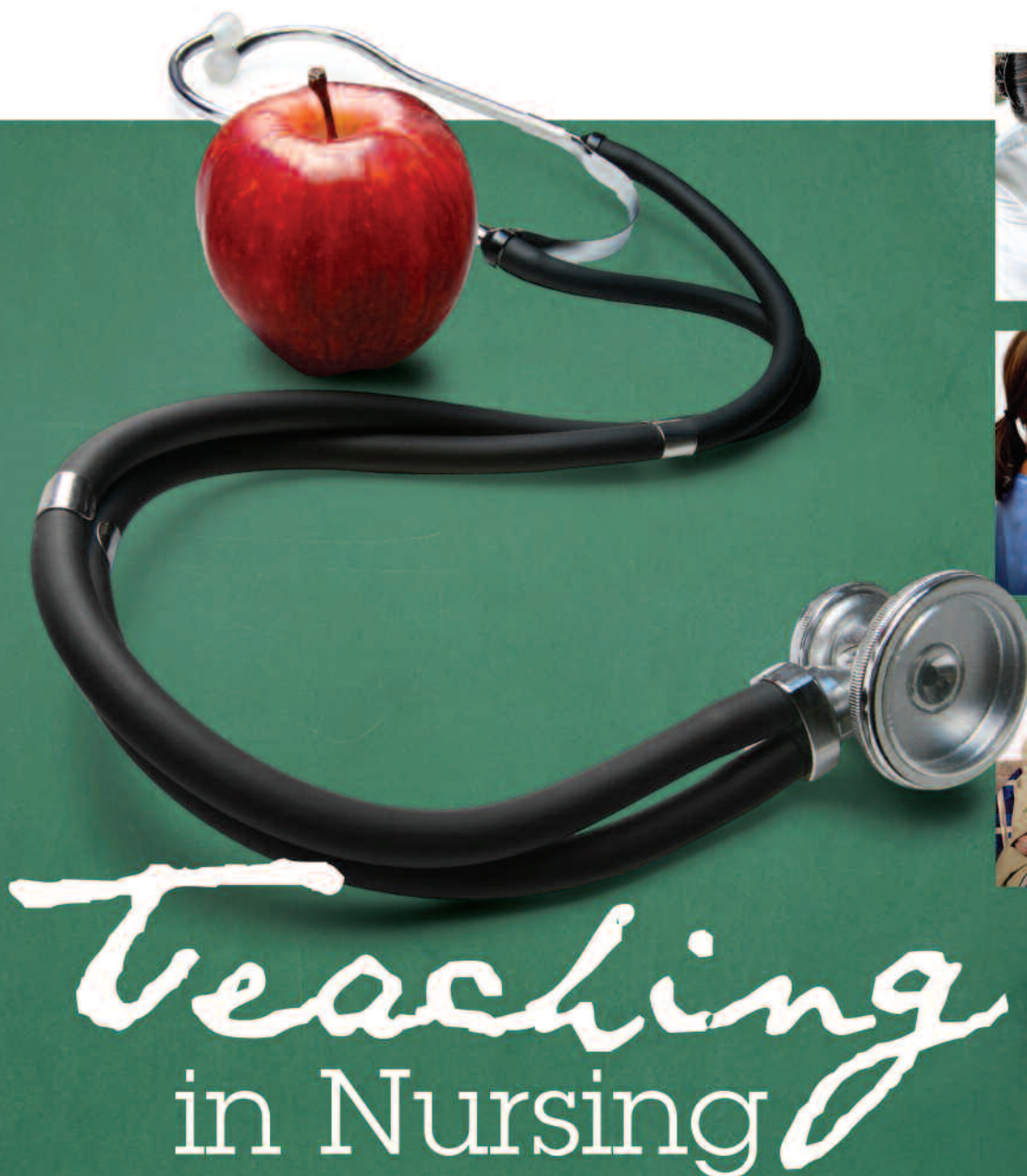




Bridges to Excellence

A publication for nurses and healthcare professionals

SPRING 2010 ■ VOLUME 4, ISSUE 1





Professional Calendar

JUNE 2010

- 1 • Pediatric and Neonatal Current Concepts
- 4 • When you are challenged...by people or situations
- 7 • Code Blue and Crisis Management for the Med-Surg RN/LPN
- 11 • Code Blue and Crisis Management for the Critical Care RN
- 12 & 13 • Trauma Nursing Core Curriculum (TNCC)
- 15 • Advanced Life Pak-20 Training
- 21 • 9th Annual Foundations of Clinical Instruction
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- 22 • First Five Minutes Course
- 24 • Wound Care Updates
- 25 • Dysrhythmia Interpretation Review Course
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JULY 2010

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- 12 • Code Blue and Crisis Management for the Critical Care RN
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- 20 • Advanced Life Pak-20 Training
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- 27 • First Five Minutes Course

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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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EXECUTIVE EDITORS

Lynn Ruoss, RN, MSN, CCRN-CSC, APN.C
Clinical Nurse Specialist, Critical Care

Stacey Staman, RN, MSN, CCRN
Clinical Educator, Trauma

Kathleen Yhlen, RN, MSN, NE-BC
Clinical Educator

CONTRIBUTING EDITORS

Dianne Charsha, RNC, MSN, NNP-BC
Chief Nursing Officer

Carole-Rae Reed, PhD, RN, CS, APN, BC
Research Coordinator

Cori McMahon, PsyD
Director Behavioral Medicine

Maryann C. Powell, RN, MSN
Director, Heart Failure Program



E-mail comments about Bridges to Excellence to:
yhlen-kathleen@cooperhealth.edu

To add someone to this mailing list, or to correct your address please email:
yhlen-kathleen@cooperhealth.edu



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From the Chief Nursing Officer

Dianne Charsha, RNC, MSN, NNP-BC • Senior Vice President for PCS/ CNO



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

I am extremely honored to open the first 2010 edition of *Bridges to Excellence* in my new role here at Cooper. In Cooper fashion, we have many challenges ahead in this upcoming year but one thing is certain; we have very dedicated nurses who work hard to meet the challenges faced by our complex patients and their families every day.

In 1986 I graduated from the University of Pennsylvania with my MSN in Perinatal Nursing and in 1992 I completed a post graduate certificate as a Neonatal Nurse Practitioner. For 20 years I worked in various Advanced Practice Nursing Roles. I enjoyed this time in my career as I had an opportunity to be a patient advocate by coordinating the plan of care, assisted my nursing colleagues with challenging situations by enhancing their knowledge and skills, and partnered with physicians to facilitate the medical plan.

Cooper has had Advanced Practice Nurses (APNs) on the team for years. This valuable resource has formally started to partner with our nursing team. In the new Nursing Council Structure, both the leadership and APN teams were recognized as important resources to a successful shared governance model.

In this edition of *Bridges to Excellence* we have APNs who have authored articles as well as APNs who are integral to service teams that are highlighted in articles to follow. APNs are our clinical nursing experts and they are a valuable resource to our nursing staff.

Dianne Charsha, RNC, MSN, NNP-BC
Senior Vice President for PCS/ CNO

Email comments to **charsha-dianne@cooperhealth.edu**



Advances in Endovascular Aortic Aneurysm Repair

Catherine Cristofalo, APN, RN • Erin Davis, APN, RN • Amy Ward, APN, RN

Cooper University Hospital's (CUH) Aortic Center was developed in 2009 and consists of experts in the fields of Cardiothoracic and Vascular Surgery. CUH's newest operating room is a \$3 million, 1300 square foot hybrid suite that combines cutting-edge surgical technology with the most sophisticated imaging capabilities. The hybrid OR is designed specifically for vascular and cardiothoracic patients and provides the surgeons the opportunity to perform intricate procedures on people with severe, life-threatening conditions, including aortic surgery. Endovascular aortic surgery of both the abdominal and thoracic aorta is also done in the hybrid OR.

