Hospital 2007 Nursing Excellence Award Recipients

Clinical Nurse Excellence Award
Diane Yerkes, RN

Staff Nurse, Voorhees Surgery Center

Charlotte Tobiason Memorial Award

Sara Dwyer, RN, BSN

Staff Nurse, Maternal/Infant

Excellence in Trauma Nursing Award

Adrienne Fowler-Bell, RN

Staff Nurse, Trauma

Jean Patterson Award

Terry Deubler-DePasquale, RN

Staff Nurse, Trauma

John Kronenberger Memorial Award

Tracy Green, RN, BSN

Staff Nurse, Neonatal Intensive Care

Research Nurse Excellence Award

Linda Gazzerro, RN, CWOCN

Woundostomy Conference Educator,
Clinical Coordinator, Cooper Institute for Wound Healing and Limb Preservation

Ronald Bernardin Memorial Award

Michael Lindsay Tronco, RN, BSN

Staff Nurse, Pediatric Intensive Care

Ruby Gross Leadership Award in Nurse Excellence

Diane Floyd, RN, BSN, CCRN, CNA

Clinical Nurse Manager, Trauma

Carol G. Tracey Compassion Award

Tabitha Leonard

Surgical Technician, Operating Room

Excellence in Perioperative Surgical Technology Award

Susan Chico

Surgical Technician, Operating Room

Excellence in Perioperative Nursing Award

Sandra Cruz-Fontelera, RN, BSN

Staff Nurse

Moorestown Auxiliary Memorial Award

for Excellence in Outpatient Nursing

Patricia Budic, RN

Staff Nurse, Special Tests

Moorestown Auxiliary Memorial Award

for Geriatric Nursing

Kiesha Shields, RN

Pool Nurse, Cardiology

Sara Hirsch Memorial Award for excellence

in Oncology Nursing Practice

Cheryl-Anne Kullman, RN

Assistant Clinical Manager, Oncology

Theodore Hirsch Memorial Award for

Excellence in Cardiovascular Nursing Practice

Henry Muzones, RN

Staff Nurse, Cardiac Cath Lab

Theodore and Sara Hirsch Memorial Award
Veronica Still

Unit Secretary, Emergency Department

2007 Nurse of the Year Award

Henry Muzones, RN

Staff Nurse, Cardiac Cath Lab

2007 Nominees for Clinical Excellence Awards:

Clinical Nurse Excellence

Eileen Danaher, RN, BSN,

Linda Sullivan, RN, BSN

Jean Patterson Memorial Award

Nancy Burke, RN, Tracy Green, RN, BSN

Ronald Bernardin Memorial Award

Jackie Whitehead, RN

Ruby Gross Leadership

Diane Flaherty, RN, MSN, MBA, CNA-BC,

Helene (Tina) Herbert, RN, BSN

Perioperative Surgical Technology

Tammy Smith, Kathy Taylor

Moorestown Auxiliary Memorial Outpatient

Nursing

Janet Ezekiel, RN, Brenda Franks, RN,

Kathy Moir, RN

Sara Hirsch Memorial Oncology Nursing Practice

Linda McReery, RN

Theodore and Sara Hirsch Memorial Award

Adrienne Craytor, RN

Theodore Hirsch Memorial Excellence in

Cardiovascular Nursing

Danielle Dougherty, RN

LADDER APPOINTMENTS:

Level 3

Jennifer Bush-Wood, RN Pediatrics,

Michelle Doyle, RN, BSN Pediatrics,

Kerri Myers, RN Pediatrics, Megan O'Kane, RN

Pediatric Intensive Care, Barbara Riley, RN

Voorhees Surgery Center

Level 4

Tania Berghaier, RN, BSN Pediatrics,

Hannah Lois Birch, RN, BSN Pediatrics,

Suzanne Butler, RN, BSN Pediatrics,

Kelly Brown, RN, BSN, PCCN Trauma Step

Down, Marla Janor, RN Voorhees Surgery

Center, Theresa Maerten, ASN, RNC, Neonatal

Intensive Care, Charlene Martin, ASN, RNC

Neonatal Intensive Care, Lois Meyer, RN, BSN

Neonatal Intensive Care, Dana Palmer, RN,

CNOR Operating Room, Susan Plasky, RN, BSN

Neonatal Intensive Care, Lucy Suokhrie, RN,

BSN, MHA, Psychiatry, Michael Lindsey Tronco,

RN, BSN Pediatric Intensive Care

Level 5

Valerie Gibson, RN Neonatal Intensive Care

Level 6

Kristen Coyle, RN, MSN, APN Mother/Infant

COUNCIL APPOINTMENTS:

Cynthia Bennett RN, BSN, Co-Chair,
Clinical Council



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