



Bridges to Excellence

A publication for nurses and healthcare professionals

FALL/WINTER 2007

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SIMULATION IN HEALTHCARE





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Happy Holidays

from The Bridges Editorial Staff

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Correction: In the last issue, clinical ladder compensation was inaccurate. The correct information is Level 3: \$1500/yr, Level 4: \$2500/yr, Level 5: \$3599/yr, Level 6: \$4500/yr.





hat is an Advanced Practice Registered Nurse? The American Nurses' Association has defined the central activities of APRN's as follows:

Advanced practice registered nurses manifest a high level of expertise in the assessment, diagnosis, and treatment of the complex responses of individuals, families, or communities to actual or potential health problems, prevention of illness or injury, maintenance of wellness, and provision of comfort. Advanced practice registered nurses continue to perform many of the same interventions used in basic nursing practice. The difference in the practice relates to a greater depth and breadth of knowledge, a greater degree of synthesis of data, and complexity of skills and interventions (American Nurses Association, 1996, p. 2).

Like almost everything else in health care, understanding who advanced practice nurses are and what they do can be challenging. There are four groups of nurses who fall into the category of "Advanced Practice Nursing." These are the clinical nurse specialist (CNS), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), and certified nurse midwife (CNM) (Hamric, 2000). At present, to practice in any of these roles, a registered nurse (RN) must successfully complete a program at the master's level in their chosen specialty. In addition, the nurse must pass a national specialty board certification exam to apply for state licensure to practice (American Nurses Association, 2007).

Requirements for licensure vary from state to state for each of the sub-groups of APRN's. In New Jersey, APRN licensure is available to both CNS's and NP's, and is regulated by the State Board of Nursing. CRNA's also fall under the Board of Nursing, but have a separate licensure. CNM's are licensed by the state Board of Medical Examiners, and have slightly different requirements relative to scope of practice and prescriptive authority. Those APRN's in any group with prescriptive privileges must also hold New Jersey State CDS (Controlled Dangerous Substance) and Federal DEA (Drug Enforcement Agency) registration. See Table 1 for a complete list of the APRN nursing specialties recognized in New Jersey (New Jersey State Board of Nursing, 2007).

Table 1 Advanced Practice Nursing Specialties Recognized by the State of New Jersey

Adult Health Family Pediatric School Gerontological	OB/GYN Neonatal Rehabilitation Psychiatric/Mental Health Community Health	 Maternal/Child Oncology Critical Care Emergency/Burns/Trauma Medical-Surgical
• Women's Health	Perinatal	

New Jersey APRN's must work with a supervising physician who oversees their practice through joint practice protocols. These protocols define the scope of medical delegation and the limits of prescriptive authority (New Jersey State Board of Nursing, 2007). APRN practice is also defined by payors. APRN's, unlike most RN's, can bill directly for their services, although reimbursement is highly variable from payor to payor. Different payors have different policies regarding reimbursement for services provided by an APRN. While Medicare and Medicaid recognize and reimburse for APRN services, they do so at a reduced rate – a percentage of the physician fee schedule. Some managed care payors do not reimburse at all for APRN services, or may limit their reimbursement to very specific services, such as outpatient primary care or women's health.

With this background, we return to the original question – what is the role of the APRN? I personally define the role as assisting a patient with multiple health care needs and challenges in a personal, holistic and collaborative way. Using the following case study, let me offer an example from my own clinical practice at Cooper University Hospital of the APRN role operationalized in clinical practice.

Background

Sally* is a 28 year old a single mother of three whom recently suffered a stroke. Fortunately, she had almost no physical deficits however, on returning to work as a medical assistant in a doctor's office, she found that she had a lot of trouble with numbers and letters. She got phone numbers wrong, transposing numbers or leaving some out. She had difficulty with spelling, and with finding the right word to finish her thought. Once while driving she became lost and drove around and around, unable to figure out where she was, even though she had driven the route many times. She was distraught - she could not physically keep up, was mixing up phone numbers, misspelling words, and getting lost. She could not afford to quit and look for another job. Her employer would not reduce her work hours. She planned to start nursing school in order to better provide for her children, but now didn't know how she would deal with the extra work and stress. She had no insurance, and therefore got no stroke rehabilitation. She was understandably overwhelmed, didn't understand her condition, and didn't know what to do – she was in tears, and begging for help.

