Cooper University Health Care

Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/SUMMER 2021 ▪ VOLUME 15, ISSUE 1

SEPSIS in the Pediatric Population

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curnew-jillian@cooperhealth.edu

Cooper
University Health Care

Our Senior Nurse Leaders

In each new edition, we will be highlighting one of our Senior Nurse Leaders. In this edition, it is an honor to share an interview with Sue Cannon, MSN, RN, CPN, NE-BC, AVP of Nursing for Women's and Children's Hospital Operations

Vision for Cooper Nursing? Priorities for 2021?

I am excited to share my thoughts on the year ahead, but cannot successfully look forward without a quick appraisal of 2020. Cooper nurses are known for being compassionate, empathetic, and fiercely dedicated to providing high quality culturally competent care to all our patients. After all that we have experienced during the past year, we can confidently add resilience to the list of attributes. This past year is all but a blur of constantly changing policies and care modalities. The one constant that continues is the fortitude of the care team. Cooper nurses were and are on the frontlines of this pandemic. Day in and out, nurses are fighting this battle along with our community at large. This perseverance will serve the Patient Care Services (PCS) department well as we explore the opportunity to pursue the ANCC's "Pathways to Excellence" designation. I envision the year ahead as an abundance of growth and opportunity. The newly redefined nursing vision, philosophy and professional practice model will guide us in our drive to ensure that frontline nurses have influence in clinical and organizational decision making. In 2021, we will continue to strengthen our shared governance structures and support past building blocks that have been placed to firmly establish evidence based care and inter-professional growth.

What are your goals for 2021?

My goals are aligned with the PCS department's journey to excellence. These goals include the ongoing development of a thriving shared governance structure, professional growth of our front line staff, establishing ourselves as a nursing leader in the region, and ultimately becoming the employer of choice in the southern New Jersey area. We can accomplish all of these goals in a stepwise fashion such as the participation of staff in regional conferences and engaging in opportunities such as NJONL Schwartz Rounds. Sustaining PCS support for "Council Day" participation and unit based activities will be paramount for the success of our goals. We will promote and uphold our close collaboration with local universities and invite nursing students back into the hospital. New to practice PCS staff are supported by the organization through programs such as the Nurse Residency program and the Safety Champion role. These programs offer the opportunity for professional growth and development; all while promoting self-care, nurturing resilience and fostering positive relationships. Cooper nurses have demonstrated their desire to embark on all these pursuits and more. Our role as leaders is to ensure the staff are supported to achieve their goals by removing barriers and providing a structure that empowers growth and celebrates achievements.

Where do you see Cooper Nursing in five years?

I acknowledged the newly developed nursing vision and philosophy that will serve as a guide to keep the department on a journey to excellence over the next five years. It is imperative as a team that we set short and long-term goals. We continue to plan our achievements in stageable increments while anticipating and mitigating potential obstacles. The foundation to support our success is the development and continuance of our safe and healthy work environment. The nursing department on all levels has placed value on developing and maintaining a nourishing environment for all to thrive. This focus has been most evident through the turbulent months of the COVID-19 response. This brings me back full circle to where we started our discussion, identifying Cooper nurses as an enthusiastic team that embodies compassion, empathy, dedication and resilience. This is a combination that will suit us well in our journey to excellence. As stated in our newly developed vision, "Cooper University Health Care nurses will lead the region in the advancement of professional, scholarly nursing practice. We will exceed all standards of excellence through the delivery of evidence-based care and clinical innovation."

Anything else you would like to add?

I am looking forward to a productive 2021. I have been given an opportunity to work with a highly skilled team of nursing leaders and frontline staff. These leaders influence the quality of care and improve patient outcomes through their commitment to excellence, development of a positive culture and a supportive work environment. These leaders, formal and informal, advocate for each other while aligning performance with organizational goals and values. Through their leadership abilities and expertise, Cooper has a nursing team that consistently raises the bar and strives to provide excellent care to our youngest neonates to our most vulnerable seniors.

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: **curnew-jillian@cooperhealth.edu**

Improving Patient Care and Teamwork through Multidisciplinary Drills

Erin McCafferty, MSN, RNC-OB
Rori Dajao, MD, Assistant Medical Director Labor & Delivery

Despite advances in healthcare and technology, maternal morbidity and mortality in the United States has increased over the last several decades. What makes this more worrisome is that the United States is the only country in the world with a rising rate. In 2018, the maternal mortality rate in the United States was 17.4% (per 100,000 live births) (CDC, 2018). The same year New Jersey (NJ) had an even higher rate of 26.7% (CDC, 2018). It is important to note that NJ has a robust Maternal Mortality Review Committee. One way to help drive these numbers down is through education of evidenced-based practice, roles and responsibilities in high-stakes clinical scenarios, and unit-based processes/policies. Although the majority of nurses and providers would be able to offer correct answers in a didactic session, this in itself is not sufficient. Translating this valuable knowledge into practice is imperative to decreasing maternal morbidity and mortality. This can be accomplished by conducting hands-on, multidisciplinary, unit-based drills.