Aortic aneurysms result from a degenerative process in the aorta for which the exact etiology is not entirely clear. Several

factors predispose individuals to aortic degeneration including infection, trauma, dissection, anastomotic degeneration of suture lines and connective tissue disorders. By far, atherosclerosis of the aorta is thought to represent the most prevalent cause for aneurismal degeneration. Smoking is the risk factor most strongly associated with aneurysm formation and familial clustering has also been observed. Abdominal aortic aneurysm (AAA) is five times more prevalent in men than women and more common in white men than African American men.

Aneurysms are defined as a focal dilation which measures greater than 50 percent of the normal luminal diameter. For example, a dilatation of the abdominal aorta is considered an aneurysm at approximately 3 centimeters (cms). The infrarenal



abdominal aorta is the most common area to develop aortic aneurysms due to a reduction of collagen and elastin in this part of the aorta. Patients usually present as asymptomatic; often diagnosed by routine exam with a finding of a pulsatile mass on or an incidental finding on a radiologic study performed for another purpose. Conversely, patients may also present with contained rupture, complaining of acute severe abdominal, back or chest pain. They may also report syncope or near syncope. Patients who have free rupture of an aneurysm are unlikely to survive prior to getting to the hospital. Patients may also present with peripheral emboli as debris from the aneurysm sac that may travel to the feet resulting in “Blue Toe Syndrome.” While risk of rupture is usually the big concern with aneurysms they can also thrombose resulting in acute aortic occlusion.

The decision to repair an aortic aneurysm is based on presence of symptoms, rate of growth of the aneurysm and size of the aneurysm. For high risk patients a risk benefit assessment is completed based on the procedure that is needed to repair the aneurysm. Generally abdominal aneurysms are repaired at 5 to 6 cms and thoracic aneurysms at 6 cms. Repair can either be performed open which is the traditional approach or by new endovascular technology.

Endovascular Abdominal Aortic Repair (EVAR) is a minimally invasive approach to aortic reconstruction that offers benefits over traditional aortic surgery such as decreased length of hospital stay, fewer complications and overall expeditious recovery for patients. The United States Food and Drug Administration (USFDA) approved this advancement in 1999. Now several devices are available for use and the volume of EVAR has increased and is a major advancement in the field of vascular surgery (Md consult, 2008). Endovascular repair of descending thoracic aneurysm (TEVAR) was first performed in the late 1990s and the first graft was approved for usage in descending thoracic aortic aneurysms (DTA) in 2005.

EVAR requires the insertion of an endograft, a tube composed of fabric supported by a metal mesh called a stent, through a peripheral artery (usually the femoral artery) and deployment

of the device into the infrarenal aorta to exclude the aneurysm sac from systemic circulation preventing rupture. This is different from traditional open surgical repair where a large incision is made in the abdomen to expose the aneurismal abdominal aorta. The aorta is cross-clamped and the diseased portion is excised and a graft is sewn into place. Operative time is reduced to approximately 2 hours versus 4-6 hours for open surgery. Additionally, patient recovery time is faster and length of stay is reduced to 1-2 days versus 5-7 days for open surgical repair.

EVAR may be offered to patients with certain anatomical features. To successfully exclude the aneurysm from systemic blood flow the patient must have sufficient healthy aorta to create a seal with the endograft below the renal arteries and distally at the level of the iliac arteries. The patient must also have sizeable access vessels, without significant occlusive disease or tortuosity, to provide an entryway for the device delivery system. Meeting anatomical criteria is necessary to avoid early and late complications associated with endografting.

Preoperative planning with careful patient selection and evaluation is key for successful endografting of the infrarenal aorta. The patient presents for full medical history and physical examination to assess co-morbidities and potential for complications. Patients undergo pre-admission testing with full lab data along with electrocardiogram (EKG) and chest radiography (CXR). A cardiac ischemia evaluation is obtained, often with a complete cardiac risk evaluation by the patient's cardiologist. Careful attention is placed upon pre-op labs as poor renal function may require pre-operative and intraoperative hydration and other renal protective strategies as iodinated contrast is used to perform the procedure. A CT angiogram (CTA) is obtained for complete anatomical evaluation and is used for appropriate sizing of the endograft in anticipation of the upcoming surgery.

The surgical procedure itself is performed under fluoroscopic guidance and although general anesthesia is typically used, it is possible to undergo EVAR with local or spinal anesthesia. This is beneficial for patients with co-morbidities and those who are poor candidates for general anesthesia due to diminished pul-

Table 1

Anatomical Considerations for Endograft Repair	EVAR	TEVAR
Quality of access	Ileofemoral: Evaluate tortuosity of vessels, calcification, degree of stenosis, size	Ileofemoral: Evaluate tortuosity of vessels, calcification, degree of stenosis, size
Proximal attachment site	Infrarenal neck: Preferably a neck of 1.5 cm in length; evaluate the amount of thrombus, plaque, and calcification	Distal to Left Subclavian: Preferably a neck of 2-3 cm in length; evaluate the amount of thrombus, plaque, and calcification. In some circumstances the left subclavian may be covered necessitating carotid to subclavian bypass
Anatomy of the aneurysm	May need to embolize large accessory renal artery or inferior mesenteric artery (IMA) to prevent type II endoleak.	In the setting of left subclavian coverage a coil embolization of the left subclavian artery can be performed. A type II endoleak may originate from intercostals vessels although they are not embolized at the time of surgery
Distal attachment site	Commonly the iliac arteries: Ideal landing zone of at least 2.5 cm (common or external iliac arteries)	Proximal to the celiac axis with a neck of 2-3cm in length

monary or cardiac capacity. The surgeon performs a cut down on the femoral artery and a sheath is placed to allow the device delivery system to be advanced into the aorta. Once the graft has reached the site of the aneurysm, the surgeon withdraws the sheath, leaving the graft in place. The graft is fully expanded against the walls of the aorta to secure it into place and to prevent blood flow to the aneurysm. A final angiography is obtained to verify endograft placement and exclusion of the aneurysm sac before the sheaths are withdrawn and the arteriotomies are closed. The patient is then taken to the post anesthesia care unit (PACU) for their recovery period and then transferred to the Intensive Care Unit (ICU) for their post-surgical care.

At CUH, it is common for patients to be discharged home the day following their endovascular AAA repair. Ongoing follow up care in the outpatient setting with imaging studies to evaluate the status of the aneurysm is necessary. Ideally, there will be no evidence of blood flow within the aneurysm sac (called an Endoleak) and the aneurysm will regress in size over time. Typically, patients will have a CTA or abdominal duplex ultrasound one month post-EVAR and every 6 months thereafter.

Similar to EVAR, TEVAR requires the insertion of the endograft through a peripheral artery (usually the femoral artery) and deployment of the device into the descending thoracic aorta (DTA) to exclude the aneurysms from systemic circulation thereby decreasing the risk of rupture. Traditionally, DTA were repaired in an open fashion via a left thoracotomy approach. Open surgical intervention results in a definitive repair by excising the diseased aorta and replacing the aneurysm with dacron graft. However, open surgical intervention does not come without risks including pneumonia, renal insufficiency or failure and paralysis. Open surgery may take up to 6 hours but can be reduced to approximately 2 hours with an endovascular repair. In addition, hospital stay may be reduced to 3-4 days versus 7-10 days with traditional open repair.