Role Interventions:

Clinically, I examined Sally neurologically, using the National Institutes of Health Stroke Scale (NIHSS) and also testing reflexes, gait, sensation, vision, and other neurological parameters. I tested word and number recognition, speech, and comprehension. I felt she would benefit from speech therapy to address cognition, number confusion, and speech, and referred her to a therapist who accepts charity care in lieu of insurance. Reviewing her stroke risk factors, I instituted antiplatelet therapy with aspirin.

*The name has been changed to protect the patient's privacy

I personally define the role [of the APRN] as assisting a patient with multiple health care needs and challenges in a personal, holistic and collaborative way.

Psychosocially, we talked about the stresses she was dealing with and her capacity for coping, including resources and support such as family and friends. Providing support and encouragement, I assured her that I would assist her and that she would recover. We talked about job accommodations that might help her to remain employed. Unfortunately, her employer could not accommodate her needs and her employment ended, adding to her stress.

Educationally, I taught her how the stroke occurred, and explained that her cognitive and language issues were likely to improve over the next 3-6 months, particularly with speech therapy. We discussed risk factor modification and secondary stroke prevention.

Collaboratively, I sent a letter to her primary physician with the results of my exam and recommendations. I spoke to the speech therapist about this patient's specific issues, and requested progress reports.

Administratively, I assisted with filing for unemployment and disability. I reviewed all hospital records, diagnostic imaging and laboratory reports to ensure that there were no gaps or duplications in care, and that care was consistent with stroke best practice guidelines. Sally continues to recover, and has made great progress with her speech and cognitive issues with the help of ongoing speech therapy. She has postponed her return to school for one semester, and is receiving disability compensation. She plans to return to work.

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Addressing the Risks: Simulation in Healthcare



Greg Staman, RN

I magine if you will your first interaction with a critically ill patient. Years of knowledge, gained through lecture, reading and limited clinical contact seem woefully inadequate when the time comes to physically engage in the act of saving a life. Hands shake, heart rate increases, and nervousness seems to paralyze every muscle fiber in your being. Knowing how to perform a procedure is a far cry from actually having practiced that procedure to perfection. If outcomes of the event are anything less than successful, you may question your competency and the role you played in the event for many years to come.

Fast forward now, to the present. Your patient is just as seriously ill, and although the rush of adrenalin in your system may still make you anxious, you approach the task at hand with confidence and purpose, secure in the knowledge that you have successfully navigated these waters a dozen times in the past. But how is this possible? As a young clinician, you have practiced your craft for only a few short years; how many high risk, low frequency events of this magnitude could you possibly have been exposed to in your short tenure?

The answer, you may have guessed, lies with simulation; the ability to replicate catastrophic but uncommon clinical conditions in simulated human patients, over and over again until competency is mastered. The technology, as it applies to healthcare, is new; but its growth and usefulness prior to clinical adaptation is well documented. As early as 1920, the fledgling aviation industry used simulation as a means to train pilots before committing men and assets to the physical act of flight. As technology advanced, other high risk industries adapted simulation as a means to train personnel in response to catastrophic events rarely seen but often anticipated; NASA, the nuclear industry, maritime corporations and the military all embraced simulation as a primary adjunct to already robust training programs. The field of Anesthesiology, reeling from the release of the program "The Deep Sleep" (a 20/20 television documentary aired nationally in 1982 which was highly critical of general anesthesia practices), began questioning the similarities between these high-risk organizations and the healthcare environment in the mid 80's. 24/7 operations, stressful conditions, changing personnel, and high degree of risk were all factors present in both industry and healthcare; why not adapt this evolving technology to better healthcare outcomes? Also instrumental in solidifying this belief was the release of the 1999 Institute of Medicine report: To Err is Human, which attributed upwards of 98,000 deaths a year to

preventable medical error. The need to hone clinical skill was evident, and simulation was poised to provide a "ready and willing patient".