To those who that do not work in obstetrics (OB), it sounds like perfection. Any OB nurse or provider cannot tell you how often they hear, "It must be so great working there. It is such a happy place." While OB is an amazing place to work, what most people do not realize is how high the stakes can be. Even patients who present without comorbidities are not guaranteed an uneventful delivery and postpartum period.

Obstetrical unit-based drills conducted in the past have covered a variety of topics such as shoulder dystocia, precipitous delivery, and code white. Unfortunately, there was not a process in place to ensure drills occurred consistently. OB Leadership set a goal for 2020 to create a process where multidisciplinary drills are conducted routinely, ideally on a monthly basis. Drills are tailored based on Joint Commission (JC) standards, staff learning needs, and current events. For example, the current pandemic generated the need for COVID-19 drills. Although this may sound unnecessary to healthcare workers in other disciplines, caring for a patient with COVID-19 who requires an emergent cesarean section involves many moving parts. The logistics of transporting a patient to the operating room safely requires staff anticipation, vigilance, and finesse. While providing hands-on practice, these

> As a High Reliability Organization, transparency is extremely important. The only way to improve is to know where the gaps exist.

Pictured from left to right: Tieg Beazer (DO), Laura Yastcemski (RN), Jillian Curnew (RN), Erin McCafferty (RN), Morghan Thornton (RN), Rori Dajao (MD), Lori Adriance (DO)

drills unveiled parts of processes that required modification. As a result, COVID-19 drills undoubtedly improved patient and staff safety during a time of unchartered territory.

Most recently, the focus has been on drilling the scenario of postpartum hemorrhage (PPH). The reason for this is two-fold: one, reducing maternal harm related to PPH (a JC standard) and two, it is a high-stakes, low-frequency event. PPH drills conducted on the Labor & Delivery, Maternal-Fetal Care, and Mother Infant Units have been invaluable. These drills have uncovered areas for knowledge reinforcement, raised questions about the availability of supplies, and sparked ideas for improving workflow. Assistant Program Director, Lori Adriance, DO, agrees that drills result in positive outcomes. "I think the drills have served as a great multi-disciplinary opportunity to improve patient safety. Particularly, I think it is important to include the postpartum nursing staff who do not routinely care for obstetric emergencies, so that we can improve our communication with them and identify opportunities to improve patient outcomes (i.e. access to meds/equipment, patient transfer logistics, etc). It also served as a great opportunity for all of us to practice SBAR," stated Adriance. These outcomes and questions are why we drill.

As a High Reliability Organization, transparency is extremely important. The only way to improve is to know where the gaps exist. Drill performance and feedback are not punitive, but rather used to improve patient care via various avenues. Promoting this type of environment and culture is especially important during drill debriefs. After each drill, the team completes a short debrief session. Debriefs are just as important as the drill itself, as the team discusses what went well, areas for improvement, and ideas on how to improve for next time. Morghan Thornton, RN stated drills and debrief sessions "bring the L&D team together and prepare us for emergency situations." Although this process may be uncomfortable for some, it is important to push forward in order to grow as a team.

Going forward, the OB Leadership team's vision is to have unit-based drills and debriefs lead by nurses and providers with leadership support. This will foster professional development from both nursing and medicine, and build trust in an area where teamwork is essential. Unit-based obstetrical drills have been an integral part of transforming processes, building teamwork, and improving patient care here at Cooper.

Email comments to **McCafferty-Erin@cooperhealth.edu**

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Our Voyage to Shared Governance

Barbara Cottrell, MBA, BSN, RN, CNML
Shannon Patel, DNP, AGPCNP-BC, NEA-BC, CPHQ

Shared governance is foundational to nurse empowerment that supports a clinical culture of inquiry and autonomous professional practice. Effective and successful shared governance has been shown to support nurse retention, engagement, interprofessional collaboration and teamwork. This enables the provision of safe, high-quality patient care. One example of the positive outcomes that can be achieved through successful shared governance implementation can be made from one of our early adopter units. Through the provision of authentic, serving and transformational leadership, trusting relationships within the Viner Intensive Care Unit (ICU) were forged. This presented a new appreciation for the power that is generated through a culture of shared governance. The empowering effects of shared governance enabled critical care nurses to swiftly achieve significant clinical outcome goals while it simultaneously prepared them for the unforeseen pandemic. Through this work, the ICU's Unit Based Council (UBC) was re-developed and they have led several successful initiatives over the past year including their Code Lavender initiative to sponsor peer support during difficult situations. The UBC also enabled the nurses to be active members in the shared decision making process that enabled the ICU to improve from 18 Central Line Associated Bloodstream Infections (CLABSI) in 2018 to 4 infections in 2019.

