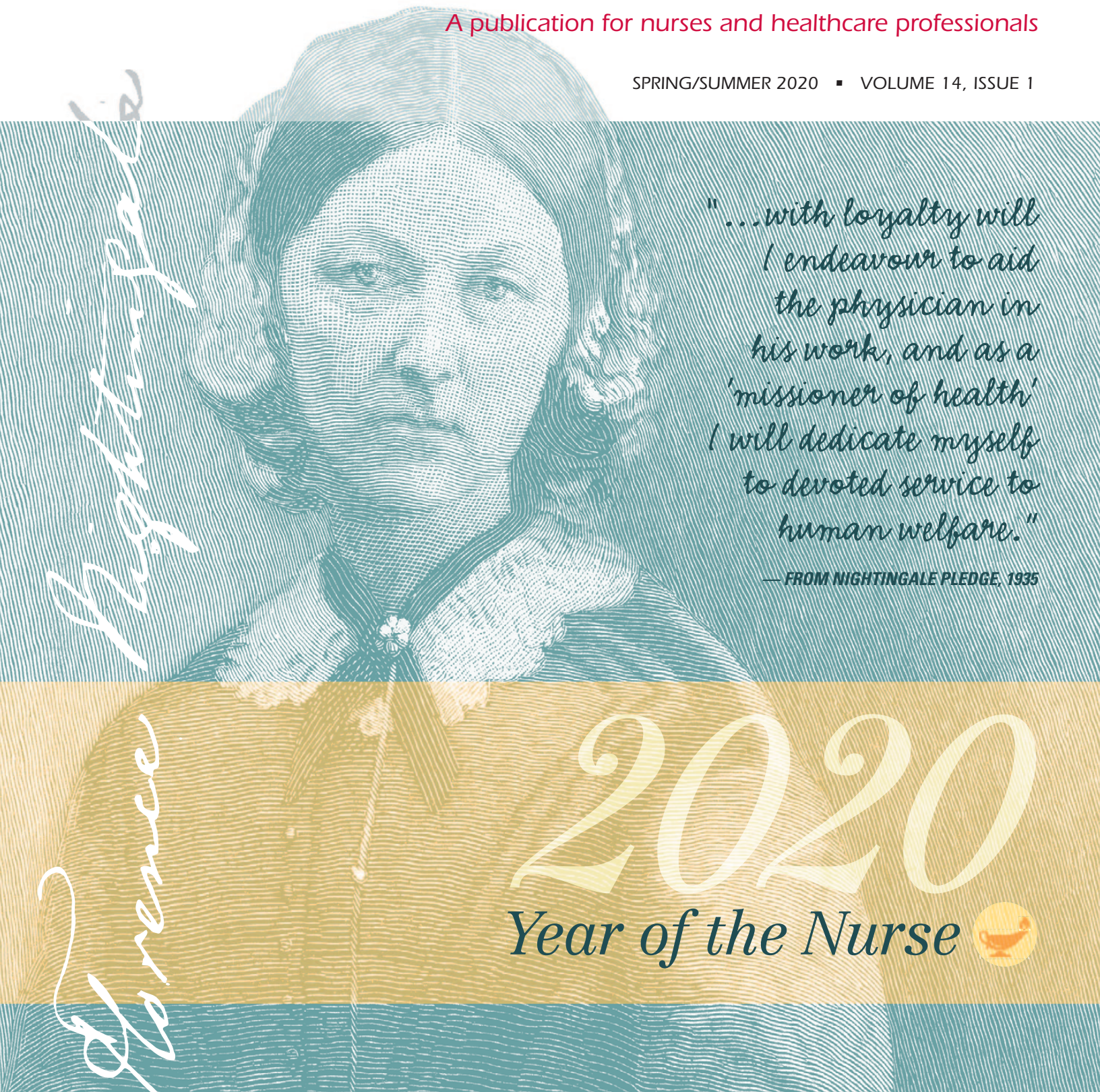
Cooper University Health Care

# Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/SUMMER 2020 ▪ VOLUME 14, ISSUE 1



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**Staman-stacey@cooperhealth.edu**

Cooper
University Health Care

# Our Senior Nurse Leaders

**In each new edition, we will be celebrating one of our Senior Nurse Leaders. In this edition, it is an honor to share an interview with Jennifer Glendening, PhD, RN, NEA-BC, CMSRN, CPHQ, and AVP Professional Development**

**EDITOR:** ***Jennifer, thank you for this opportunity. As AVP, could you share your vision for Cooper Nursing? What are your priorities for 2020?***

**JENNIFER:** Cooper Nursing will continue to expand on foundational work previously implemented to support and strengthen clinical practice through professional development and evidence-based practice. My vision for 2020 includes another year full of robust growth and development across our Patient Care Services teams. The healthcare landscape continues to evolve and grow. Therefore, the time is now to listen, inspire, encourage, and support each other to promote and uphold a rewarding nursing culture. Nurses take on many roles and all serve the organization and the community as leaders of clinical excellence. Whether at the bedside, in the classroom, out in the community or from behind a desk, nurses advocate on behalf of patients. Nurses also teach the next generation of caregivers and move the industry forward with innovative practices and technological advancements. One key 2020 priority of the Senior Nursing Leadership team includes the implementation of a nurse-driven professional practice model and shared governance framework for Cooper Nursing practice.

**EDITOR:** ***What are your goals for 2020?***

**JENNIFER:** Nursing teams that share a common vision in which high-quality patient care is key. Key goals for 2020 include ongoing efforts to stabilize clinical education, quality, and patient safety improvement plans. One goal includes efforts to strengthen interprofessional partnerships including educational support and mentorship between the advanced practice nurse and the bedside nurse as well as an enhanced Nurse Residency program for our new-to-practice nurses. Continued work to strengthen the foundational work of the Nurse Champion program dedicated to quality outcomes, and the continued work of the New Jersey Hospital Association's Nursing Workplace Environment and Staffing Council (NWESC) will help support the 2020 nursing work plan and achieve key goals in quality, safety, and service.

**EDITOR:** ***Where do you see Cooper Nursing in five years?***

**JENNIFER:** I believe Cooper Nursing will continuously move in a positive direction towards social change filled with enhanced levels of shared governance. I believe the 2019 strict dedication to continuing education, professional development, and clinical innovation will serve as a strong framework to support healthy work environments, nursing professional growth, and develop comprehensive clinical teams dedicated to quality and safe patient outcomes. In five years, I envision Cooper Nursing on the pathway to professional excellence. Through teamwork and interdisciplinary partnerships, we will maintain a healthy work environment for our nurses and continue to support the professional growth and development of our nursing work force.