Great strides have been made in the last decade, and today's patient simulators bear little resemblance to their early relatives. Evolving technology has made them smaller, lighter and more lifelike than ever before. Perform a clinical assessment on these patients, and you will be able palpate pulses, auscultate lung and heart sounds, and evaluate breathing rate and depth. Place your patient on a monitor, and you have the ability to monitor cardiac rhythm, oxygen saturation,



Great strides have been made in the last decade, and today's patient simulators bear little resemblance to their early relatives. temperature, circulatory status and cardiac output. Should it be necessary, clinical interventions might include cardiac defibrillation, external pacing, needle decompression, chest tube placement and advanced airway management. Cannulate a vein correctly, and your patient will bleed. Computer driven, these patients respond in real time to clinical intervention constantly adapting to changes in physiology, intervention, and care pathways. Most importantly, the simple push of a button restores a "failed intervention" to a healthy patient, ready to provide realistic training again and again.

Cooper University Hospital embraced simulation in the fall of 2005, with the purchase of a single adult training platform. In the roughly eighteen months following Simlab inception, over 1500 healthcare personnel have benefited from discipline specific training which utilized simulation. 65 clinicians are currently trained to facilitate lab based education in areas as diverse as airway management, central line placement, advanced life support, basic BLS and team communication/resource management. Institution wide, simulation has been embraced by Anesthesia, Pediatrics, Emergency Medicine, Critical Care, Surgery/Trauma, Obstetrics/Gynecology and Nursing. The lab environment at Cooper has grown to include both adult and pediatric patient simulation equipment, and is fully equipped to accommodate video capture and debriefing of all lab sessions. Scenario timelines are linked second to second with patient physiology readouts, 3-view digital image streams and 2zone audio capture. This offers a robust tool for debriefing and evaluation of all participants, in either group or individual student settings. The simulation experience, however, is not limited to the lab itself. Each device is mobile, and may be configured to provide realistic training in any clinical area or setting throughout the institution. This becomes a particularly useful tool during the evaluation of code response and intervention, when team dynamics play an integral part in patient outcomes.

Program growth, which has exceeded all forecasts, is not solely driven by internal educational factors. The Accreditation Council for Graduate Medical Education (ACGME) has begun the process of mandating simulation training for specific residency programs, a number of which are accountable to be in place by the fourth quarter of 2008. In addition, medical school programs are embracing simulation as a core educational component during both classroom and clinical rotations. Programs such as anesthesia and surgery have begun investigating simulation as a required component of the board certification process, and in specific instances have linked hospital privileges to simulator driven



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competency evaluations.

Cooper University Hospital, with its stated mission of outstanding clinical care, innovative research and quality education is uniquely positioned to also assume the mantle as a benchmark organization and center of excellence for simulation in the tri-state area. Our University of Medicine and Denistry of New Jersey affiliation and strong cadre of associate professors, the CUH School of Allied Health, and the robust institutionally based clinical education program currently in place have provided the fertile ground necessary to nurture this project and bring it to fruition. Our efforts to provide quality instruction in all aspects of patient care have captured the attention of not only our own clinical providers; healthcare associates from across the southern New Jersey area have either directly benefited from simulation time in the lab, or expressed a desire to have such instruction afforded to their personnel. Cooper's reputation for a strong clinical education syllabus, along with the use of cutting edge technology and a restructured mission statement, are part and parcel of the forces driving this trend.

We have the technology, ability and responsibility to provide our patients the highest quality care available in the world today. The use of simulation to train clinicians in those high risks, low frequency events is invaluable, to both the patient and the practitioner. As simulation technology advances and becomes fully integrated into all facets of medical education, there will come a day when the phrase "I've never done that" is no longer spoken.