Barbara Cottrell

Shannon Patel

Our recent article published in the January 2021 issue of ***The Voice*** *(American Organization of Nursing Leadership)* entitled ***Righting the Ship: Reinvigoration of Shared Governance at the Unit Level*** highlighted inspiring examples of efforts led through the collaboration of the ICU Unit Based Council and Clinical Leadership Team. These initial successes have since served to ignite the spirit of shared decision making; inspiring units to recharge and re-establish Unit Based Councils which foster an organizational culture grounded in Shared Governance.

Eliminating Unplanned Extubations in the Pediatric ICU

Suzanne Butler, BSN, RN-BC, CPN, CCRN and Cari Rinaldo BSN, RN, CPN

There are times when children who are critically ill may require an endotracheal tube (ETT) for mechanical ventilation to ensure ongoing oxygenation, ventilation, and hemodynamic stability. These children are at risk for unplanned extubations, unintended dislodgement or displacement of their ETT. These situations may lead to critical complications, such as aspiration pneumonia, hypoxemia, respiratory failure, hypotension, brain damage, and death.

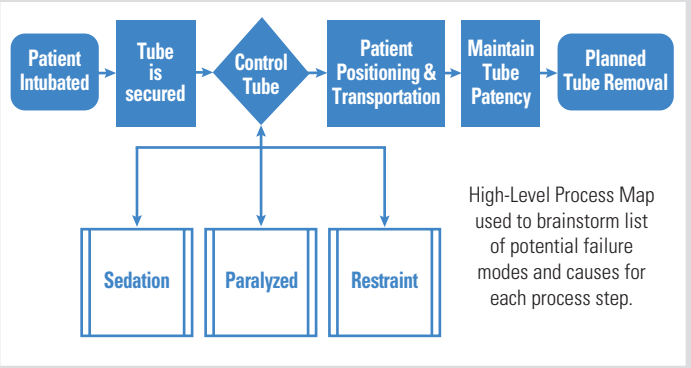
Our Pediatric Intensive Care Unit (PICU) identified an increase in the number of unplanned extubations in our six-bed unit from January through July 2019. A total of three events were reported during this time frame resulting in adverse effects and increased risk of mortality and morbidity. In response, the primary goal was to standardize intra-professional care of the PICU intubated patient to prevent unplanned extubations.

Brainstorming Session (Phase 1)

A newly created intra-professional team — Pediatric leadership team, Quality Improvement, Process Improvement, Respiratory Director and therapists, Pharmacists, and PICU RNs met on July 17, 2019. The failure mode and effect analysis (FMEA) tool was the structured approach the team utilized to identify potential failure modes that could lead to unplanned extubations in the PICU.

A high-level process map was used to help the team look at the process of caring for an intubated patient. A timeline was created from the start of intubation, throughout care, and to the planned removal of the ETT to identify possible errors at every step. A Risk Priority Number (RPN) was then assigned to each identified potential failure mode. Once the top five RPNs were identified, then the team was able to focus attention on how to prevent each future failure. (Figure 1)

FIGURE 1: High-Level Process Map



High-Level Process Map used to brainstorm list of potential failure modes and causes for each process step.

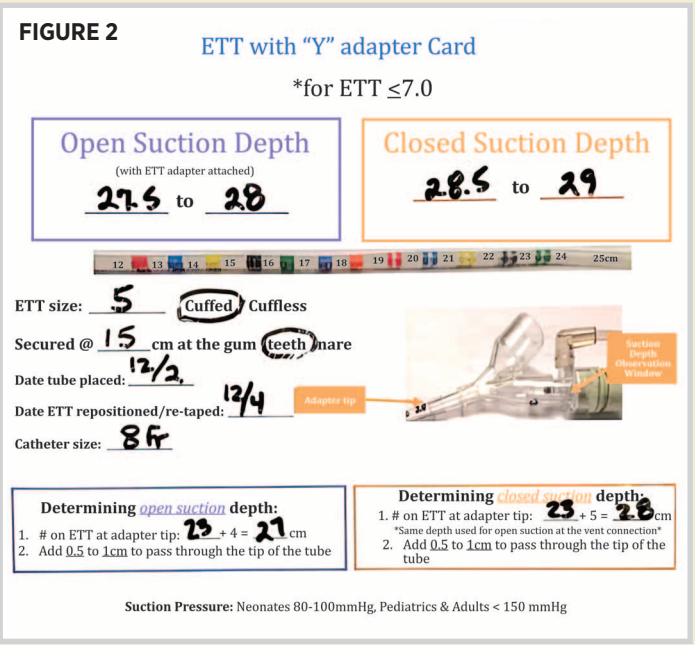
At our second meeting on August 8, 2019, multiple interventions and action plans were developed for each high-risk failure mode identified as outlined.