Not all patients are considered candidates for TEVAR. Eligibility for endovascular repair of the thoracic aorta is also based primarily on anatomic considerations (see Table 1). The descending aorta resides in the chest and extends from the left subclavian artery proximally to the celiac take off distally. Intercostals arteries, which contribute to spinal cord blood flow branch off of the thoracic aorta. Close attention must be paid to the vascular supply of the cerebral and mesenteric arteries when considering placement of an endovascular graft. Like EVAR, a sufficiently healthy aorta is necessary to create an effective seal and sizeable access vessels without occlusive disease are necessary.

Preoperative planning is of utmost important in this patient population. A detailed history and physical must be performed to assess for pertinent co morbidities and the potential for complications. This requires routine preoperative testing including complete labs, EKG and CXR. Carotid ultrasounds are obtained to assess for stenosis and risk assessment. In addition, cardiac evaluation may be necessary. The patient must be deemed an appropriate candidate based on CTA as this study allows planning of graft placement and graft size. In some clinical scenarios, placement of the graft over the left subclavian artery is necessary to assure a proper seal. In this scenario, the cardiothoracic surgeon along with the vascular surgeon may plan to perform a

carotid to subclavian bypass or subclavian transposition in order to ensure adequate blood flow to the left arm after the stent graft has been placed. Without this intervention the patient may experience symptoms of vertebral basilar insufficiency or left arm claudication. The left subclavian artery will then be coiled at the time of stent placement. The blood flow to the spinal cord becomes important in patients with endovascular stent grafting. The graft covers intercostal vessels thereby decreasing blood flow to the spinal cord which can result in lower extremity weakness or paralysis. The larger the area of descending aorta that is covered by the stent graft, the greater the risk of paralysis.

TEVAR placement is performed in the same manner of EVAR with a few exceptions. If the patient is deemed a significant risk for paralysis, a lumbar drain may be placed at the beginning of the procedure to monitor cerebral spinal pressure (CSP) and is used to drain cerebral spinal fluid (CSF) if necessary to decrease this pressure and increase spinal perfusion. An increase in CSP may place a patient at increased risk for paralysis. Patients are admitted to the ICU or Intermediate Care Unit postoperatively for a 1-2 night stay depending on co-morbidities, blood pressure management and neurovascular examination. The patient is then transferred to the floor where they remain until discharge. Blood pressure is closely monitored in all clinical settings. Due to the risk of paralysis, higher blood pressures are preferred and preoperative anti-hypertensives may be held during this time.

Following discharge, patients will follow up in the office in approximately one month for postoperative evaluation. They will continue with ongoing aortic surveillance with CTA on a 6-12 month schedule.

Although most endovascular procedures are performed without complications; there are risks associated with this type of surgery. A potential complication specific to endovascular aortic surgery is called an endoleak. This occurs when there is any continued blood flow with the aneurysm sac that can allow further expansion of the aneurysm and potential rupture. Endoleaks may occur at proximal or distal landing zones, graft to graft anastomosis sites, unsuccessfully obliterated vascular source, porous graft leaks, or disruption of the graft. Endoleaks may require added surgical intervention depending upon the type of leak and the presence of aneurismal expansion.

The CUH Aortic Program consists of a team of physicians who specialize in these less invasive techniques for aneurysm repair. With the addition of the new hybrid OR facility we are able to provide state of the art treatment of aortic disease. If patients are suitable for these minimally invasive methods for repair there are clear benefits including decreased days in the hospital and shorter overall recovery.

Email comments to Cristofalo-Catherine@cooperhealth.edu

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Increasing Postoperative Adherence to Recommended Urological Follow-up in Patients Who Have Prostate Cancer and Undergo Radical Prostatectomy.



Jaime Austino, RN BSN OCN

Introduction

Prostate cancer is the most common cancer among men and it is well established that radical prostatectomy is the treatment of choice for many men with localized prostate cancer. There is a significant risk for biochemical recurrence following radical prostatectomy. A significant proportion of men who have biochemical recurrence, following radical prostatectomy, obtain biochemical control through salvage radiotherapy. Evidence suggests early detection and treatment of a biochemical recurrence may be more effective. A nursing education intervention is recognized as a contributor to adherence to medical care. This research study addressed increasing adherence to urological follow-up, in men who underwent radical prostatectomy, through a nursing educational intervention. A theoretical framework will be described that supports the intervention.

Significance of the Problem

Prostate cancer is the most common non-skin cancer in the United States and the second leading cause of cancer deaths among men. In the year 2009, it is estimated there will be 191,532 cases of prostate cancer in the United States with approximately 26,328 deaths. Prostate cancer accounts for 25% of male cancers and the majority of men who are diagnosed with localized prostate cancer undergo radical prostatectomy (Horner et al., 2008).

Approximately 35% of men who undergo radical prostatectomy will develop biochemical recurrence, which is easily detectable through surveillance of serum PSA and is managed by the urologist postoperatively (Pound et al., 1999). Approximately 10% to 66% of these men can obtain biochemical control through salvage radiotherapy (Quero et al., 2008). Trock et al. (2008) concluded that salvage radiotherapy administered within 2 years of biochemical recurrence was associated with a significant increase in prostate cancer-specific survival among men with a PSA doubling time of less than 6 months. Quero et al. (2008) concluded that radiotherapy is an effective treatment for biochemical recurrence after radical prostatectomy, when delivered early or before the pre radiotherapy PSA reaches 1 mg/ml. The need to identify biochemical recurrence early is demonstrated and is crucial to patient outcomes.

A combination approach that includes the removal of barriers to adherence, education, and cognitive behavioral strategies has the ability to increase adherence to medical treatments (White, 2004). Patient education, as an intervention, has been identified as a major contributor to adherence of many types of medical care. A need has been identified to determine if preoperative education will increase adherence to urological follow-up in this population.

Study Aim

The aim of this study is to explore the effectiveness of preoperative nursing education as an intervention and its impact on the adherence to urological follow-up after radical prostatectomy. The research question has been developed utilizing the PICO format, which includes patient population, intervention of interest, comparison intervention or status, and outcome (Melnik & Fineout-Overholt, 2005). The research question is “Does preoperative nursing education increase adherence to postoperative urological follow up in patients who have prostate cancer and undergo radical prostatectomy?”

Theoretical Framework

Self-regulation theory has demonstrated that when care provided by staff nurses is guided by theory, patient outcomes improve and nurses have the ability to derive interventions to modify patients' responses to their physical illness (Johnson, 1999). Self-regulation theory can transform interventions based on theory into guidelines for practice and serves as a foundation for nurses to demonstrate that their interventions are significant in regards to positive patient outcomes. There is an expectation that patients are active participants in their medical care and in order to be active participants, it is important to understand how and why patients react to their physical illness. A body of research exists on self-regulation theory and its relation to patient reaction to illness.