**EDITOR:** ***Anything else you would like to add?***

**JENNIFER:** For me, leadership means believing in and respecting human dignity. It means being attentive, encouraging and upholding a rewarding culture. It means comprehensive nursing management that consistently focuses on quality, service and safety. All nurses should be admired as role models. I believe every nurse holds the key to be a successful educator, mentor, and leader of healthcare delivery.

**Cooper Bridges Mission:**

*"To communicate and educate nurses and healthcare professionals to foster excellence in the delivery of patient care."*

Cooper Nurses interested in authoring an article for a future edition of *Cooper Bridges* may obtain submission guidelines by contacting: **Staman-stacey@cooperhealth.edu**

# Dissecting Dizziness

Molly Hammond, CORLN, APN

Complaints of dizziness and vertigo are quite common in primary care and emergency medicine. These complaints are estimated to make up 5% of outpatient adult primary care visits. About 20 % of patients who present with this concern do not receive a definitive diagnosis and are referred out to a specialist (Dickerson, 2010). Patients typically present to the Emergency Department (ED) with severe and sudden onset of symptoms. Primary care providers see about 50% of the initial presentations (Herbert, et al., 2017).

Acute dizziness is one of the most common presenting concerns in patients presenting to the ED. The term "dizziness" is quite vague. There are generally four specific forms of dizziness: vertigo, presyncope, disequilibrium and lightheadedness. Disequilibrium is a sensation of an impending fall or of the need to obtain external assistance for proper locomotion. It is sometimes described as a feeling of improper tilt of the floor, or as a sense of floating. This sensation can originate from the inner ear, other motion sensors, or the central nervous system. Presyncope or near-syncope denotes near fainting or a prodrome of syncope. The most uniform definition is "feeling like one was going to pass out but without actual loss of consciousness" (Whitledge, et al, 2019). Near syncope can last for seconds to minutes. Symptoms may be accompanied by a feeling of lightheadedness, general weakness, warmth, diaphoresis, nausea, palpitations or blurry vision. When assessing patients with dizziness it is imperative to obtain a thorough history of what dizziness feels like to the patient, in what situations they feel dizzy, how long the symptom lasts (episodic vs. constant) and which changes in position may bring on their symptoms.

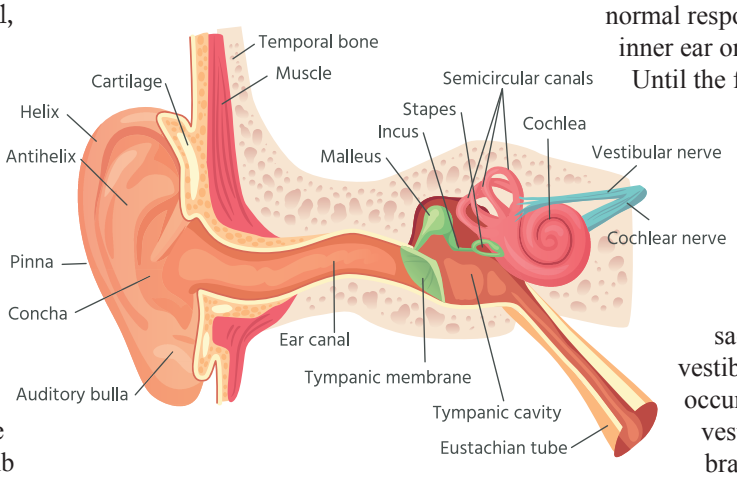
Vertigo can be triggered by spinning or being spun around quickly. The feeling of spinning that continues after the body/head stops moving is vertigo. This is a normal response because the fluid in the inner ear organs takes a moment to settle.

Syncopal and near-syncopal episodes in the absence of disequilibrium and vertigo are unlikely caused by an otologic (ear) issue. Syncopal episodes are concerning for a non-otologic problem and this should be evaluated by primary care providers initially or in the ED. Problems with blood pressure, cardiac rhythms, orthostatic hypotension, hypoglycemia, or neurologic (central) issues are likely involved with this sort of presentation. Typically, once neurologic and cardiac etiologies have been ruled out, a patient is sent to an Otolaryngology (ENT) specialist for further evaluation of vertigo.

Vertigo and disequilibrium are evaluated further by an ENT specialist because there is often an issue with the peripheral vestibular system. The vestibular system is an intricate body system with both peripheral and central components that processes information about head movements, the coordination of visual input and changes to body position to essentially tell the brain what the body is doing in regard to changing positions. The peripheral portion of the vestibular

system is in the inner ear and continually reports information about the motions and position of the head and body to integrative centers located in the brainstem, cerebellum, and somatic sensory cortices (Purves, et al, 2001).

The five major structures of the peripheral vestibular system are in the inner ear: the utricle, the saccule, and the semicircular canals (lateral, superior, and posterior).




Hair cells in these structures are involved in transmitting the sensory input to the processing centers in the brainstem and cerebellum (Welgampola, et al., 2019). Vision and proprioception are also involved in this system. Proprioception is the sense of self-movement and body position. Proprioceptors are sensors in the body that provide information to the brain about limb and joint positioning as well as muscle tension. This information is integrated to give information about the position of the limb in space. All of this information is processed by the central vestibular pathways (e.g. vestibular nuclei) and maintains our sense of balance and position. In order to feel balanced and sure of one's body position, all aspects of the vestibular system must be intact and functioning; otherwise, vertigo occurs. Vision, or more specifically the presence of horizon lines (horizontal and vertical) in our environment, allows the brain to create a map of our surrounding space. The agreement of these visual stimuli, proprioception, and peripheral input allow the body to maintain balance.

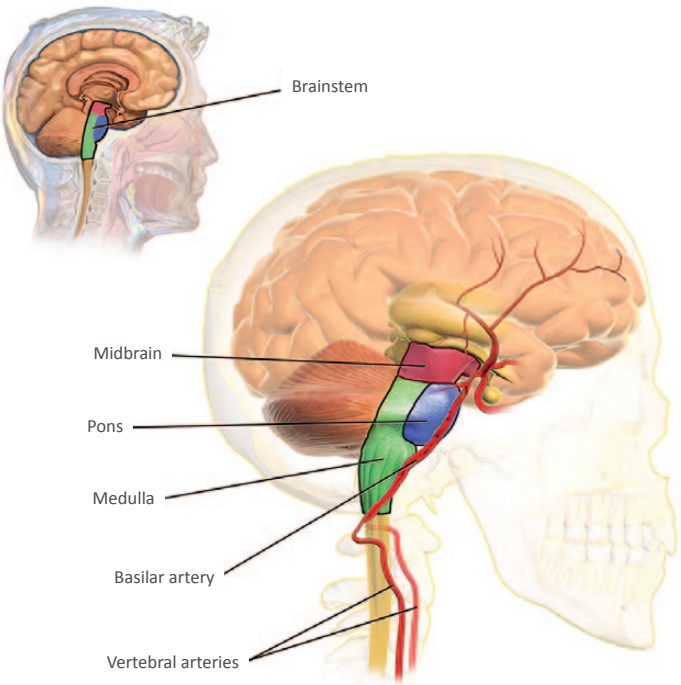
Vertigo is a feeling of motion or spinning that can be described as the patient spinning (subjective) or the room spinning (objective).Vertigo can be triggered by spinning or being spun around quickly. The feeling of spinning that continues after the body/head stops moving is vertigo. This is a normal response because the fluid in the inner ear organs takes a moment to settle. Until the fluid stops moving, the message continues to the brain that the head is spinning.