1. **FAILURE: Misunderstanding the state behavioral scale (SBS) and inadequate sedation**
   Interventions:
   - SBS education for residents and nurses
   - SBS detailed laminated bedside signs
   - SBS used to identify appropriate dose of sedation med
   - SBS documentation in EPIC every 4 hours

   RESULT: Use of SBS scoring encourages use of the same language by all team members and ensures the patient is adequately sedated. Appropriate sedation decreases the risk for agitation and unplanned extubation.
2. **FAILURE: Lack of standardization in taping of ETT**
   Interventions:
   - Revised and updated ETT securement policy
   - Standardized securement procedure
   - ETT securement education for nurses and respiratory therapists
   - Hands on competency for nurses and respiratory therapists
   - ETT securement rounds completed by the provider during assessments and before the completion of the provider's shift
   - Standardized indications for the need to re-secure the ETT

   RESULT: The manner that all ETTs are connected is standardized and this ensures an airway is secure, thus preventing possible dislodgement.
3. **FAILURE: Inconsistent communication and documentation of ETT placement**
   Interventions:
   - Depth and suction laminated bedside signs for ETT

FIGURE 2



- Staff hand-off report to include placement of ETT depth-mm at level of teeth or gum.
- Record depth of ETT in EPIC and patient Kardex

RESULT: Reporting ETT placement at the same level ensures appropriate positioning or the need for possible adjustment.

4. **FAILURE: Lack of knowledge with trouble shooting ETT displacement and obstruction**

Interventions:

- Reviewed "DOPE" mnemonic with nurses and residents **DOPE** is a mnemonic used by staff to identify causes of sudden deterioration and hypoxia in intubated patients by checking for: **D**isplacement or **O**bstruction of ETT, **P**neumothorax, and **E**quipment failure.
- Review ways to troubleshoot ETT obstruction and displacement
- Ongoing education provided by Respiratory therapists who review vent alarms with nurses
- Ongoing mock codes now include airway management for nurses and providers
- Implemented 2-person suction policy for patients with ETT sizes <4.5 mm

RESULT: Staff are more confident in managing intubated patients, successfully trouble-shooting ventilator alarms and identifying more efficiently when to request assistance from the respiratory therapist.

5. **FAILURE: Knowledge deficit regarding sedation medications and lack in availability.**

Interventions:

- Improved ordering and delivery process with Pharmacy leadership for both inpatients and incoming transfers
- Create RN sedation weaning policy
- Created PICU Sedation and Withdrawal Assessment (SBS and WAT) policy
- Education on sedation and analgesia given by a Pediatric Pharmacist to nurses and residents
- Education provided quarterly on the care of the intubated patient
- Education monthly for residents at beginning of their PICU rotation
- Education provided to the staff on the use of paralytics based on best practice
- Collaborated with Admissions department to ensure timely receipt of transfer Face Sheets, allowing quicker access to needed medications

RESULTS: Sedation medications are delivered by pharmacy prior to patient arrival resulting in less delay of initiating and managing continuous infusions. Staff have a greater knowledge of these high risk medications used for the intubated pediatric patient.

From the initiation of Phase 1 on August 1, 2010 to November 30, 2019, there were zero occurrences of unplanned extubations in the PICU. The outcome was a direct result of the identification and implementation of an intra-professional plan to mitigate risk and improve the quality of care provided.

Following our success in Phase 1, before starting Phase 2 on March 9, 2020, we created a binder to allow a quick and efficient way of tracking intubated patients admitted to the PICU and any unplanned extubation events that occurred. A detailed instruction sheet with the night and day shift charge nurses' responsibilities were listed on the project binder cover.

Staff huddles were performed to introduce phase 2 of our project, and to educate nurses on specific documentation needed to be included in our project binder.

In order to track the results, patient information and events were reviewed by our PICU physicians and leadership team.