Four assumptions exist related to self-regulation theory and coping with physical illness. First, perceptions and interpretation of perceptions highly influence responses and behavior related to physical illness. Second, a schema or knowledge about the illness is highly influential in the response to the illness. This concept is most important for the current research. Nurses have the ability to change or alter a patient's schema regarding illness, through education, which is crucial to the patient's understanding of the necessary follow-up for that illness. It is reasonable to conceive that enhancing a patient's knowledge about a disease and its follow-up is likely to impact adherence to follow-up. Third, information on a patient's schema is organized and priorities are placed higher on certain items within the schema. This assumption may be influenced through the current research as nurses are able to depict where priorities should lie. Lastly, discrepancy may exist between a patient's goal and what exists to motivate the patient to take action to reduce the discrepancy (Johnson, 1999). Overall, it is reasonable to expect that increasing patient knowledge regarding a disease will positively influence the response to that disease, thus allowing for better patient outcomes.

Methodology

Research Design: A retrospective analysis of a cohort of 168 men undergoing radical prostatectomy at Cooper University Hospital (CUH) from 2006–2008 was conducted and then followed up through February 25, 2009. Of those 168 men, 124 received the educational intervention and 44 received no intervention.

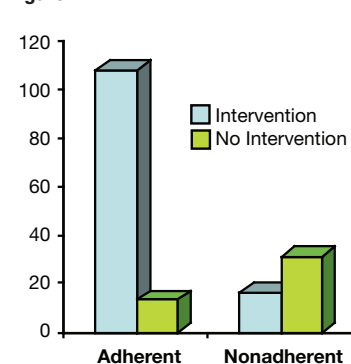
Subjects: Between June 2006 and February 2008, 168 men were diagnosed with clinically localized prostate cancer and underwent radical open retropubic prostatectomy or robotic radical prostatectomy at CUH in Camden, New Jersey; and either received the educational intervention (n=124) or no intervention (n=44). Patients were followed for a year after surgery from 2007 through 2009. IRB approval was granted by CUH in June of 2009. Data were obtained from the CUH Urological Radical Prostatectomy database, the Genitourinary Oncology Nurse Coordinator's database, and a computerized information system. Men who met the following criteria were eligible for the study: underwent radical prostatectomy at CUH between June 2006 and February 2008, were logged into the CUH Urological Radical Prostatectomy database, those scheduled to have routine postoperative follow-up care with Cooper Urology. Men who chose to have routine postoperative follow-up with the referring urologist were excluded from this analysis. A convenience sample of men who underwent radical prostatectomy and met the inclusion criteria were a part of the analysis.

Variables: The men in the experimental group received a preoperative, in-person, nursing education session, which lasted approximately 30–60 minutes in time. The nursing education session focused on prostate cancer and the surgical experience. Patients were also provided with written educational materials and surgical instructions. The content of the verbal and written information included diagnosis, surgical procedure, preoperative medications, preoperative testing, diet and bowel prep prior to surgery, arrival location and time the day of surgery, postoperative diet, postoperative activity level, postoperative urinary catheter and drain care, postoperative medications, common postoperative complications, postoperative complications that require immediate attention, recovery time, management of urinary incontinence and erectile dysfunction, and routine postoperative urological follow-up with emphasis on PSA level. Patients were also provided a new patient packet which included community resources, hospital resources, business cards of key people involved in their medical care, and a calendar. The importance of routine postoperative urological follow-up was depicted in great detail in both the written and verbal instructions.

Adherence to routine postoperative urological follow-up is defined as a digital rectal examination and serum PSA level every three months in the first year, every six months the second year, and yearly from then on. For the purposes of this study, adherence is defined as routine postoperative urological follow-up every three months during the first year.

Potential extraneous or confounding variables include demographic information, such as socioeconomic status, educational background, race, age, disabilities, and ability to travel to physician appointments that may impact adherence to routine urological follow-up and were not analyzed.

Figure 1



Data Analysis

A convenience sample was utilized for the analysis. The data were analyzed using SPSS software. Analysis using Pearson's chi-square was employed to compare adherence to urological follow-up in those who received the intervention and those in the control, with $p < 0.05$ being considered significant. From June 2006 through February 2008, 168 men (n=168) were diagnosed with localized prostate cancer and underwent radical prostatectomy at CUH. Of these men, 124 (74%) received the intervention and 44 (26%) remained in the control.

Of the 168 men included in the analysis, 121 (72%) adhered to urological follow-up and 47 (28%) did not. Of the 124 men who received the intervention, 108 (87%) adhered to urological follow-up and 16 (13%) did not adhere to urological follow-up. Of the 44 men who did not receive the intervention, 13 (30%) adhered to urological follow-up and 31 (70%) did not adhere to urological follow-up (see figure 1). The relationship between preoperative nursing education and adherence to routine urological follow-up was statistically significant ($p < .000$) when Pearson's chi square was performed.

Conclusion

Results from this study indicate that a preoperative nursing education intervention is an effective measure to increase adherence to routine postoperative urological follow-up in men who undergo radical prostatectomy. Not only will a preoperative nursing education intervention impact adherence to follow-up, it may ultimately impact prostate cancer survival. These findings should be validated through the use of a randomized clinical trial. Research looking at a preoperative nursing education intervention and its impact on prostate cancer survival would be logical to pursue.

Email comments to Austino-jaime@cooperhealth.edu

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Impact of a Central Line Insertion Checklist on Staff Compliance with Established Policies



Stacey Staman, RN, MSN, CCRN, Mary LaChant, RN, Adrienne Bell, RN, RN, Deborah Cannon, RN, Jamie Eisele, RN, Susan Hoffman, RN, Christine Kelly, RN, Alethia Mimm, RN, Patricia Osterheldt, RN

BACKGROUND: Central venous catheters (CVC) are an integral part of trauma care. However, complications after CVC insertion can significantly increase morbidity and mortality for all critically ill and injured patients. One of the most serious complications is the development of Catheter Related Blood Stream Infections (CR-BSI). CR-BSI can increase the patient's risk for sepsis and death, with over 80,000 cases occurring, resulting in over 28,000 deaths each year. Compliance with national guidelines for CVC insertion has been shown to decrease CR-BSI to zero (Pronovost, 2006).

OBJECTIVES: Findings from previous studies indicated that dramatic reductions in CR-BSI occur when multiple interventions (bundles) are implemented. Because these studies combined interventions together, it is difficult to know the impact of each intervention. The purpose of this study was to evaluate one intervention; the effectiveness of a CVC insertion checklist to improve compliance with the national guidelines for CVC insertion

METHODS: This Internal Review Board approved study was conducted in a 10 bed Trauma Intensive Care Unit (TICU) and 9 bed Trauma Step Down Unit (TSDU) at Cooper University Hospital (CUH). A pre and post intervention observational study compared observed staff compliance with established CVC insertion policy before and after the implementation of a CVC insertion checklist. Observations were collected by trained study investigators who were members of the trauma nursing staff. Observations were completed on trauma providers during line

insertion in hemodynamically stable patients. Informed consent was obtained from Attending physicians, Residents and Nursing staff prior to observations. Nursing staff was educated on the use of the checklist and empowered to stop the procedure if any steps were missed. Repeat observations were made following the education and implementation of the checklist. Pearson chi square and Fischer's exact test were used (as appropriate) with alpha level $< \text{or} = 0.05$ a priori.

RESULTS: Forty two central line insertions were observed; 22 pre and 20 post-checklist. Overall staff compliance with each of the identified elements in the pre-checklist observations was 9/22(41%). After the checklist was implemented, staff compliance increased significantly 17/20 (85%) with $p < 0.003$.

CONCLUSIONS: In our units, the use of the checklist improved overall staff compliance with two clinically important issues: time out and hand washing. A checklist can be utilized as a prompt and a tool to empower the nurse at the bedside to ensure staff compliance with hospital policy and CR-BSI prevention guidelines. This nurse driven-process can ultimately improve patient safety and outcomes.