There are central and peripheral etiologies for vertigo. Peripheral vertigo occurs from abnormalities of the semicircular canals, the saccule, the utricle, and the vestibular nerve. Central vertigo occurs from problems with the vestibular nuclei, cerebellum, brainstem, spinal cord, and the vestibular cortex of the brain. Central abnormalities are present in about 25% of patients with vertigo and/or disequilibrium. The more common reasons for central vertigo are vestibular migraine, lesions in the cerebellopontine angle or posterior fossa of the brain, and vertebrobasilar ischemia leading to decreased blood supply to the brainstem, cerebellum, and inner ear (Muncie, Sirmans & James, 2017).

> True vertigo is treatable and often curable with proper management.

The most common types of vertigo managed by ENT specialists are benign paroxysmal positional vertigo (BPPV), vestibular neuritis, and cochlear/endolymphatic hydrops, i.e., Meniere's disease. BPPV is the most straightforward presentation and can be treated with maneuvers in the office. BPPV can occur without reason or after an event that could have dislodged the otoliths such as riding a roller coaster or trauma to the head. Patients who have BPPV share that there are certain changes in body position (rolling over in bed, bending forward, turning head to one side) that will trigger vertigo and the feeling of spinning stops within a minute or so of its onset. Performing a Dix Hallpike exam in the office can most often diagnose this problem. The Dix Hallpike exam entails having the patient lay flat with their head turned to the side while being examined. Eyes are kept open to watch for torsional (geotropic or ageotropic) nystagmus, which is considered a positive response. Once BPPV has been identified with a positive Dix Hallpike exam, canalith repositioning can help the otoliths (small crystals in the inner ear organs) get back in the correct area, so vertigo no longer occurs.

Vestibular neuritis is the second most common type of vertigo and can occur after exposure to common viruses that can lead to an upper respiratory tract infection (URI). Patients with this issue typically share a severe onset of symptoms (usually after/during a URI) of vertigo that is often accompanied by



VRT has been a highly effective treatment modality for most adults and children with disorders of the vestibular or central balance system.

nausea and vomiting. Symptoms typically lessen over days to weeks and often resolve after months. In this case, vertigo is more constant. Canalith repositioning will not help in this case. Anticipatory guidance about this taking sometimes months to resolve and symptom management help most patients.

Cochlear or Endolymphatic Hydrops (i.e., Meniere's disease) is best diagnosed by an ENT specialist. This issue is unlikely to be diagnosed by case history alone. The symptoms of Meniere's disease include recurrent episodes of vertigo that last hours accompanied with unilateral, fluctuating, predominantly low-frequency hearing loss, tinnitus and the sensation that the ear is blocked or full. Serial hearing testing is crucial in the diagnosis of Meniere's, as the hearing is likely to fluctuate. Central issues, such as vestibular migraines, can have similar symptoms initially (Whitledge et al., 2019).

True vertigo is treatable and often curable with proper management. Vestibular rehabilitation therapy (VRT) is a form of physical therapy that uses specialized exercises that result in gaze and gait stabilization. Most VRT exercises involve head movement, which are essential in stimulating and retraining the vestibular system.

In conclusion, obtaining the relevant history for complaints of dizziness is essential for proper evaluation and management of vertigo. Many patients can be managed for non-otologic issues by their Primary Care or ED Providers. Referral to ENT is appropriate when cardiac and neurologic issues have been ruled out and the history is consistent with a vestibular problem.

Email comments to **Hammond-Molly@cooperhealth.edu**

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## 2020 Nurse of the Year:
### Steven Teitelman, BSN, RN, Flight Nurse Coordinator, Air Medical Services

Steve is the model nurse, as he remains dedicated to helping his colleagues provide the best possible care and embracing challenges along the way," said Kathy Devine, DrNP, RN, NEA-BC, Senior Vice President and Chief Nursing Officer at Cooper. "Cooper's Air Medical Services is a crucial program providing transportation services to critically ill and injured patients. Steve is a valued member of that team and a true leader."

# Cooper University Health Care's Journey to High Reliability

Laura Bolt, MSN, RN, NE-BC, PCCN-K

Cooper University Health Care (CUHC) is on a journey to become a High Reliability Organization (HRO). As part of the New Jersey High Reliability Collaborative New Jersey S.T.R.O.N.G. (Speak up for Safety – Think Critically – Reliably Communicate – On Task – No Harm – Got Your Back) (Figure 1). Cooper is part of a statewide initiative for healthcare systems to become HROs. The New Jersey Hospital Association (n.d.) explains "According to the experts in high reliability and healthcare, "High Reliability creates an organizational structure that supports a team-based safety culture that ensures inevitable mistakes do not lead to patient harm." The HRO Safety Culture can be seen in military, wildfire fighting, nuclear power and aviation. High Reliability in healthcare will improve communication and processes with the goal of achieving zero patient harm.


**Figure 1**

Cooper holds a Safety Huddle each weekday in which over sixty departments including all nursing units participate. Every Safety Huddle begins with a Safety Story that is written to reflect High Reliability principle tools, recognize 'Good Catches' and underscore policies, procedures or issues that may need to be brought to light. A Good Catch is a patient safety event in which a deviation in generally accepted performance standards was caught by a barrier or an unplanned catch by chance. The departments in the huddle also discuss staffing, patient volume and patient acuity for each nursing unit. Resources, problems with supplies and product recalls are discussed. Safety issues such as patient falls and injury are discussed for each unit or department. Each department then identifies any particular safety issues for their designated areas. This is a great opportunity to problem solve in real time as each department is in attendance either in person or on the phone. The data from the meeting is entered into a data collection program for reverse these to trending issues and tracking resolution. Leaders of the departments are tasked with the issues to resolve anything that could not be resolved during the meeting. Work groups and Task Forces are often created to help get key stakeholders involved in improving the existing processes or creating and implementing new processes.