Phase 2: Data Collection

From April 1, 2020 to June 1, 2020, we continued to have no unplanned extubations using our standardized ETT securement policy. On June 2, 2020, we continued into the second part of Phase 2 – trialing Endotracheal Tube Attachment Devices (ETADs) for ETT sizes > 5, with continued use of our standardized ETT securement policy for ETTs < 4.5.

FIGURE 3

FIGURE 4

On August 1, 2020, we celebrated 365 days without an unplanned extubation in PICU.

Progress and Future Goals

We continue to track and analyze effectiveness in using both ETADs and our standardized ETT securement policy for our intubated patients. The PICU team will continue to focus on continuous process improvement in all aspects of care to ensure our patients receive evidence based, high quality care with excellent outcomes as demonstrated through this project.

Email comments to **Butler-Suzanne @cooperhealth.edu**

Team members Pictured (back row l-r): *Shannon Patel, DPN, APN-C; Susan Cannon, MN, RN; Karen Walker, MD; Cari Rinaldo, RN;* **Front Row (l-r):** *Marina Dvortsy, RN; Suzanne Butler, RN; and Brian Miller, RRT*

Sepsis in the Pediatric Population

Chris Unander, MS, BSN, RNC

Each year over 750,000 children in the United States develop sepsis. Sepsis is a dysregulated response to infection that may lead to multisystem organ failure. Sepsis results from an infection leading to Systemic Inflammatory Response Syndrome (SIRS), which in children can alter core temperature, heart rate, and respiratory rate based on age plus abnormal white blood cell count.

Identifying and treating Pediatric Sepsis has become a national focus. In September 2018, the New Jersey Hospital Association Sepsis Learning Action Collaborative featured Pediatric Sepsis as a topic. The following day, the collaborative sponsored a Pediatric Sepsis Conference at Morristown Medical Center. Morristown Medical Center's Goryeb Children's Hospital participated in a study led by the Children's Hospital Association to develop protocols to recognize and address sepsis among the pediatric population. The Cooper Pediatric Sepsis Workgroup was formed in March of 2019 to develop the Pediatric Sepsis screening and treatment process.

Why not use the Sepsis protocols and alerts already developed for the adult population? The adult screening and protocols are not appropriate for children for several reasons. First, the normal and alert vital signs for children differ from adults and change as the child develops. For example, normal heart rate in a toddler is 80-130 beats per minute, while a school age child is normal between 70-110 beats per minute.

Neonatal sepsis (occurring in the first month of life) presents differently than sepsis in a 10-year-old child. Physiological adaptation to sepsis also differs in children. For example, the adult response to hypotension it to increase heart rate and stroke volume. In younger children, the primary response to hypotension is increased heart rate; the inotropic response is not fully mature. Laboratory studies routinely used in adults are not as useful in children. Finally, dosing for fluid resuscitation and medication in children must be weight-based dosing.

Early in 2019, a multi-disciplinary team formed to determine best practice for recognition and management of Pediatric Sepsis here at Cooper. The Pediatric Sepsis workgroup consists of members from the pediatric ED, Pediatric Intensive Care Unit (PICU), Pediatrics in-patient, pediatric pharmacy, medical informatics, and quality and patient safety. The team began with

The Cooper Pediatric Sepsis Workgroup was formed in March of 2019 to develop the Pediatric Sepsis screening and treatment process.