Email comments to Staman-Stacey@cooperhealth.edu or Lachant-Mary@cooperhealth.edu

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Teaching in Nursing

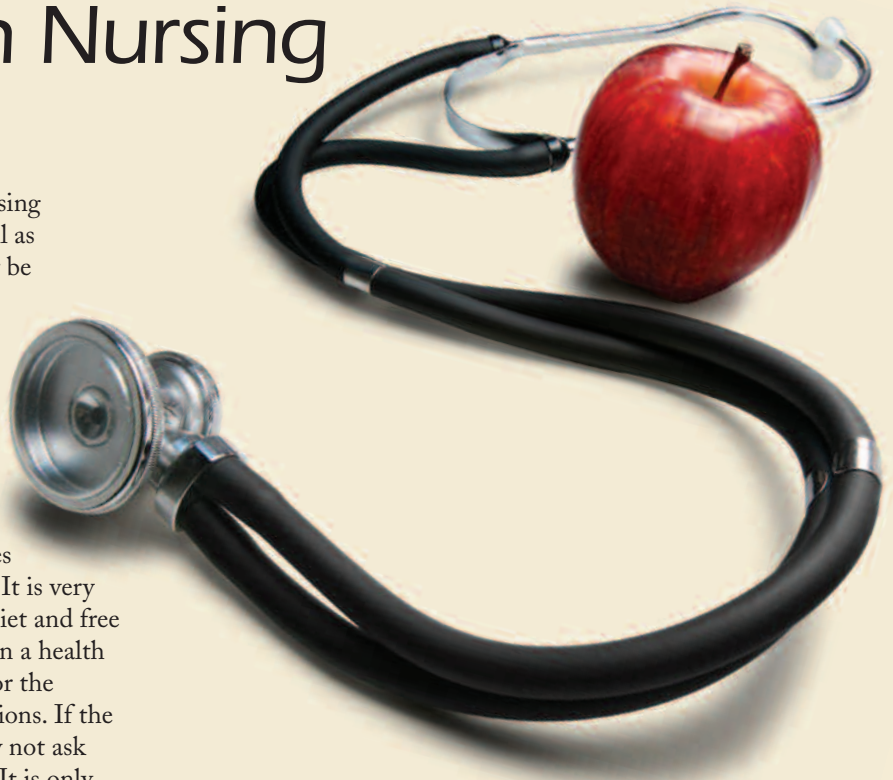
Mary Francis, RN, MSN, ACNP-BC

Teaching and learning is entrenched in the nursing profession. Nurses are lifelong learners; as well as teachers. It is essential that the role of teacher be performed by nurses to improve patient outcomes. The nurse has the responsibility to ensure that patients understand their medications, plan of care, procedures and tests. Nursing research has demonstrated that if the patient has knowledge about medications, diets, and diagnosis, there will be an increase in compliance. Our patient population represents many cultures, learning styles and languages. The nurse must recognize the variables in the patient and tailor the information accordingly. It is very important to create a learning environment that is quiet and free of distractions. This is not an easy thing to facilitate in a health care setting. It is helpful to “schedule” specific time for the educational session; allowing adequate time for questions. If the learner perceives that the teacher is hurried, they may not ask their questions for fear of wasting the teacher’s time. It is only through a reciprocal relationship that the teacher can determine if the student has comprehended the information (Driscoll, 2005). The questions a patient may ask the nurse regarding discharge instructions or medications may reveal the gaps in the learned information.

Teaching patients about their health care needs can make a difference in a patient’s quality of life. Nurses should develop a teaching plan according to the assessment needs identified by the patients and the information obtained during their history and physical. The teaching plan should incorporate the patient’s cultural, economic and practical needs. A mutual goal should be

developed and it must be obtainable for the patient. It is helpful to establish a time frame for the goal to be accomplished. This is beneficial when determining the effectiveness of the interventions, if the goal is met in the time frame allotted for the goal (Lewis, Heitkemper, Dirksen, 2004).

The teaching method utilized should reflect the learning style of your patient. The resources available will also be a factor when determining the teaching method. The method generally utilized by nurses is discussion with handouts. When providing discharge education, nurses may have medication and/or wound care education sheets available for the patient to take home with



Teaching patients about their health care needs can make a difference in a patient’s quality of life. Nurses should develop a teaching plan according to the assessment needs identified by the patients and the information obtained during their history and physical.



Our patient population represents many cultures, learning styles and languages. The nurse must recognize the variables in the patient and tailor the information accordingly.

them. The demonstration/return demonstration is another common teaching method utilized by nurses to teach a motor skill (Lewis, Heitkemper, Dirksen, 2004). Patients are now expected to perform many skills at home to maintain their health, such as dressing change, giving injections for insulin or managing the output from a drain. The patient's physical ability impacts whether or not a patient can successfully master this skill. For example, patients must have dexterity and fine motor skills in order to manage an insulin injection. The patient's vision, reading ability and organizational skills must also be assessed. The best way to evaluate whether the patient has learned the skill is to have the patient return demonstration to the nurse. During the return demonstration the nurse should assess for signs of confusion and clarify any issues that may arise.

The process of learning new skills and information can be uncomfortable for patients and their families. Learning new material is stressful and the patient may also be worried about the economic cost of their illness, changes in lifestyle that may need to occur, self-image change, role change in the family or at work. The nurse must be aware that their patients may be struggling with these anxieties. It is helpful if the nurse keeps the teaching session nonthreatening. Self awareness, self reflection and internal work will assist nurses in recognizing how they are perceived by others. An adult learner has a heightened sensitivity when engaged in the learning process. The nurse may believe they are being calm and focused but must validate the perception by observing and critically listening to their patient. The patient's needs should direct what information is provided. It is very important to consider the patient's previous experiences and knowledge regarding the subject. The teaching plan should be individualized to the patient even if standardized plans are available (Lewis, Heitkemper, Dirksen, 2004).

The next step in the learning process is evaluation. Short-term evaluation can be utilized while the patient is in the hospital. Long-term evaluation may need to occur as an outpatient or follow-up at doctor's office. It is also necessary for

the patient and family to have a plan of action if complications occur and further information may be needed when home. The patient should have contact phone numbers, instructions on how to get supplies and making follow-up visits.

The final step is to document the educational interaction. This documentation should be forwarded to the agency providing follow-up care. The documentation of teaching is very important for many reasons. The documentation serves as a teaching plan for the patient; this allows for improved consistency for the patient during their follow up care. Practice guidelines for wound care, weight control, and hypertension are a few examples of post hospital illnesses that need follow up and could be improved with a consistent plan that is documented. This would serve not only to improve practice guidelines, but also to facilitate nursing research and determine the effectiveness of nursing interventions. The nursing care will become more visible for all essential parties. The financial responsibilities will also be better defined. Nursing documentation of teaching allows for providing a continuing evaluation of nursing effectiveness.

In closing, in order for a nurse to be an effective teacher, the nurse has to do more than pass on information. Recognition of learning styles, patient's physical abilities and stress levels are vital for the nurse to be a successful teacher. The education process begins with assessment of learning needs and abilities. There is a greater potential for knowledge acquisition for the patient if their particular needs are accommodated. Documentation of the education process allows for improved continuation of care. Nursing has a wonderful opportunity to embrace the teaching process and provide comprehensive patient education.