The information is then organized and disseminated via a Safety Huddle Summary to hundreds of leaders in the CUH orgainzation. The leaders then share the information with their employees in real time. This creates increased employee awareness and engagement. High Reliability classes are held weekly. The HRO class dates and times are announced via the organization's portal, at the Safety Huddle and then published in the Safety Huddle Summary. Classes review the High Reliability principles and tools. High Reliability principles include Preoccupation with Failure, Reluctance to Simplify, Sensitivity to Operations, Commitment to Resilience and Deference to Expertise. The tools of High Reliability, which spell out STRONG, include Speaking up for Safety using ARCC (Ask-Request-Concern-Chain); Thinking Critically using a Questioning Attitude and Validate and Verify; Reliably Communicate ,using SBAR (Situation-Background-Assessment-Recommendation), Repeat/Read Back and Clarifying Questions; On Task using STAR (Stop-Think-Act-Review); No Harm using Stop the Line; and Got Your Back using cross checking and coaching teammates (NJHA, n.d.).

High Reliability in healthcare will improve communication and processes with the goal of achieving zero patient harm.

The Quality Improvement (QI) Outcomes Managers review the Event and Activity Reporting System (EARS) daily during a conference call. Per policy, EARS events should be entered for anything that is not consistent with routine operations. Each QI Outcomes Manager is assigned to certain areas of patient care and investigates each event in their area to determine if there is a gap in standard practice and/or if a patient has been harmed. The Team members each report out during the call using the Safety Event Classification tool from the Healthcare Performance Improvement. Each event is classified by level of harm to the patient. Once it is

determined that there is a deviation in practice or standard of care the event is classified according to the severity of harm.

In HRO, the Swiss Cheese Effect is a model that explains how human error can line up with system problems and result in events of patient harm. The model, developed by Dr. James Reason, explains how catastrophic safety failures are rarely caused by a specific person and almost always caused by multiple, smaller errors within the system. The errors, characterized by the holes in the Swiss cheese, line up and the error goes right through all safety barriers to cause a catastrophe (Patient Safety Primer, 2019). Typically, not all of the holes line up and therefore the harm does not pass through. The errors that get through one or two holes in the Swiss cheese represent Near Misses.

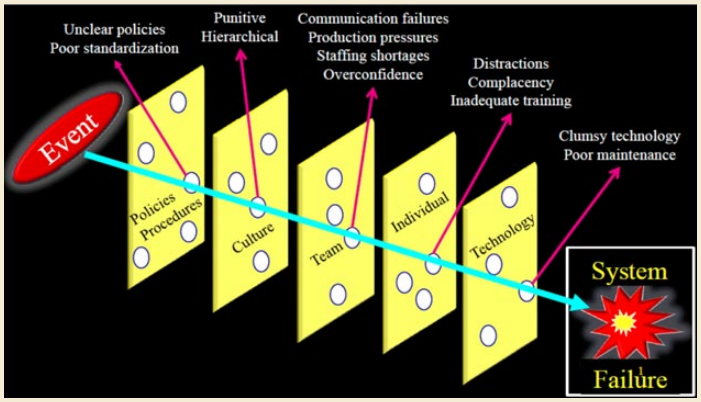


**Figure 2**

There are Near Miss events, Precursor Safety Events, and Serious Safety Events. The Near Misses are often associated with a Good Catch. Near misses are deviations that were caught by an earlier barrier catch, a last strong barrier catch, or an unplanned barrier catch. The Precursor Events are deviations that either created no harm or created minimal harm. Serious safety events encompass events that create moderate or severe temporary harm, permanent harm or death. Each Serious Safety Event is separately investigated to determine what work process, activity, human error, individual and/or system failure modes led to the deviation and patient harm.

The goal of the High Reliability training is to have everyone who may impact the patient in any way learn and utilize the HRO principles and evidence-based tools in order to make a positive culture change. The patients and the organization are set up for success when employees understand the HRO principles and utilize the HRO tools. The knowledge from HRO training help everyone to create a shared mental model and gives a clear communication style template that improves patient care.

As of March 2020 fifty-two percent of the employees at CUH have been trained in HRO principles. The greater the number of people who attend the classes, the quicker the principles and tools can be utilized and put into practice by everyone. Remember that each person that you take care of is someone's special person! If you have not signed up for the class, please go into CLN and sign up! Be a leader in changing the culture to one of High Reliability and reducing harm in our patients!

Email comments to **Bolt-laura@cooperhealth.edu**

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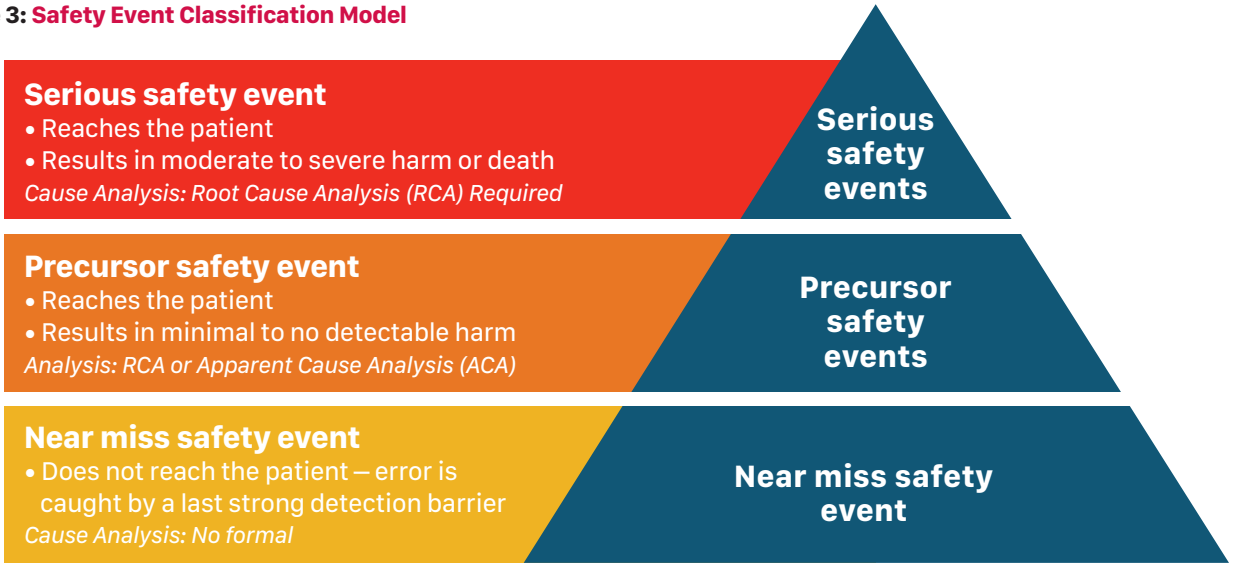
**Figure 3: Safety Event Classification Model**



# Organization Mission, Vision and Values

Michelle Mento, BSN, RN, SRNA

I have had the honor and privilege of working as a registered nurse in the Intensive Care Unit (ICU) at Cooper University Hospital (CUH) since 2014. My employment began as an optimistic new nursing graduate and continues today in a per diem capacity as I work full-time towards my doctoral degree in anesthesia to become a certified registered nurse anesthetist. CUH has been a major healthcare provider in southern New Jersey for over 130 years with a mission "To serve. To heal. To educate" (Cooper University Hospital website, n.d.). This vision encompasses both the character of CUH in her core ideology as well as an envisioned future within the community.