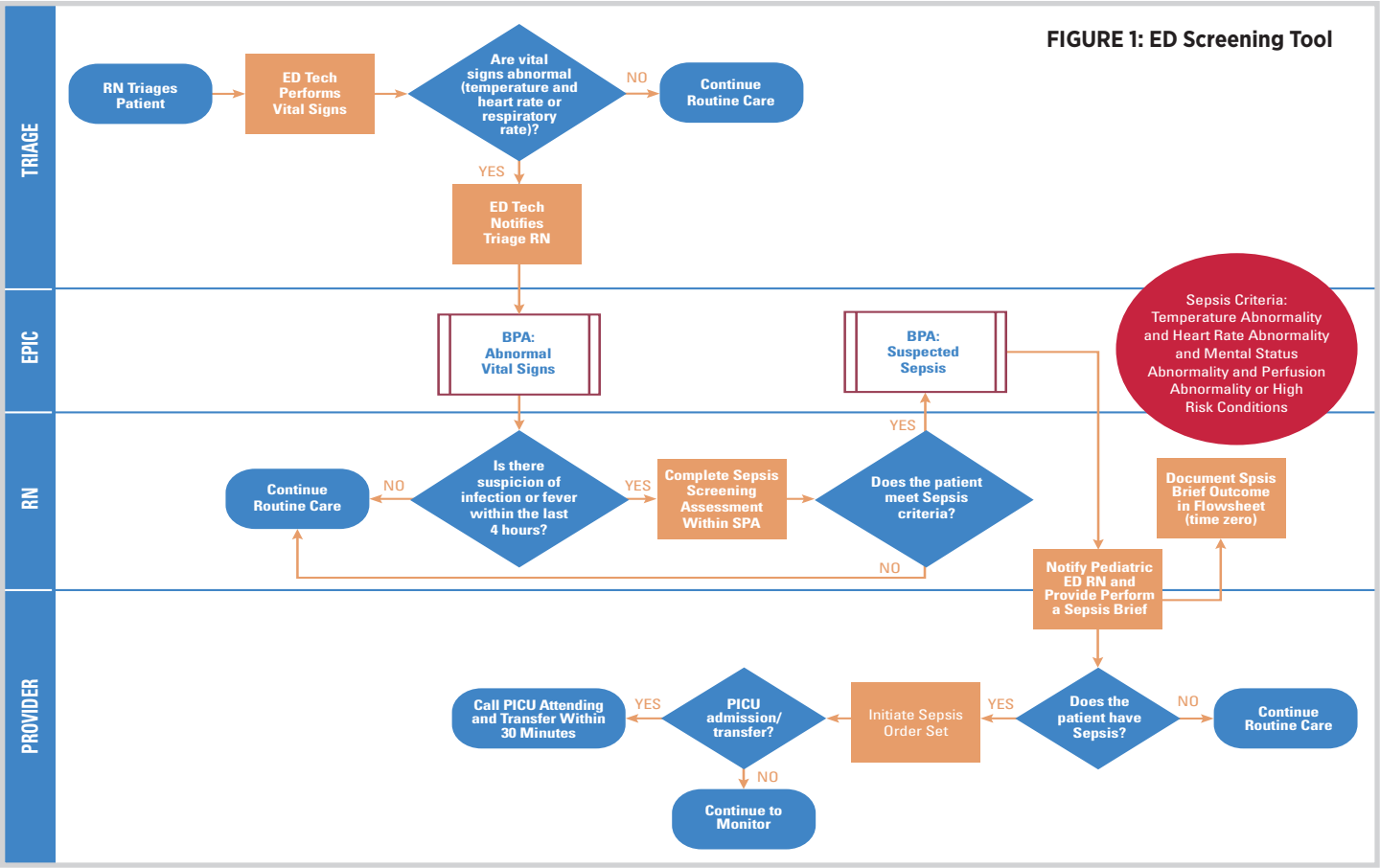
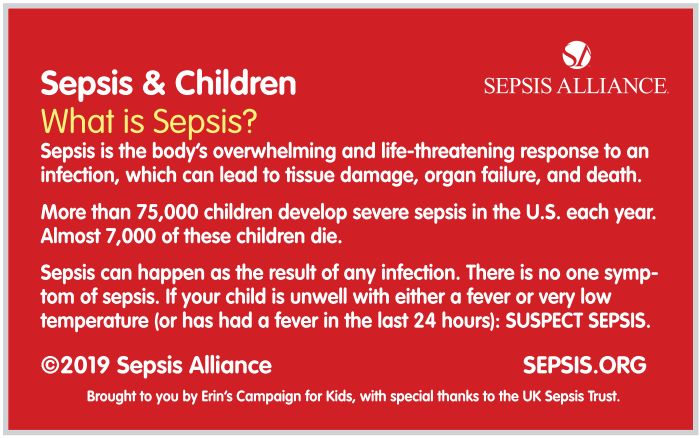


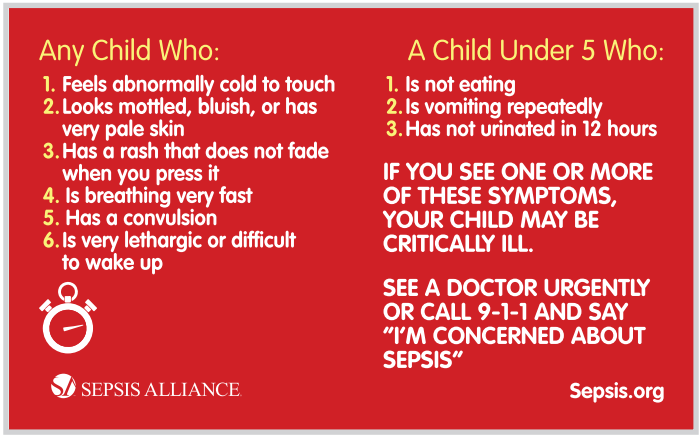
FIGURE 1: ED Screening Tool

a review of the available literature and best practices. The team also reviewed and updated the sepsis order set that is implemented once sepsis is determined. The Cooper University Health Care (CUH) team developed a screening protocol using resources from the Children's Hospital Association and Children's Hospital of Philadelphia.