Email comments to francis-mary@cooperhealth.edu

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Shared Governance: Re-Designing Structure and Process, and Impacting Outcomes

Kathleen Yhlen RN MSN NE-BC

Earn Contact Hour Credit (Contact Hour: 1.0)

Learning Objectives

1. Define what control over nursing practice is.
2. Identify the differences between hospital-based and unit-based accomplishments.

The concept of nursing shared governance was originally developed to give clinical nurses a way to participate in the decision-making processes that affect their practice. According to Hess (2004), the concept of shared governance was introduced in 1976 and appeared for the first time in the literature in 1978 as a model that assembled the interests of different organizational groups to formulate policy. The concept of shared governance has evolved over the past 30 years; there is no end point it is a process that needs to be revitalized and renewed. Today, shared governance is defined as an organizational structure through which nurses control their practice and are allowed and expected to participate in decision-making processes affecting that practice (Kramer et al., 2008).

Shared governance is a structure that activates, enables and promotes control over nursing practice (CNP). According to Kramer and associates (2008) CNP is one of the processes identified by staff nurses in Magnet designated hospitals as essential to a productive and satisfying work environment. Nurses practicing in Magnet hospitals define CNP as input, including access to and exchange of information, views and judgments, and decision-making on issues such as practice standards, policies, equipment that affect the nursing profession, the practice of nursing, and the quality of patient care (Kramer et al., 2008, p. 540). Consensual decision-making, group facilitation, conflict resolution, and negotiation are essential in CNP.

The most common model of shared governance is the councilor model which integrates decisions made by staff and managers in hospital-based councils or subcommittees. In addition some hospitals integrate individual unit-based councils that directly link to the hospital-based council structure (Force, 2004, Frith & Montgomery, 2006). Incorporating unit-based councils is one of the most important elements in designing and implementing a nursing shared governance model. Dunbar and colleagues (2007) recommended that each council or subcommittee have defined purposes and functions. Member

composition should be varied in number and expertise including representation from each practice area. Staff nurses serve as chairpersons, and co-chairpersons, with at least one nurse manager and one advanced practice nurse on each council. In addition, each council is assigned a professional advisor to act as a resource member. Dunbar and associates (2007) further suggested that there be hospital-based councils, consisting of only registered nurses and unit-based councils consisting of any level of nursing staff. Finally, a formal election process and bylaws are instrumental in ensuring effective ownership and smooth operation of all councils from year to year.

Today, shared governance is defined as an organizational structure through which nurses control their practice and are allowed and expected to participate in decision-making processes affecting that practice.



The specific structure and function of hospital-based and unit-based councils can differ in every organization. Typically there are five to eight councils organized into functions such as quality, professional development, research, clinical practice and a coordinating council that oversees the functions of all councils and provides linkage to all hospital-based and unit-based councils (Rush University Nursing, n.d.; Wake Forest University Nursing, n.d.; University of North Carolina Nursing, n.d.; Fox Chase Nursing, n.d.). Unit-based councils are also part of the structure. Each nursing unit develops and implements a council to address unit-specific issues. Shared governance structures encourage nurses to take responsibility and have accountability in decision-making related to patient care and nursing practice (Frith & Montgomery, 2006). Outcomes of shared governance vary from hospital to hospital. Examples of hospital-based council outcomes may include the development of action plans for nursing strategic goals, developing or revising policies, establishing evidenced-based practice requirements, and approving nursing research studies.

Unit-based councils grew out of the concept of shared governance. Each council designs a unit-specific plan with a staff member facilitating the group. Unit-based outcomes may include the development of unit goals and action plans, addressing unit issues that enable more efficient work and system processes, and development and implementation of evidenced-based unit specific protocols.

Many attributes and skills contribute to the success of shared governance. In a 1991 study, Reeves concluded that staff nurses considered five skills critical in successful shared governance models. These include:

1. Ability to engage in decision making about patient management issues
2. Ability to engage in the development of standards of practice
3. Ability to engage in quality assurance monitoring
4. Ability to use conflict resolution skills
5. Ability to utilize negotiation skills

In another study (Kramer et al., 2008) four attributes were found to contribute to the viability of shared governance structures. The first attribute, access to power, referred to the sharing of power, not exerting power over someone. The nurses in the study described the informal power of collaborating with physicians and seeking out or being sought out by peers, managers, and other professionals. The next attribute, breadth and depth of participation, referred to the degree of participation in the council structure. Recognition of the shared governance structure and activities of nurses was the third attribute that referred to nurses having knowledge of the councils, what they did, and how they could contribute. The last attribute included pride in accomplishment, effective outcomes, and action. This attribute referred to nurses citing outcomes that had been achieved by hospital and unit-based councils.

Willing participation by nurses is essential for the viability of the shared governance structure; both hospital-based and unit-based. In the above study (Kramer, et al., 2008) the major reasons for nonparticipation included staffing issues related to patient coverage for the nurse leaving the unit to attend a meeting, nurses just not interested in "meetings", and

personal/family obligations that prohibit participation. Some of the strategies used to increase staff nurse participation in the study included financial compensation, compensatory time off to attend meetings with adequate unit staffing, extended day-long or half-day council meetings, and council members soliciting their own replacements.

Initiating or re-designing a shared governance structure is a journey. It requires a major change in nursing culture and perceptions, time, and commitment from all involved in the process. When shared governance is seen by clinical nurses as chiefly structural without decision making ability, the result is reluctance to assume nursing accountability. Research has demonstrated that this innovative organizational model gives staff nurses control over their practice (Kramer et al., 2008). Shared governance fosters professional growth and creates an environment that gives nurses the ability to effect change, ultimately leading to improved patient care.

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POST TEST: Shared Governance

Earn contact hour credit (1.0) • Please circle the correct answer.

- Shared governance structures can promote and provide avenues through which nurses are empowered to participate in decision-making processes that affect nursing practice.
 - True
 - False
- A process that is essential to a satisfying and productive work environment is:
 - The orientation process
 - Control of nursing practice
 - Decisions made at the unit level
 - Mobile phones for direct contact between nurses and their patients
- When designing and implementing nursing shared governance models one of the most important elements necessary for continued support is to:
 - Incorporate the unit-based councils
 - Promote a change in the nursing culture
 - Emphasize command and control
 - Eliminate hierarchical models
- Control of nursing practice includes all EXCEPT:
 - Access to and exchange of information
 - Practice standards
 - Decision-making on issues of importance that affect the nursing profession
 - Certification in nursing specialty
- Control of nursing practice is defined by nurses in Magnet hospitals as:
 - Input and decision making on issues of importance
 - Input and access to nursing research
 - Input regarding nursing management innovation
 - Evidence based policies, practice and quality of care
- Staff nurses serve as chairpersons on councils in the shared governance councilor model:
 - True
 - False
- An election process with bylaws can be an instrumental aspect of ensuring effective ownership and smooth transition of councils from one year to the next.
 - True
 - False
- Which of the following is NOT considered a hospital-based accomplishment?
 - Action plans for nursing strategic goals
 - Developing and revising policies
 - Establish evidence based practice requirements
 - Interdisciplinary team formed to address unit issues
- Which of the following is NOT considered a unit-based accomplishment?
 - Developing unit-specific goals
 - Addressing unit issues
 - Developing unit-based protocols
 - Development of JCAHO mock survey
- When shared governance is seen by clinical nurses as chiefly structural without decision making ability, the result is:
 - Reluctance to assume nursing accountability
 - Increased viability of councils
 - Decreased falls and medication errors
 - Increased clinical autonomy and individual decision making
- The transition to a shared governance model does NOT require a major change in nursing culture and perceptions.
 - True
 - False

EVALUATION FORM (required)

Have the following learner objectives been met. Circle response please

- Define what control over nursing practice is.Yes No
- Identify the differences between hospital-based and unit-based accomplishments.....Yes No

Please rate each of the following.