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Bands for Safety

Danielle Majuri, RNC, MSN, APN-C Mary Stauss, RN, MSN, APN, CEN

any healthcare facilities have color coded "alert" wristbands to serve as visual cues for staff to identify patients' particular conditions such as a medication allergy or a fall risk. However, wristband colors can have different meanings from one institution to the next. This lack of standardization is placing patients at risk.

Background

Patients, consumer advocacy groups, and regulatory and accrediting bodies have spoken out about the importance of patient safety in the health care environment (Parisi, 2003). Several documented cases describe situations in which healthcare providers resuscitate "do-not-resuscitate" (DNR) patients, administer harmful medications in the face of known allergies, and fail to prevent falls (Matthews, 2007). The public is dismayed, healthcare providers are unnerved and the public is left unsafe in an inconsistent healthcare system (Matthews, 2007). Through analysis of these life altering situations, healthcare institutions have discovered that many of these mishaps were caused by a breakdown in communication amongst care providers. In order to bridge these gaps in communication, healthcare providers have worked diligently to create more efficient systems for identifying the problems or risks in patients. Colored wristbands offer quick visual cues to the bedside providers regarding issues that exist for a particular patient. In recent years, healthcare facilities throughout the tri-state area and nationally have been utilizing colored wristbands to relay pertinent patient information. However, a yellow wristband at Cooper University Hospital that helps staff identify patients on fall precautions does not necessarily mean the same thing at other local institutions.



The Problem

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Hospitals and healthcare facilities determine what each colored wristband represents. The meaning can fluctuate from institution to institution therefore the use of color-coded wristbands becomes a patient safety issue for healthcare providers who work in multiple institutions. A hospital in Pennsylvania submitted a report to the Pennsylvania Patient Safety Reporting system describing an event in which clinicians nearly failed to rescue a patient who had a cardiopulmonary arrest because the patient had been incorrectly designated as "DNR". The source of the confusion was that a nurse had incorrectly placed a yellow wristband on the patient. In this particular hospital, the color yellow signified that the patient should not be resuscitated. In a nearby hospital, where the nurse also worked, yellow signified "restricted extremity," meaning this arm is not to be used for drawing blood or obtaining IV access (Patient Safety Authority, 2005). This incident prompted the Pennsylvania Safety Authority to form the "Color of Safety" taskforce in 2006. The taskforce investigated and concluded the color-coded wristbands could have vastly different interpretations from institution to institution.

The Color of Safety task force surveyed 139 healthcare facilities. Seventy-eight percent of the survey respondents' were currently using patient wristbands to communicate clinical information to providers throughout the institution and most admitted they were using specific colored bands that had a specific meaning within the institution. The respondents sent in details regarding their colored wristband programs. A blue wristband was found to have ten different meanings. In several facilities, the blue band communicated that the patient is a DNR. While others utilized a blue band to designate a patient for fall risk, a pacemaker, an elopement risk, a latex allergy, diabetes, anticoagulant

therapy, a name similar to another patient's, outpatient status, or do not draw blood from this arm. As a result of their findings, the Pennsylvania Color of Safety task force advocated the voluntary adoption of six colored wristbands each having a standardized meaning. Participation was voluntary. Other states have also identified this as a problem and have created similar initiatives to assist with implementation. In fact, some have even issued a statewide mandate to adopt the standardized colored wristband program.

From the Chief Nursing Officer

Elizabeth Bobulski, RN, BS, MPH • Senior Vice President of Patient Care Services and Chief Nursing Officer



Dear Colleagues,

Welcome to the fall/winter edition of Bridges to Excellence. In this issue, you will explore the broad landscape of nursing practice. Of note, you will find articles that focus on education, clinical practice and patient safety. I hope you will find this edition informative and inspiring. Thank you for your continued interest. We would value your comments to any of the e-mail addresses you will find in this publication.