In February of 2020, the Emergency Department implemented the Pediatric Sepsis Screening. The active participation and input of Emergency Department providers and nursing team was critical to the development of this tool. The goal was to implement robust tool that would fit into an optimal workflow. Extensive education was provided to the nursing, provider, and pharmacy teams, which resulted in an effective rollout with the tool correctly used in over 80% of children during the first month. The committee continues to use feedback to adjust the tool as needed. The quality department is currently monitoring the tool along with feedback from the Pediatric ED and Pediatric inpatient teams to ensure sepsis cases are promptly recognized and the sepsis order set is initiated.

The tool uses a two-stage approach to identify sepsis (Figure1). The first step is to identify abnormal vital signs based on the age of the child. This will trigger a Best Practice Alert (BPA) indicating the need for a Registered Nurse (RN) to assess the child's mental status, perfusion, and risk for infection. If the second alert triggers based on the assessment, there is an immediate bedside evaluation of the child with the RN and the provider. The team will review the child's current clinical status, history, and risk factors to determine how best to proceed. If it is





The multi-disciplinary team involved in development of these tools facilitates best practice in care. Each team member has contributed their expertise and knowledge toward this goal of providing the best possible care for all pediatric patients coming to Cooper.

determined that the child likely has sepsis, the pediatric sepsis order set is placed.

The involvement of Medical Informatics (MI) has been key to the success of this process. The MI team is able to run the BPA in the background to look at how the alert is working. The team was able to modify the tool prior to implementation. The goal is to promptly and accurately identify children at risk without creating alarm fatigue. The Medical Informatics and Adult Sepsis group members have extensive experience with the Adult Sepsis alert process which is very helpful. The Pharmacy Team ensures appropriate dosing of medications based on the child's weight and are readily available for consultation. As part of the quality metrics, both the clinical and quality teams monitor the medication utilization.

Since beginning the use of the ED Pediatric Sepsis screening tool in February of 2020, there has been a recent modification based on review of data. The Pediatric Sepsis Workgroup is using the Plan Do Check Act model of process improvement. The initial plan was implementation of the Pediatric Sepsis BPA in the pediatric emergency department. Compliance with completion of the tool is running at 90% to 95% completion. Team members provided feedback on how the tool was working resulting in changes to improve workflow and specificity. Additional support from the Quality Department allows for timely review of the sepsis cases to further measure effectiveness.

The Pediatric Sepsis workgroup is now working on the inpatient tool. As with the ED process, the collaborative efforts from nursing and providers is critical to create a tool that will identify children at risk. The tool in development will utilize assessment data already documented by the nursing team. The Pediatric Early Warning System identifies increasing risk based on the assessment date and alerts the team to evaluate the child. Sepsis is one of the conditions that may trigger this alert, once determined then the Pediatric Sepsis Order set will guide care. Education on this tool is in process for all pediatric care providers. [Planned implementation is for February of 2021.]

The multi-disciplinary team involved in the development of these tools now utilize them to facilitate best practice in care. Each team member has contributed their expertise and knowledge toward this goal of providing the best possible care for all pediatric patients coming to Cooper.

Email comments to **Unander-Chris@cooperhealth.edu**

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Guardian Angels

By Julia Porter, BSN, RN (Pool RN)

Nursing is known to have a guardian angel reputation. Every day we discover new ways to care for our patients, explain and educate different personalities within patient's family dynamics, and simultaneously balance multiple tasks successfully.

As if nursing was not challenging enough, this year nurses have been faced with the COVID-19 pandemic. Along with management, educators, and other ancillary teams, we were all thrown into disorganization with new rules and regulations changing daily. Although nurses are flexible, not many were ready for the anxiety and fear that this pandemic brought upon us. Most nurses that I came across were not worried for themselves, but for their families when they return from work. Other nurses I came across were fearless and came in and out of work doing what they had to do while using the current proper protection of that time. Although strong, we are all human and being overwhelmed at times was expected, to say the least.