	A (Excellent)	B (Good)	C (Fair)	D (Poor)	E (N/A)
3. This teaching method was effective					A B C D E
4. Opportunity to keep my knowledge current.....					A B C D E
5. Expectation of earning continuing education.....					A B C D E
6. Relevance of course agenda to practice					A B C D E
7. Opportunity to enhance professional effectiveness and practice.....					A B C D E

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REFLECTIONS (continued from page 15)

that the hospital has a “zero tolerance” for violence and abuse (verbal and physical, even when implied). Staff joined the hospital’s CARE task force and I joined the Security Strategy Committee. This was our first major step in resolving this safety concern – knowing and following our own policies and using the resources available to us.

- Addressed issues regarding disruptive visitors and patients directly, immediately and with support: We realized the need to face problems head-on the first time an issue arises. Each nurse agreed that when a problem was identified with a family they would notify a member of the clinical management team. If no manager was on the unit, the staff was instructed to contact the Clinical Operations Director. Management would meet immediately with the family to make it clear what they could expect from us and what we could expect from them. We identified clear-cut boundaries and consequences for non-compliance with maintaining the boundaries and the agreement.

Privacy was another concern that needed to be addressed. When the Trans Nursery is at or near capacity, it is impossible to have private conversations, including those on such sensitive topics as drug use, paternity, STDs, infertility, adoption and child welfare

interventions. The staff identified a simple solution to protect patient confidentiality. Any sensitive conversations between family members and others (including representatives of outside agencies) would occur outside the nursery in a private conference room; a simple solution to a complex problem.

Our results

Within three months of initiating planned changes, we began seeing meaningful results. The families were more satisfied and the staff, across all disciplines was committed and engaged. Our patient satisfaction scores went from the 23rd percentile in March 2008 to the 98th percentile in September 2008. These outcomes have been sustained over time. We scored in the 94th percentile in December 2008 and 94th percentile March 2009. Three gold medal quarters in a row! Everyone on the team was proud of what we had accomplished and have been able to sustain.

Our efforts to sustain these improvements continue. There are still days when communication breaks down, when there is overcrowding and when families and staff experience frustration. The difference comes in knowing that we have the power to ask for what we need and that together, as a Team, we are willing to work for what we want. We are confident that our success will endure.

Email comments to fox-joanne@cooperhealth.edu

The Amazingly True Story of a Unit Turnaround

Joanne Fox BSN, RNC-NIC. Clinical Director Neonatal ICU



Had I not seen it with my own eyes, I would not have believed it was possible. The staff and leadership of one unit with two specialized patient care areas, the Neonatal Intensive Care Unit (NICU) and Transitional Nursery (Trans), dramatically transformed the culture of care for patients, families and staff in less than a year. The journey was not easy and still continues, but there are key elements that made it possible. This included a high level of teamwork within and outside the units, involvement and commitment of the entire staff and the support of nursing leadership. The staff believes some of the lessons learned can help other nurses committed to making significant improvements in their patients' and family experiences. This is our story.

In the beginning

At the beginning of 2008, soon after becoming Clinical Director of the NICU and Trans, I spent the vast majority of my time responding to family and staff complaints. The magnitude of the dissatisfaction was reflected in the patient satisfaction scores, which fell into the 20th percentile. Most of the complaints revolved around the Trans, in particular, staffing levels, family and patient concerns about safety, and confidentiality of conversations on the units.

Our approach: engaging all stakeholders:

To address these issues, the unit-based council (UBC) knew we needed the involvement of the entire staff as well as input from our patients' families. The UBC knew they needed to give 100% of the staff a chance to participate in improving the unit. A decision was made to convene as many meetings as possible for the sole purpose of identifying problems and solutions. Next, the staff asked families to give feedback regarding their experiences in the NICU and Trans. I walked through the units several times a day to speak with and listen to family concerns. Additionally, we contacted discharged families to learn specifically about their experiences. After the information was collected and analyzed, we looked for a quick win. The UBC recruited a committed RN volunteer, Cindy Garretson, as the Core RN in the Trans Nursery. She put together a plan, outlining what nurses perceived as their most urgent issues.

The first issue was staffing in the Trans. Nurses from other areas with the required nursing skills, yet outside their comfort zones in handling discharges, admissions and other complicated social issues, were assigned to work in the Trans. The staff depended on nurses to "help out" on this unit without having anyone actually accountable for insuring that this occurred. To alleviate this, all staff committed to the creation of "truly workable" staffing assignments in the Trans.

The second most important issue was the need for open and frequent communication. The staff recognized that the only way this plan would work was to get frequent feedback and suggestions from all staff and families. At each staff meeting, staff was asked to report on anything that caused disruptions in the delivery of care. As a team, the nurses listened carefully to the families and each



From left to right starting in the rear: Gary Stahl, MD; Jackie George, RN, ACD; Joanne Fox, CD; Jim Hart, Respiratory. Front row: Genellen Bona, RN; Anna McCausland, RN, Mary Evers, Social Worker; Judy Saslow, MD; Michelle Basile, RN

other and addressed all problems as quickly as possible. In particular, the staff educated families about the Trans as early as possible and reassured them that their babies would be cared for by the same staff who had worked in the NICU. In addition, the staff quickly educated families on how Trans was different from the NICU and what they could expect from the staff after the baby was transferred to the Trans. Lastly, Cindy, the Core RN, completed a daily report and briefed me on each patient at the end of the week. The weekly briefing included a social history, an updated problem list and current discharge plan.

Safety was another important issue that needed our attention. The most challenging issue was how to create a safer environment for staff, patients, and families. Staff and families expressed serious concerns about the babies' safety, given the percentage of family members in the Trans with challenging social issues and threatening behaviors. This is what the staff did:

- Set boundaries for unacceptable and threatening behaviors: In an effort to be patient and family-centered (e.g., 24-hour visitation and creating a warm, friendly and non-judgmental environment), we previously allowed some family members to engage in unacceptable and intimidating behaviors. Our concern was being perceived by family members as "intolerant and unfair." Upon reflection, we realized we had gone way too far in our efforts "not to offend" and well-defined boundaries were required.
- Carefully reviewed hospital policies and other specific unit practices related to disruptive visitors and patients: Staff determined that the required hospital policies were already in place and other units had already addressed similar issues. Many tools were already available, but were not being used. We asked the Security Department to help us and also learned that the Social Work and Pastoral Care Departments were also available for support in difficult situations. Most importantly, I communicated to staff

(continued on page 14)



Professional News

DEGREES:

Phyllis DiCristo, RN-BC, BSN, OCN, Drexel University

Jodi O'Shea, RN-BC, MSN, Drexel University

Sharon Byrne, DrNP, APN, NP-C, AOCNP, Doctor of Nursing Practice degree from Drexel University – March 2010.