Best regards,

Elizabett Bobulori

Email comments to Bobulski-liz@cooperhealth.edu

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**



Awareness of the risks associated with color coded patient alert wristbands is increasing across the United States. To date, nine states have implemented standardization programs based on the original Pennsylvania model.

The Solution

Awareness of the risks associated with color coded patient alert wristbands is increasing across the United States. To date, nine states have implemented standardization programs based on the original Pennsylvania model (Matthews, 2007). Attentive to this trend, the New Jersey Department of Health and Senior Services and the New Jersey Hospital Association formed a coalition of healthcare providers representing the continuum of patient care to assess if a similar problem exists in New Jersey (NJ). Eighty healthcare institutions participated in a survey providing a broad overview of current practices. The survey revealed that NJ facilities use a variety of colored wristbands, stickers, and signs to alert healthcare workers to patient risk factors. Not surprisingly, the results were similar to those found by Pennsylvania and other states such as California, Oregon, Arizona, and New Mexico (Matthews, 2007).

Clearly, current practices place New Jersey patients at risk. The colored patient alert bands provide non-verbal cues that foster a sense of security and complacency in healthcare workers. The setting is ripe for errors to occur when the color and meaning change from place to place and when healthcare providers change jobs or work in multiple facilities. Recognizing this, in June of 2007, the NJ Work Group announced a statewide initiative to standard-ize the colors of patient wrist bands across the continuum of care in New Jersey (Ditri, 2007). Participation is voluntary at present.

Changes at Cooper University Hospital

We are very excited to be early adopters of this important patient safety initiative. Cooper University Hospital staff is known for their dedication and excellence in patient care. Communication among caregivers is of utmost importance everywhere but even more

Table 1 Patient Alert Wristbands

Color	Meaning	Change
RED	Medication Allergy	New Color
YELLOW	Fall Risk	New Color
GREEN	Latex Allergy	New Color
PINK	Limb Alert	No Change
WHITE	Patient Identification	No Change

so in a tertiary care center. With this in mind, on October 15, 2007 we implemented the recommendations of the NJ Work Group to standardize the colors and meanings of our patient alert wristbands. Fortunately, this necessitated just a few modifications in our current practice. The following are the recommendations we adopted:

- 1. Adopt standardized colors & meanings (see Table 1).
- Imprint bands with a clear message as to their intent. For example, the medication allergy band states "ALLERGY" in large, bold letters.
- **3.** No writing on the patient bands. Ink can smear and writing can be illegible. Also, patients frequently remember allergies after a band is applied. Writing on the band provides a false sense of safety.
- **4.** Ask the patient to remove any social cause bands to minimize confusion. An example of a social cause band is the yellow rubber bangle bracelets that promote prostrate cancer awareness.

Color coded patient alert wristbands are powerful communication tools used daily by healthcare providers but wristband color and intent vary between institutions. The NJ Hospital Association (NJHA) and the New Jersey Department of Health and Senior Services (NJDOHSS) have established color-coded wristband standards in an attempt to safeguard patient safety in the State of New Jersey. In Cooper's continued commitment to top quality patient care for the community we serve, we have adopted these recommendations and standardized our colorcoded patient wristbands.

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SIDS: The Silent Infant Killer

Terry Merola, RN MSN, CPN Linda Wicker, RN, BSN, CCRN



udden infant death syndrome (SIDS) is defined as "the sudden death of an infant less than one year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history" (Aris, et al., 2006 p. 282). In 1992 The American Academy of Pediatrics has recommended that infants be placed to sleep on their backs to reduce the risk of SIDS. Since that time, the frequency of prone sleeping has decreased from greater than 70 percent to less than 20 percent of United States infants and the number of deaths associated with SIDS has decreased by 40 percent (American Academy of Pediatrics Task Force on Sudden Infant Death Syndrome, 2005). SIDS remains the highest cause of infant death beyond the neonatal period (American Academy of Pediatrics Task Force on Infant Sleep Positions, 2000).