"To serve. To heal. To educate."

This simple, yet inspiring mission statement embodies the core ideology that defines the character of CUH and provides sustainable guidance for growth while adhering to a fundamental principle (Collins & Porras, 1996). To serve, heal, and educate are ambitious goals that are dynamic and are continually pursued as progress continues. These core values to serve, heal, and educate are timeless ideals that capture the purpose of CUH and serve as a beacon of truth to carry the organization towards all future endeavors (Collins & Porras, 1996).

Collins & Porras outline the importance for a corporation to participate in an introspective analysis to find a clear purpose and a meaningful framework for employees to engage in that purpose (1996). It is within this process that an authentic core ideology is unearthed and can serve to guide and inspire employees. CUH clearly embraced this concept of introspective analysis to develop a mission to inspire us within the organization to commit to these core values. This commitment to core values expressed in a concise mission statement is a key element to influence employees to engage in a high level of participation towards the organization's success (Gulati, Mikhail, Morgan, & Sittig, 2016).

CUH elaborates on her mission by providing a value purpose statement. "We accomplish our mission through innovative and effective systems of care and by bringing people and resources together, creating value for our patients and the community" (Cooper University Hospital website, n.d.). This statement further solidifies the mission of Cooper University Hospital. Leadership demonstrates an ability to communicate their vision to employees and the community aligning staff members with the efforts of the organization to accomplish goals (Gulati et al., 2016).

CUH also shares a vision statement to further translate the organization's vision from intentions to realistic actions effectively transforming her vision into organizational objectives and goals (Gulati et al., 2016). "Cooper University Health Care will be the premier health care provider in the region, driven by our exceptional people delivering a world-class patient experience, one patient at time, and through our commitment to educating the providers of the future" (Cooper University Hospital website, n.d.). This component of the vision framework encompasses the envisioned future with a concrete aspiration for the organization (Collins & Porras, 1996).

### Personal Vision and Mission

Taking the time to complete my own personal vision and mission statement has been therapeutic and revealing. I was able to articulate my personal vision for success and solidify my goals by committing these ideas to concrete words on paper. This exercise successfully exposed my core values and identified what I do, why I do it, and what my true purpose is in life, which are all key components to one's mission (Marshall & Broome, 2017). My personal mission statement is to make meaningful and healing connections within the community while continually expanding on my knowledge base to provide the best medical care possible. The vague dreams of what my future could be are now solidified with a proper vision statement. The undertaking of strategically planning my envisioned future has given me a pathway to reach that preferred life as an effective strategic leader with a focus on the big picture (Marshall & Broome, 2017). My personal vision statement is to master the art of anesthesia and provide excellent patient care with compassion at the forefront.

At the completion of this personal vision quest, I realize that I have reaffirmed who I am as a nurse and why I have chosen this profession. My path of success has been lined with these core values and envisioned future all along without my full awareness to my driving forces. Introspective analysis is often a painful process and exposes us to our own subconscious motivating factors. Material things are not a consideration in my visualization of success and fall to the background when I articulate my future vision. I am able to see clearly that I am a voracious self-learner in my day-to-day life. I am driven by a constant need to improve as a valuable team member that can work independently, while being respected and admired. For a team to function well, the team leader must be highly respected and viewed as credible often relying on intuition, experience, and wisdom to make difficult decisions (Marshall & Broome, 2017). I have often used my mission to work autonomously in high-pressure situations and have gained the respect of my teammates in those instances. It has allowed me the opportunity to mentor novice nurses confidently and share my experiences to improve the team and quality of care for our patients.

Obtaining my DNP in anesthesia is absolutely essential to my future successes and advancing my career. As a doctoral-prepared certified registered nurse anesthetist, I will bring a unique expertise to my field allowing me the opportunity to become a leader and a change agent providing compassionate, efficient, and effective health care (Marshall & Broome, 2017). It is precisely activities such as a personal vision and mission analysis required of the DNP student that will propel me towards my goals with a clear pathway to anesthesia mastery and a passion for continuing education.

### Analysis

CUH has expressed a mission and vision congruent with the actions it embodies and guides her employees as one team focused on one purpose: to serve, to heal, and to educate. This is an example of an effective mission and vision that elicits employee commitment and motivates team members' behavior towards a common cause (Kopaneva & Sias, 2015). While CUH's mission statement succinctly answers the question of why we are here, her organizational actions provide a framework necessary for employee engagement (Kopaneva & Sias, 2015).

> "I find myself able to flourish in the diverse and emergent nature of anesthesia and embrace the learning prospects that continue to arise with a strong foundation gained at CUH."

In the ICU, collaboration is at the forefront of every decision we make as a team that can affect patient care. We have created "lean rounds" which include all health care team members' input as well as family members in developing a plan. Active participation is expected and encouraged and learning opportunities are actively sought in an effort to incorporate the best evidence based care possible. We meet as physicians, nurses, pharmacists, respiratory therapists, social workers, and physical therapists to create an action plan that covers every aspect of a patient's hospitalization needs. It is an opportunity for each specialty to educate team members on their concerns for the patient and offer solutions to improve care. This act of bringing together varying groups of practice in a common organizational function strengthens the vision and mission in everyday practice (Kopaneva & Sias, 2015). Although worldviews and opinions often differ, every individual has an equal level of input and all conversation is valued and respected. I have often been given opportunities by my attending physicians during rounds to educate the residents and interns offering a unique nursing perspective to critical patient care. I am respected and appreciated as a key team member working towards the common goal of serving, healing, and educating.

Utilizing that same spirit of shared governance, the ICU conducts weekly collaborative meetings that are open to all unit employees to have a voice at the table where policy and practice changes are initiated. Every week the critical care physician director, clinical director and nurse educator meet in an open forum to discuss clinically relevant challenges and invite team members to participate in developing solutions and policies to address the issues. This is an opportunity to communicate

solutions in an environment that can effect change while keeping the vision and mission of the organization present in the conversation (Kopaneva & Sias, 2015). By including all team members in developing policy changes, CUH has been able to practice her vision in real-time and we have successfully implemented sedation and ventilator wean policies, rapid response team debriefings, and infection prevention practices with the buy-in from all key staff members.