Although I have only been a nurse for three years, my experience at Cooper has already bestowed on me so much knowledge and growth that I could never forget. Within those three years, I have always felt strongly regarding my care and have never had a patient break me down until this year. This patient I speak of has unfortunately passed away. This individual was cared for mostly by one of my closest co-workers and myself. He was within his 60s and had already been through a great deal. He had stage IV pancreatic cancer, COPD, and had recently gone through leg amputation surgery. He too was someone who was COVID-19 positive, but after a couple weeks in the hospital, it seemed like he was turning the corner. I vividly remember to this day, while we helped bathe him, we played Motown music for him and he would dance in bed while we danced around him. He would always say "I feel like a king." Throughout my experience getting to know him more, we learned he had no family. He had just one friend he would talk to everyday. He not only spoke about the regrets of his life, but how he is on the path of making everything right. "You're never too old to turn your life around", he told me. Then a major event occurred for both him and me. One night, while he was in my care, his O2 saturation was dropping while he was on vapotherm. At this point, he was a DNR/DNI and unfortunately there was nothing else I could do. All through the night he felt fine until that morning. Suddenly, his O2 saturation decreased and remained in the 60s and he subsequently became very lethargic. I sat with him that morning knowing it would be the last time I would hear him speak. I will always remember that morning when we laughed together for the last time. One of the last things he told me was to have a "good morning, I'll see you tonight." He was correct. I sure did see him later. I came in an hour and half before my shift worried that I missed his passing. When I arrived, he was not speaking; he was just idling on a morphine drip. As before, I sat with him and held his hand while I watched his monitor. An hour later, his heartbeat began to slow down. His pulse ox was now unreadable. I watched his face and told him "it's ok, you did good." Within minutes, he flat lined on the monitor. At this point I was in tears. Although I knew it was coming, I had the privilege to be with someone during their last hours on Earth.

I feel that there is more to nursing than just keeping people alive. I believe, as nurses, we also treat death with humanity.

At this time in my nursing career, I was not an ICU nurse accustomed to dealing with multiple pumps, ECMO, or dialysis machines while a patient is sedated. My training had ended at the intermediate level. However, I feel that there is more to nursing than just keeping people alive. I believe, as nurses, we also treat death with humanity. That's why nurses do what we do. I believe every human life has a greater impact on one another, and one day we too will have a guardian angel taking care of us.

Email comments to: **Porter-Julia@cooperhealth.edu**

Professional News

We encourage our nursing staff to become certified.

Look for certification preparation and review classes offered by the Professional Development department or inquire by emailing **PCSClinicalEducators@cooperhealth.edu**

DEGREES:

Patrice Adimaro, BSN, RN, graduated from Walden University with a BSN

Sandra Crosson, MSN, RN, graduated from Immaculata University with a MSN

Erica Eisenstein, MSN, APN, AGACNP-BC, graduated from Rowan University with a MSN and her NP certification for Adult-Gerontology Acute care NP

Brittany Galloway, MSN, RN, graduated from Wilkes University with a MSN in Nurse Executive

Iona Garate, BSN, RN, graduated from Wilmington University with a BSN

Krystal Lazos, MSN, RN, graduated from Rowan University with a MSN

Angela Murphy, BSN, RN, graduated from Western Governors University with a BSN

Christie Perrello, MSN, FNP-C, graduated from Rowan University with a MSN and her NP certification in Family Nurse Practitioner

Brittany Schumacher, BSN, RN, graduated from Wilmington University with a BSN

Thomas Thompson-Quartey, BSN, RN, graduated from La Salle University with a BSN

Ceitnee Weiah, BSN, RN, graduated from Widener University with a BSN

CERTIFICATIONS:

Laura Bolt, MSN, RN, NE-BC, PCCN-K, CPPS, has obtained a certification as a Professional in Patient Safety

Tierra Cote, BSN, RN, has obtained her certification in Oncology Chemotherapy

Julia A. DeFillippis, BSN, RN, CEN, has obtained a certification in emergency nursing

Janice S. Drake, BSN, RN CPEN, CPN, has obtained the certification in pediatric nursing

Carly Eaise, BSN, RN-BC, has obtained a certification in medical-surgical nursing

Kelly Hoyt, MSN, RNC-NIC, CNL, C-ONQS, IBCLC, has obtained a certification in Obstetric and Neonatal Quality and Safety

Kimberly Jones, BSN, RN, CNOR, has obtained her certification in Operating Room nursing

Sigal Middleton, BSN, RN, CEN-Certified Emergency Nurse

Lisa Moriarty, RN-BC, MSN, CNS, ONC, has obtained the certification in medical-surgical nursing

Shannon Perocho, BSN, RN, CCRN, has obtained the certification in critical care nursing

Dylan Toolajian, BSN, RN, OCN, has obtained the certification in oncology nursing

PUBLICATIONS:

Shannon Patel & **Barbara Cottrell** published *Righting the Ship: Reinvigoration of Shared Governance at the Unit Level* in the *Voice of Nursing Leadership,* a journal from the American Organization for Nurse Leaders