The majority of SIDS deaths occur during a narrow developmental window between one and four months postnatal age. During this time significant changes occur in the organization of sleep and circadian rhythms. There is a consensus that SIDS typically occurs during sleep periods, but it is unclear as to whether SIDS occurs during deep sleep, within the transition between sleep and waking, or between sleep states (American Academy of Pediatrics Task Force on Infant Sleep Positions, 2000). It is also generally agreed that infants who are at risk for SIDS may have central nervous system abnormalities at birth that may be too subtle to detect clinically. There is evidence that suggests there is a biological link contributing to the incidence of SIDS in some cases. The results of an

autopsy study done at Boston Children's Hospital showed a correlation between a deficiency in the 5-HT receptor binding capacity and the demise of an infant from SIDS. 5-HT, found in nuclei in the medulla has an effect on the respiratory drive (Barclay, 2006). So while we may be able to help prevent some cases of SIDS related deaths through education of risk factors, still other cases may be inevitable. But it's that one saved life that makes the effort worth it.

Although the original American Academy of Pediatrics (AAP) guidelines in 1992 did not specifically include preterm infants, subsequent statements also support the recommendations for supine positioning for sleep in the preterm infant population. In 2005 the AAP reaffirmed the recommendation for "Back to sleep" for all term and healthy preterm infants. Current evidence has shown an even stronger correlation between the preterm infants and the incidence of SIDS, further emphasizing the importance of the supine position for this population (Ariagno, R. and Mirmiran, M, 2006).

Though the exact etiology of SIDS

Table 1 Risk factors associated with SIDS

- Low socioeconomic status
- Less than 37 week gestation
- Birth weight less than 2500 grams
- Side or prone position
- Overheating infant
- Prenatal and postnatal smoke exposure
- Co-bedding of infant
- Soft or loose bedding

Table 2 Key Steps to Promote Safe Sleep in Infants

- Supine position when put to sleep
- Firm sleep surface
- Keep stuffed animals and toys out of the infant's crib.
- No smoking during pregnancy or around infant
- Do not share a bed with infant, keep infant in the same room as mom in separate bassinette.
- Consider offering a pacifier to infant at nap time. For infants that are being breastfed, delay the pacifier until one month of age.
- Avoid overheating the infant, use light clothes during sleep, with no blanket.

remains unknown, the factors listed in table 1 have been shown to be associated with an increased risk of SIDS.

As nurses we have a responsibility to educate caregivers on the importance of proper positioning of their infants. An ideal opportunity to review proper positioning techniques is while an infant is hospitalized or at well baby check ups. It should also be stressed that this practice be continued once the infant is home for those who are hospitalized. In addition, the caregivers should be made aware of the identified risks associated with SIDS and in the subsequent changes in care that can help prevent their infant from becoming a statistic. Table 2 illustrates the recommendations identified by the AAP to promote healthy sleep practices in infants.

As nurses caring for infants, we can make a huge impact on the safety and wellbeing of infants just by reinforcing the significance of proper positioning and accommodations of the infant during sleep. Perhaps we will continue to see a drop in the number of fatalities associated with SIDS if we all ban together and stress these points to caretakers throughout the country.

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Reflections: A Nursing Journey Just Another Day in Trauma David Mitchell, RN, BSN, Cooper Trauma, Staff RN

"What do you do?"

"I save lives. I'm a trauma nurse at Cooper Hospital."

very time I am asked, the answer usually provokes fur-

ther questioning from the inquisitor and invokes a sense of pride as I respond. But as I reflect on what I, and 60 or so of my colleagues do everyday, I realize that our work is simple yet complex, exciting yet routine. My day begins with shift report from the charge nurse giving a brief summary of all the Trauma Intensive Care Unit (TICU) patients, and these 10 minutes might be the only reprieve we get all shift from impending chaos. Of course, helicopters and ambulances don't discriminate, and so my shift begins. "Trauma alert to admitting!" blares out over the TICU loudspeaker. On this particular shift I am designated as the 1st alert nurse (in addition to having a patient assignment in the TICU, I will also respond to all helicopters and ambulances that arrive at Cooper). Together with the primary nurse, whose job it is tonight to coordinate and document all of the chaos of the trauma alerts, we run downstairs to the Trauma Admitting Area (TAA) ready to treat whoever may roll through the door. Did I mention I have not gotten report on my patient assignment upstairs in the TICU yet?