I was immediately attracted to CUH when I read her nursing job description that included "therapeutic use of self" as a core competency for the job. This statement embodied everything I believed nursing to be as a new graduate eager to have a positive impact on the critically ill patient population. My time at CUH in the ICU has taught me how to manage acutely ill patients in a dynamic setting with a focus on interdisciplinary communication including family members and afforded me a great deal of autonomy and professional growth. Within this fast-paced environment, I have developed critical thinking skills that have carried me through the challenges of entering the operating room as a student registered nurse anesthetist and will continue to serve me throughout my future career. I find myself able to flourish in the diverse and emergent nature of anesthesia and embrace the learning prospects that continue to arise with a strong foundation gained at CUH.

## Summary and Conclusion

I've enjoyed my nursing career in critical care at CUH thus far and now realize that my enthusiasm for knowledge and education is matched by the organization's core values and principles embodied in her mission and vision statements. My time at CUH as a critical care nurse has given me the opportunity to incorporate my personal mission and vision to have a healing connection with the community while constantly developing my knowledge as I challenge myself to master the art of anesthesia and provide excellent, compassionate patient care. I have become completely engrossed in the nursing profession through the scope of CUH's organizational mission and vision. My passion for learning was fostered and my continued growth within the organization has led me to become a certified registered nurse anesthetist. The possibility of having a career that requires and encourages continued education with a loving touch is definitely the path I must travel and I hope to do so with CUH by my side.

Email comments to **Mento-michelle@cooperhealth.edu**

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The possibility of having a career that requires and encourages continued education with a loving touch is definitely the path I must travel and I hope to do so with CUH by my side.

# Drug Diversion in Health Care: Disguised Addictions and Collateral Damages

Devyn Berry, BSN, RN, BC

"Every day, more than 130 people in the United States die after overdosing on opioids" (NIH, 2019). According to the Centers for Disease Control and Prevention (CDC), "68% of the more than 70,200 drug overdose deaths in 2017 involved an opioid" (CDC, 2018). Unfortunately, opioid abuse emerges in health care by way of disguised addictions among health care professionals. Just as 8% of the general population suffers with drug dependency, 15% of health care workers (HCWs) are dependent on drugs and alcohol (McClure, 2019). Therefore, Health Care Organizations (HCOs) across the country are facing a unique and extraordinarily dangerous crisis of their own; drug diversion. Drug diversion is considered the illegal transfer of a prescription drug to an unlawful channel for personal or illicit use.

Drug diversion is comprised of many complexities; therefore, detecting diversion is often compared to trying to find a needle in a haystack. Many HCOs have laxities around narcotic controls and struggle with overall compliance of proper narcotic storage, handling, wastage and administration which contributes to the conundrum of the problem. Nurses, pharmacy personnel and anesthesia providers have frequent access to powerful narcotics that are intended for patients. HCWs that are suffering from addiction pilfer a patient's pain medication to soothe the fervent desperation of their disguised dependency.

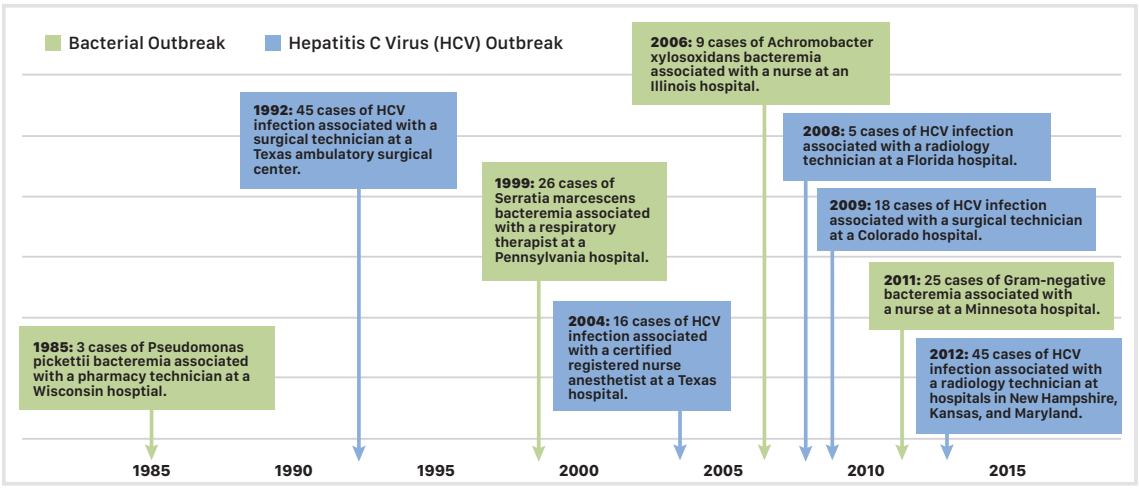
To summate the prevalence of the problem, it is estimated that 18-21% of pharmacists have misused prescription drugs and 10-12% of physicians will develop a substance use disorder during their careers (Catizone, 2016, p. 4). Furthermore, according to the American Nurses Association (ANA), an estimated 10% of nurses are dependent on some type of drug. The ANA used the analogy that "if one works with 10 nurses, one of the 10 is probably struggling with some type of addiction" (Catizone, 2016, p. 5). Additionally, the ANA estimates that approximately 6-8% of nurses are practicing while impaired (Tanga, 2011). To further underscore the magnitude of this issue, there were "166% more legally prescribed opioids stolen in 2018 than the year before; of these, 34% happened in hospitals, private practices, long term care facilities and pharmacies" (Campbell, 2019). According to the same report, doctors and nurses are responsible for opioid diversion 67% of the time.

Drug diversion also comes with a significant financial burden as the estimated cost of controlled prescription drug diversion and abuse to both public and private medical insurers is approximately $72.5 billion a year" (Ahlstrom, 2018). These astounding figures highlight the immensity of drug diversion and how multiple victims are affected. Health care professionals have the privilege to care for the most vulnerable populations who are trusting them with their lives. HCWs who divert narcotics are putting those same vulnerable populations in harm's way, as they become collateral damage to powerful addictions and desperate measures.