CERTIFICATIONS:

Certified in Oncology Nursing

Agnes Asamoah RN, OCN

Carolyn Ali RN-BC, OCN

Jonelle O'Shea RN-BC, BSN

Audrie Orzechowski RN, OCN

Certified in Medical Surgical Nursing

Cassandra DeMoss, RN-BC

Jennifer Yoder, RN-BC, BSN

Carolyn Ali RN-BC, OCN

Jodi O'Shea RN-BC, MSN

Lorri Vantrieste, RN-BC

Susan Nawoyski, RN-BC

Certified in Progressive Care Nursing

Sarah Stockum, RN, PCCN

PRESENTATIONS:

Donna O'Shea, RN-BC, BSN, and **Cheryl Koehl, RN**: Poster presentation "Career Enhancement: Professional Development of the Clinical Educator" at NJ State Nursing Convention in Atlantic City on March 25-26, 2010

Kathy Devine, RN, BSN, CCRN and **Stacey Staman, RN, MSN, CCRN**: Poster presentation "Competency validation: Not just going through the motions" at New Jersey State Nursing Convention in Atlantic City on March 25-26, 2010

Mary Jo Cimino, RN, BSN, CCRN: Poster presentation "The differences in outcomes of patients transferred to the ICU vs transferred in by Rapid Response" at the Society of Critical Care Medicine Conference in Miami on January 11 2010

Christa A. Schorr, RN, MSN and **Karen Vito, BSN** along with Stephen Trzeciak MD, Barry Milcarek PhD, Joseph E. Parrillo MD, FCCM and R. Phillip Dellinger MD: Poster presentation "Assessing trends in presentation, process and outcome following the Surviving Sepsis Campaign (SSC) performance improvement program in patients presenting to the emergency department with septic shock" at the Society of Critical Care Medicine Conference in Miami on January 11 2010

Mary Stauss, RN, MSN, APN, CEN: Presented a lecture "New Frontiers in Emergency Nursing: A-Lines & CVPs in the ED" at the NJENA conference in Atlantic City on March 19, 2010

Lynne Duffy, RN, MA, CEN: Poster presentation "Use of Personalized Care Plans for Difficult/Repetitive Patients" at the NJENA conference in Atlantic City on March 19, 2010

Beth Sherman, RN, BSN, CEN and **Mary Stauss, RN, MSN, APN, CEN**: Poster presentation "Hemolysis of Coagulation Specimens: A Comparison of IV Draw Methods" at the NJENA conference in Atlantic City on March 19, 2010

Sharon Byrne DrNP, APN, NP-C, AOCNP, Tondalya Deshields RN, BSN, and **Mary Ellen Smith Glasgow PhD RN**: Poster presentation "Factors Associated with Decrease Utilization of Mammography by African American Women Residing in Camden County, New Jersey," Drexel University College, National Consortium of Breast Centers, Inc., 20th Annual Interdisciplinary Breast Cancer Conference, March 20-24, 2010, Las Vegas, NV.

Sharon Byrne DrNP, APN, NP-C, AOCNP, and **Evelyn Robles-Rodriguez MSN AOCN**: Poster presentation "Home Health Parties as an Educational Outreach Strategy to Promote Breast Health Awareness: Two Years of Experience." National Consortium of Breast Centers, Inc., 20th Annual Interdisciplinary Breast Cancer Conference, March 20-24, 2010, Las Vegas, NV

Linda Wicker, RN, MSN, CCRN: presented, "Effect of a Comprehensive Infection Control measures on the Rate of Late on-set Infection in the Very Low Birth Weight Infant," Eastern Society for Pediatric Research on March 27, 2010, Philadelphia, PA

APPOINTMENTS:

Christa A. Schorr, RN, MSN was inducted as a Fellow into the American College of Critical Care Medicine, January 2010.

PUBLISHED:

Gail M. Horvath, BSHS, RN, CNOR, CRCST – "Crew Resource Management in the Operating Room: A Review of Literature" article accepted for publication in OR Nurse 2010.

CONGRATULATIONS TO THE 2010 NURSE EXCELLENCE AWARD WINNERS

The 2010 Nurse of the Year is **Patricia Pearlman, R.N.**, a direct patient caregiver in Cooper's Neonatal Intensive Care Unit. Pat, who lives in Cherry Hill, is extremely active in patient and nurse advocacy and continues to create better ways to promote patient and family centered care within the NICU department. Two years ago, she began "Clare's Cupboard" to help raise money towards the purchase of basic baby supplies such as diapers, bottles, formula, clothing and other essentials for NICU patients and their families. To date, the program has helped over 100 families and raised more than \$50,000. Pat also received the Kronenberger Memorial Award for Neonatal Nursing.

Charlotte E. Tobiason Memorial Award: **Margaret Stager, R.N.C.**, from Pitman, NJ – Maternal Intermediate Care Unit

The UC/CADV Award for Excellence in Cardiovascular Nursing Practice: **Debbie Shannon, R.N.**, from Albion, NJ – Cardiac Catheterization Lab

The Selma & Martin Hirsch Clinical Excellence Award: **Dawn Davila-Blake, R.N., B.S.N.**, from Smyrna, DE – ICU/CCU

Cooper Nursing Alumni Clinical Nurse Excellence Award: **Kathryn Dunn, R.N.**, from Blackwood, NJ – Cardiac Catheterization Lab

Carol Tracy Compassion Award: **Lisa Passero, R.N.**, SDS/SPU/PAT, from Turnersville, NJ – Outpatient Chemotherapy Infusion

The Moorestown Auxiliary Memorial Award for Excellence in Geriatric Nursing: **Mary DiBenedetto, R.N., CAPA, SDS/SPU/PAT**, from Cinnaminson, NJ – Outpatient Chemotherapy Infusion

John Henry Kronenberger Memorial Award for Neonatal Nursing: **Patricia Pearlman, R.N.**, from Cherry Hill, NJ – Neonatal Intensive Care Unit

The Philip & Carole Norcross Award for Excellence in Nurse Leadership: **Lisa Geoghegan, R.N., SDS/SPU/PAT**, from Delran, NJ – Outpatient Chemotherapy Infusion

The Barbara & Jack Tarditi Family Award for Nurse Mentorship: **Tony Solomon, R.N.**, from Williamstown, NJ – Emergency Department

The Barbara & Jack Tarditi Family Excellence Award for Nurse Research: **Beth Sherman, R.N., B.S.N., CEN**, from Mickleton, NJ – Emergency Department

The Philip & Carole Norcross Award for Excellence in Oncology Nursing Practice: **Jennifer Kubat, R.N., B.S.N.**, from Pitman, NJ – North/South 9

The Moorestown Auxiliary Memorial Award for Excellence in Outpatient Nursing: **Lisa Passero, R.N., SDS/SPU/PAT**, from Turnersville, NJ – Outpatient Chemotherapy Infusion

Ronald Bernardin Memorial Award for Pediatric Nursing: **Janet Ezekial, R.N., B.S.N.**, from Audubon, NJ – Outpatient Pediatrics

Award for Excellence in Perioperative Nursing: **Elizabeth Maryanski, R.N., SDS/SPU/PAT**, from Pennsauken, NJ – Outpatient Chemotherapy Infusion

Award for Excellence in Perioperative Surgical Technology Practice: **Andrea Reeve, R.T.**, from Cherry Hill, NJ – Cardiac Catheterization Lab

The Lynn Nelson Memorial Award of Excellence: **Jack Leshnov, B.A., C.S.W.**, from Merchantville, NJ – Emergency Department

Excellence in Trauma Nursing Practice: **Sherry Wright, R.N.-C.**, from Pennsauken, NJ – Trauma Services

The Barbara & Jack Tarditi Award for Excellence in Patient Care (NON-NURSE): **Edward Lemmo, R.T., (RO) (ARRT)**, from Mount Royal, NJ – Emergency Department