I don my 20-pound lead apron, so x-ray films can be obtained without interrupting patient care, while receiving report from the TAA primary nurse; "MVA(motor vehicle accident), 20-something year-old male, ejected from the vehicle, traumatic amputation of the lower extremity". Standing next to an empty stretcher with hat, mask, impervious gown, and gloves I begin to prime the intravenous (IV) tubing and make sure the Mayo stand beside me has all my "tools" (#14 and #16 gauge IV catheters, 4x4 gauze pads, Betadine prep, 60cc syringe to obtain the blood for all the necessary lab tests, oral gastric tube with syringe for insertion post-intubation, and an occlusive dressing). I begin to sweat under all my protective clothing as the primary nurse raises the room temperature to 80 degrees (trauma patients need a warm environment to help in their survival). Now, the trauma team waits for the patient to arrive and we make small talk to help pass the time or perhaps subconsciously prepare ourselves for the stressful job ahead.

Suddenly the TAA doors fly open and medics rush in a semiconscious young male covered in dried blood with a cooler containing his missing extremity inside. The medics have already started 2-large bore IVs and I notice they both have pressure bags fully inflated to help infuse the IV fluid as fast as possible. And much to my relief, both IVs work! As we transfer the patient onto the stretcher the team starts to work at a feverish pace with everyone doing their particular job as quickly yet efficiently as possible, because in trauma time is not on our side.

I lean over the pale man and introduce myself, "I'm Mitchell. I'll be your nurse. We're going to take good care of you." The patient's only response is a barely audible moan. Immediately I start my routine of assessing breath sounds, palpating for a radial pulse, and obtaining a manual blood pressure when I overhear our at-



tending shout out to prepare for intubation. I continue, and shout out to the team "82/50, heart rate 130!" Our patient is in shock and his life is on the line.

After the patient is intubated I assess another set of vital signs, hang more IV fluid bags as fast as they run dry, and insert an oral gastric tube to prevent aspiration. Throughout the entire process I am calling out my assessment findings to the team as we race to correct this patient's hypovolemia. The trauma attending physician along with the orthopedic physician are now assessing the left stump that is filled with grass and dirt from the accident scene as they search for viable tissue. With the patient exsanguinating from his torn flesh, I assist the orthopod by holding what remains of the left thigh so a pressure dressing can be applied to control bleeding. The decision from the trauma attending is then made, "Level 1 to the OR"! Without hesitation we connect the patient to a trauma transport monitor, the respiratory therapist begins to manually ventilate the patient with an ambu bag, I grab the blood bank's cooler that contains the blood transfusions the patient will desperately need to survive, and we rush out of the TAA doors. A Level 1 patient has 15 minutes or less to get to the OR, without a surgeon the patient will not survive. Before the patient is transported, we stop so the patient's sobbing mother and father can kiss their son on the forehead before he goes to surgery. It may be the last time they see him alive. Most people view this scenario and possibly breakdown; but trauma nurses learn to disassociate themselves from the reality of the situation so they can instinctively react to provide the best chance of recovery for the patient. It can make nurses numb, but it is what makes us good. The surgical team anxiously greets us as soon as we enter the OR. I methodically give report to the anesthetist regarding all the procedures, medications, vital signs, and IV fluids we have given to our critically ill patient.

I can now take off all my protective gear and head back to the TAA to help the primary nurse finish documenting everything that happened in the last 20 minutes of controlled chaos. My scrubs are soaked in sweat, and as I walk my mind starts to wander about what has just occurred. I wonder... "Trauma alert to admitting!" once again blares over the hospital loudspeaker. I think to myself, "I can not wait to see what is in store for me now." Oh, and I wonder if I'll ever get my report tonight.