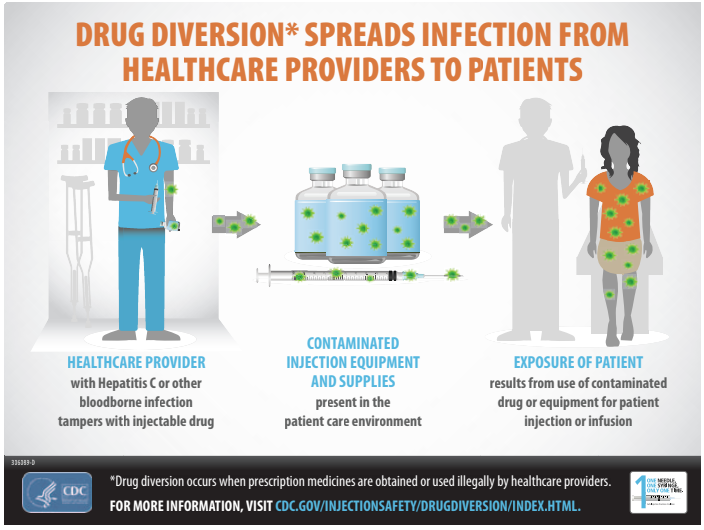
HCWs have a legal, moral and ethical obligation to first do no harm. Patients that end up in the crosshairs of drug diversion suffer from an array of consequences. Such consequences include unnecessary pain and suffering because the prescribed medications are being substituted and stolen. For example, diverters may substitute Oxycodone pills with 'look-alike' medications. The patients are then given a placebo leaving them in pain and subsequently documentation is falsified in the medical records. Patients do not deserve poor quality erroneous care that they would receive by an impaired HCW. The diverter and patient could be at an increased risk for exposure to blood-borne pathogens if intravenous narcotics are tampered with, contaminated or diluted. These types of egregious behaviors are the most dangerous to the diverter and patients. In fact, the CDC records that nearly 30,000 patients were potentially exposed to blood-borne pathogens from January 1, 2000 through December 13, 2013 (Schaefer, 2014).

In the case of a traveling radiology technician, who was infected with Hepatitis C, there were 45 people in four states diagnosed with Hepatitis C secondary to his disguised addiction. Sadly, one woman died from her infection. The chart supplied by the CDC provides insight into bacterial and Hepatitis C Virus outbreaks from 1983 through 2013 directly related to drug diversion. *(See Figure 1.)*

**Figure 1. Bacterial and Hepatitis C Virus Outbreaks** *from 1983 through 2013*



Although the diverter had no direct access to intravenous narcotics, he was able to raid trash receptacles retrieving partially empty vials of medications for self-use. He also diverted narcotics that were signed out and left unattended by nurses and doctors. To feed his addiction, the technician would remove the narcotic from the vial with a syringe, inject himself, and then refill the vial with saline or other solutions using the same contaminated syringe. After satiating his addiction, the technician would then replace the vial to be used for a patient. After years of causing harm, the diverter was finally caught and charged criminally for his actions. The technician is currently serving a 39-year prison sentence. This case, like many others, has exposed laxities around the proper handling of narcotics by licensed personnel and the consequences of criminal behaviors.




HCOs are also falling victim to collateral damages of diversion as hospitals across the nation are paying massive fines to the Drug Enforcement Agency (DEA) and other regulatory entities. These fines are issued for failing to prevent, detect, mitigate and properly report cases of drug diversion. Poor record keeping and lax controls are amplifying the costly burdens for many institutions. "In 2015, Massachusetts General Hospital (MGH) agreed to pay $2.3 million to resolve allegations that lax controls enabled MGH employees to divert controlled substances for personal use" (Ahlstrom, 2018, p. 2).

The DEA has fined several large health systems for like reasons. The penalties are getting more severe for HCOs who do not implement safeguards to limit opportunities for diversion. Any entity that handles narcotics bears the responsibility to have adequate controls in place for diversion prevention. Adequate controls, such as regular narcotic counting and second witness to narcotic wasting are imperative to safeguard narcotics from the time of procurement to the time of administration to the patient. Beyond monetary fines, there are other consequences for HCOs such as negative publicity and public scrutiny. Drug diversion, especially when harm reaches a patient, does not go away or unnoticed. Many cases have been reported to news outlets and regulatory agencies which create negative publicity. Negative publicity tarnishes the reputation of an organization and in turn the community's trust is lost. In addition, HCOs are at risk for facing litigation from affected patients while jeopardizing reimbursement from insurances companies and other responsible financial parties. Diversion also affects nursing peers as drug diversion in nursing departments "creates disorganization, demoralization, and promotion of feelings of betrayal among other nurses (Tanga, 2011, p. 15).

Disguised addiction cultivates an unsafe environment where injury and death can occur. Diversion prevention requires a relentless commitment to protecting the most precious assets HCOs have; PATIENTS. This can only be accomplished via a multidisciplinary approach, which includes dedicated professionals who are willing to speak up against diversion and addiction.

Cooper University Health Care (CUHC) has taken a monumental stance to prevent and mitigate diversion within its enterprise by establishing a drug diversion prevention program. This program is led by the Drug Diversion Specialist who plays a vital role in limiting risk to patients, employees and the Organization. To ensure a safe environment for everyone, one must be willing to report curious activity or suspicions as the consequence of ignoring drug diversion is too great. CUHC has developed several avenues to report drug diversion which are listed in the side box.

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# Organ and Tissue Donation

Nicole Caristo, BSN, RN

Nursing school teaches you a lot of things, from life to death and everything in between. They touch on end of life and organ donation but I never knew just how much impact it would have on my career once I became a bedside nurse in the ICU.

Getting involved with the NJ Sharing Network started when I cared for a young man who was designated as an organ donor on his license. He made his own decision to save the lives of many. To this day, almost five years later, I still remember him and his family. I cared for him and his family, for three days in a row and had developed a bond with them that I will never forget. I saw a family who was losing their son, brother, and "best uncle in the world." The night before his procurement, I left work and knew that I needed to do something special for this family. I went to the store and got a sympathy card, a jar, some clay, and ink. I made them a little box that included his left thumb print (chosen because it is the closest to his heart) in clay and a card that simply said, "Our thoughts and prayers are with you and your family during this difficult time, Love your ICU family." I left the box in the room for them on the counter in the morning. When they returned that day they opened it up as a family. The patient's step mother came out with tears in her eyes and gave me the biggest hug, I have never forgotten that hug. That day we took him down to the PACU and removed him from life support, he passed away peacefully with his family at his side. His family said their last goodbyes and we took him to the Operating Room. Moments after we got to the OR, I realized I never said goodbye to his family. I raced back to the PACU in hopes of catching them. Sure enough there they all stood, a brother, a mother, a brother, a sister who in a matter of days were like family to me. With tears in my eyes, I hugged them all goodbye. That day this family lost a loved one, but his legacy will be forever remembered for his selfless act to choose organ donation. He saved the lives of other people. This family needed me as much as I needed them. From this day forward I knew I wanted to be heavily involved with the sharing network and their cause.

> "You were made for the place where your real passion meets compassion because there lies your real purpose"
>
> — ANN VOSKAMP

A nurse driven Sharing Network Committee was being formed, and I joined as chair/co-chair. The thumb prints and cards, along with some other personal touches were formed into the ICU bereavement boxes. We provide these boxes to families upon the death of their loved ones that are both organ donors and non-organ donors.

In October, spearheaded by one of our brand new nurses, we did our first "Walk of Honor." The entire ICU staff lined the hallways of the ICU linked together by blue and green ribbon (Sharing Network colors) to honor the patient, and their family. She was a patient who at one point was awake and talking to us. She was here for several days and both her and her family became close with many from the ICU staff. Tragically, the bleed in her brain got worse and there was no chance of recovery. Her family made the decision that their loved ones death would save the lives of others as they made her an organ donor. Her daughter selected the music to be played during the walk.

All of the ICU staff, from housekeeping to the attendings were all involved. Patient relations remained past their normal hours to be a part of this amazing moment. To say that there was not a dry eye in the house is an understatement. We came together, as a team and family, to honor a young woman (and her family) for her ultimate gift. The gift of life. Since then we have done countless more Walk of Honor's, each one just as special as the last.

We hosted our first donor memorial in March 2017. Approximately 20 families and friends, 80 people in total, of loved ones who donated their organs and tissues were invited to come to Cooper University Hospital for a memorial of their lives and the gift of life that they gave to others. We had speakers from Cooper, Sharing Network, a donor recipient, and family member of an organ donor. Green and blue pinwheels were given out to each family; they wrote a special message on each and then planted them in planters. We were supposed to plant them outside in the garden but ironically, it snowed that day. Each family brought in a picture of their loved one to place on a table for everyone to see, the sharing network flag was signed by them and raised on the flagpole outside of Cooper to honor those that gave the gift of life. The memorial was beautiful from start to finish and truly celebrated those loved ones that were lost too soon but will be forever remembered for the incredible gift of life that they bestowed onto others.

The Sharing Network Council at Cooper was to host their second Donor Memorial this spring. Unfortunately, due to the pandemic we were forced to postpone it until a later date that has yet to be determined. This year we planned to have a nurse speak to the donor families about what it is like to take care of a Sharing Network patient.

"My name is Nicole Caristo and I have been a nurse in the ICU at Cooper for six years and I wanted to say a few words on what organ and tissue donation means to us. When you first meet your nurse for the day we are strangers. Over the next few hours, or more if we work a few days in a row, we get to know each other and your loved one. If we are lucky, you open up to us. You tell stories about your loved one, the good, bad, funny, and sweet. Some of your stories make you cry but they often make us cry too. We eventually form a bond, a bond where your family becomes ours. They say when someone dies a piece of you dies. As your nurse, and now family, I want you to know that you and your loved one's memory become a piece of us. A piece that will never be forgotten, a piece of us that reminds us this is one reason why we became nurses and love what we do. This piece that will live with us forever. So, thank you, all of you and your loved ones for giving the ultimate gift, the gift of life."

Although getting involved with the sharing network started off with a tragedy, this family will forever be a part of my life, a part of my nursing career, and memories. I am so thankful that life brought us together. They helped shape me into the nurse that I am today and the impact that they left on my life has guided me to help other families in their time of need.

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**Kelemen N/S 9,** *Medical Surgical Unit*
recipient of ***The Outstanding Team Award***

**Judy Acevedo, CCT**
*Critical Care Technician, Pavilion 7*
recipient of ***The Carol G. Tracey Compassion Award***

**Agnes Asamoah, BSN, RN, OCN**
*Registered Nurse, Pavilion 5*
recipient of ***The Rose Smith & Sue Zamitis Memorial Award for Excellence in Inpatient Oncology Nursing***

**Karen Babik, BSN, RN, CCRN**
*Registered Nurse, Trauma Unit*
recipient of ***The Award for Excellence in Trauma Nursing***

**Toya Bennett, BSN, RN**
*Registered Nurse, Pavilion 6*
recipient of ***The Ruth Parry/Mooretown Auxiliary Award for Excellence in Geriatric Nursing***

**Gina Brouster, BSN, RN**
*Registered Nurse, Pediatric Intensive Care Unit*
recipient of ***The Ronald Bernardin Memorial Award for Excellence in Pediatric Nursing***

**Nicole Caristo, BSN, RN**
*Registered Nurse, Intensive Care Unit*
recipient of ***The William and Eileen Archer Award for Excellence in Critical Care Nursing***

**Shelby Casey, BSN, RN**
*Registered Nurse Kelemen 9*
recipient of ***The Selma and Martin Hirsch Award for Excellence in Medical Surgical Nursing***

**Maryanne Figueroa, BSN, RN, CNOR**
*Registered Nurse, Voorhees Surgical Center*
recipient of ***The Philip and Carole Norcross Award for Excellence in Perioperative Nursing***

**Diane Fletcher, MSN, RN, CBC, CCBE**
*Registered Nurse, Labor and Delivery*
recipient of ***The Charlotte Tobiason Memorial Award for Excellence in Obstetrical Nursing***

**Liezel Granada, CCBE DNP, RN, BC**
*Senior Medical Informatics Analyst, Medical Informatics*
recipient of ***The Barbara and Jack Tarditi Award for Excellence in Nursing Research***

**Elizabeth Locke, BSN, RN, CEN**
*Registered Nurse, Cardiac Care Unit*
recipient of ***The Cooper Heart Institute & Heart House Award for Excellence in Cardiovascular Nursing***

**Lawrence Matthews, MD**
*Physician, Critical Care Unit*
recipient of ***The Nursing Alumni Excellence Award for Nursing-Physician Partnership***

**Anna McCausland, BSN, RN-C**
*Registered Nurse, Neonatal Intensive Care Unit*
recipient of ***The John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing***

**Hillary Oldt, LSW**
*Transitions Navigator, Transitional Care*
recipient of ***The Barbara and Jack Tarditi Award for Excellence in Service***

**Jamie Rubino, DPT**
*Physical Therapist, Physical Therapy*
recipient of ***The Women's Board of Cooper University Health Care Allied Health Professional Excellence Award***

**James Scharff, RN**
*Registered Nurse, Emergency Department*
recipient of ***The Lynn Nelson Award for Excellence in Emergency Nursing***

**Lisa Schrieber, BSN, RN, CAPA**
*Registered Nurse, Clinical Director, Post Anesthesia Care Unit*
recipient of ***The Philip and Carole Norcross Award for Nurse Leadership***

**Amanda Sndyer, LPN**
*Practice LPN, The Ripa Center for Women's Health*
recipient of ***The Women's Board of Cooper University Health Care Award for Excellence in Ambulatory Nursing***

**Rosemarie Stag, MSN, RN, APN-C, FNP-C**
*Advanced Practice Nurse, Primary Care*
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***The Moorestown Auxiliary Award for Advanced Practice Nursing***

**Steven Teitelman, BSN, RN, CFRN, CCRN-CMC, CTRN, CEN, TCRN, MICP, NRP**
*Flight Nurse Coordinator, Air Medical Services*
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**Julie Whitman, BSN, RN**
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**Rebecca Yarnell, BSN, RN**
*Registered Nurse, Intermediate Care Unit*
recipient of ***The Shaina Horton Memorial Award for Excellence in Service***

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***The Nurse of the Year***