Email comments to Mitchell-david@cooperhealth.edu



DEGREES:

Lisa Durfee, RN, BSN, Clinical Educator, OR, Immaculata University

Jennifer Hosking, RN, BSN, **TICU Staff Nurse** Wilmington College

Mary Jo Cimino, RN, BSN, CCRN, Clinical Manager ICU/CCU, Immaculata University

Laura Decker RN. BSN. CCRN. ICU Staff Nurse, Immaculata University

Rowena Ripa, RN, BSN, PCCN, Clinical Educator. PCU. Wilmington College

Pamela Kaufman, RN, MSN, NP-C N7 Staff Nurse, University of Medicine and Dentistry of New Jersey

PRESENTATIONS:

Drexel University's Nursing Education Institute, Miami, FL; June 7-10, 2007. Poster presentation: Utilizing Simulation Technology to Enhance Critical Thinking in the Novice Nurse Stacey Staman, RN and

Danielle Majuri, RN

University of Maryland Medical Center's Special Topics in Trauma 2007 Managing the Pregnant Trauma Patient Stacey Staman, RN, MSN, CCRN

APPOINTMENTS:

Joanne Porter RN, BSN Administrative Director of Accreditation and Regulatory Affairs, Cooper University Hospital

Katrina Edoo, RN, BSN, CCRN Quality/Education and Research Committee of the Board of Trustees. Cooper University Hospital

CERTIFICATIONS:

Lynn Ferchau, RN, MSN, CCRN-CSC, APN.C, certification in Cardiothoracic Surgery Lari Michael, RN, OCN, certification in Oncology Nursing Elisa DiBennedetto, RN, BSN, OCN, certification in Oncology Nursing Terri Merola MSN, RN, CPN, certification in Pediatric Nursing

Nancy Chew-Hancock RN, BS, CNOR, certification in Operating Room Nursing Christina Y. Smith RN, MSN, CNA, BC, certification in Nursing Administration Kathleen Yhlen, RN, BSN, CNA, BC,

certification in Nursing Administration

Donna O'Shea, BSN, RN, BC, certification in Medical-Surgical Nursing Cheryl Koehl, RN, MSN, APN, CEN, certification in Emergency Nursing Elizabeth Adomanis, RN, CCRN, certification in Critical Care Nursing

PUBLISHED:

Christa Schorr, RN, and Mary Stauss, RN participated in an interview for ED Nursing, "Identify septic patients at triage to improve outcomes" "Early interventions in the ED stop rapid deterioration," May 2007 issue

Dr. Matthew J. Finnegan and Linda Gazzerro RN, CWOCN

(2007). Comparing the effectiveness of a specialized altering air mattress replacement system and an air-fluidized integrated bed in the management of post-operative flap patients: A randomized controlled pilot study. Journal of Tissue Viability 2007, 17, 2-9.

LADDER APPOINTMENTS: Level 3

Kelly Jakubowski RN Brooke Walsh RN **Janet Ulrich RN Ebony Marinnie RN** Holly Kiernan RN Kathy Dunn, RN Jacqueline Brooks, RN, BSN Kristen Mangeney, RN Barbara Riley, RN **Diane Yerkes**, RN

Level 4

Andrew Bergman RN CCRN Nancy Schmidt, RN Kimberly Vaughan, RN, BSN Carolyn Scratchard, RN, MSN Nick Blanck, RN, BSN Sherry Wright, RN Bernadette Malinowski, RN, BSN Marla Janor, RN, BBA Angela Jones, RN, CAPA Patricia Reitmann, RN, CAPA

Level 5

Deihann Cooper, RN, BSN, CAPA Angela Jones, RN Fran Orth, RN Rose White, RN

COUNCIL APPOINTMENTS:

Katrina Simmons RN to Performance Improvement Council Phyllis Mazzullo, RN to Clinical Council



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