



Cooper Bridges

A publication for nurses and healthcare professionals

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**Compassionately
Promoting Safe and
Healthy Families**

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Nursing as a science is guided by nursing research and nursing theory. Nursing theorists have created the models of nursing by which we practice today. In our earliest training we are introduced to nursing theorists including Dorothea Orem, Jean Watson, Hildegard Peplau and many others. Our education is grounded in a particular theorist and her nursing model which shapes our views of human beings, health, nursing practice and the environment in which we practice. While the models vary, one thing is consistent; all of these models were developed to guide and enhance the way we care for our patients.

Beyond theory we also learn the science of nursing. We begin to understand anatomy and pathophysiology and normal body function. We learn to identify defects and treatments modalities. It is an exciting time when we make the connection between heartbeat, blood flow and oxygen exchange. We can take a blood pressure, listen to hearts and lungs and learn how to assist a person with normal daily activities. As we continue our education we advance our understanding of baroreceptors and identify how pharmacologic and non-pharmacologic treatment modalities are affected. The commitment to a life of learning the science of nursing is grand and truly commendable.

For some of us, the science of nursing is not what called us to the profession. It is to the art of nursing that we gravitate. The word nursing is derived from the Latin words 'nurtrire' which means 'to nourish' and 'nutrix' meaning 'nursing mother.' According to Donohue (Nursing The Finest Art, an Illustrated History, 1985, Mosby, p. 5), in the sixteenth century the word nurse became associated with a woman who cares for the sick. This desire to help and care for another person in a time of need is what inspired many of us to become the nurses of today. The art of nursing is referenced throughout literature in many different ways but holds true as the connection one makes with another person in a time of need.

As with the science of nursing, we learned many things from our nursing theorists. We learned to give a bath, turn a person or assist them with walking. With the art of nursing, we gained an appreciation and skill for making a genuine personal connection, which enables us to actively listen to our patients concerns and fears. Our caregiving is flexible and dynamic. We are advocates, confidants and teachers. Having the ability to positively impact a person's life is amazing.

Florence Nightingale, known as the founder of modern nursing was a statistician who embraced nursing and the care of the human body and soul; hence her name the 'Lady with the Lamp.' She maintained impeccable records to provide statistics and trends that supported treatment modalities that impacted the ill and created social reform. Florence Nightingale epitomized nursing science and art. In healthcare today it is easy to become mired down with the tasks of nursing. I challenge each of you to embrace the art of nursing in the care you provide.

"Nursing is an art; and if it is to be made an art, it requires an exclusive devotion as hard a preparation as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is one of the Fine Arts: I had almost said, the finest of Fine Arts."

— Florence Nightingale

Lisa Laphan-Morad

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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

Holistic Nursing Practice

Carmen McDonald, PhD, MSN, RN, AHN-BC, NEA-BC

“Holism” in nursing emanated from Florence Nightingale, who believed in care that focused on unity, wellness, the interrelationship of human beings, events and the environment (Moore, 2015). Hippocrates, who is often referred to as the father of Western medicine, promoted a holistic approach to healing when he taught physicians to observe their patients’ life circumstances and emotional states. Socrates was quoted as saying, “Curing the soul; that is the first thing” (ANA, 2007). Holism is defined as the whole that is greater than the sum of its parts (ANA, 2007). Eliopoulos (2004) explains that when holism is applied to health, harmony of the body, mind and spirit create a higher, richer state of health than would be achieved with attention to just one part, such as physical functioning. While some people equate holistic health care with use of complementary and alternative therapies, this philosophy of care encompasses a wider range of approaches which are used to establish and maintain balance within an individual. Complementary and alternative therapies may be part of this practice as is counseling, prayer, conventional (Western) medical treatments and other interventions.

The American Holistic Nurses Association

In 1981, the American Holistic Nurses Association (AHNA) was created by a small group of founding members who gathered from various healthcare arenas. The vision of the group was to assist nurses everywhere in finding their way “home to the heart of nursing” (Andrus & Crawford, 2008). The AHNA developed the standards of nursing practice for holistic nurses in 1998 and the organization began to grow. In 2006, the American Nurses Association (ANA) recognized Holistic Nursing as a specialty and published the scope and standards for practice. Achieving this recognition provided holistic nursing with legitimacy within the nursing profession and the broader healthcare system (Andrus & Crawford, 2008).

Academic Recognition and Professional Certification

This significant shift toward holism in nursing has included a growing number of academic and continuing education programs based on principles developed by holistic nursing theorists. Many nursing schools offer holistic nursing classes at both undergraduate and graduate level. Certification in Holistic Nursing has become a reality because of the increase in educational options and the research



that the field has generated, thus providing more opportunities for nurses to expand their knowledge. Since its inception in 1983, the *Journal of Holistic Nursing* has published research concerning holistic nursing care (Andrus & Crawford, 2008). At the AHNA annual conference, research presentations and an annual research award illustrate the impact evidence-based care has on nursing practice.

The ANA revised *Holistic Nursing: Scope and Standards of Practice 2nd Edition* in 2013 at an opportune time for healthcare as the Healthy People 2020 campaign became a focused priority. This nationwide initiative designed to promote health and improve quality of life and well-being aligns perfectly with the core values of Holistic Nursing; a practice grounded on a philosophy of patient-centered care (ANA, 2013). Society and consumers of healthcare have come to expect an experience which includes caregivers that are not only knowledgeable experts in their profession; but also able to provide a sense of wholeness, peace and healing. The AHNA has graciously accepted this challenge to establish standards that guide the practice and protect those entrusted in our care (Roberts, 2015).

Florence
Nightingale



Integrative Healthcare

An evolution is occurring in practice integration and research among healthcare organizations from the East coast to the Hawaiian Islands. Holistic nurses integrate complementary/alternative modalities (CAM) into clinical practice to treat their patients' physiological, psychological and spiritual needs. Doing so does not negate validity of conventional medical care, but serves to complement, enrich and broaden such modalities to help patients achieve the ultimate healing potential (ANA, 2013). Integration, not separation, is the approach for the best patient experience. Erickson (2009) describes the holistic nurse as an instrument of healing and a facilitator in the healing process as he/she becomes the therapeutic partner with individuals, families and communities. This individual can be in any setting where there are patients in need of nursing care, and draws on nursing knowledge, theories, research, expertise, intuition and creativity.

Holistic Nursing Ethics and the Future of Practice

The ANA position statement and code of ethics for nursing is congruent with the AHNA standards; believing that promotion of health, healing and alleviation of suffering are fundamental responsibilities of the nurse (ANA, 2013). Respect for life, dignity

and the rights of all persons are the foundation of all nursing practice and patient-centered care. As providers of care, nurses must allocate their time to establish and maintain therapeutic nurse-patient relationships through the nursing process in an effort to maximize patient outcomes (Jones, 2010).

The future of holistic nursing practice is vibrant and exciting. Healthcare organizations link holistic care with improved patient and nursing satisfaction. Holistic nursing practice blends easily into hospital systems today; mainly due to regulatory agency guidelines for patient and family-centered care (Moore, 2015). With the intention of providing a caring culture and healing environment, holistic nurses enhance patient care quality as well as integrate self-care, self-responsibility, spirituality and reflection in their own lives. Cooper University Hospital is embracing this concept and forming a Holistic Nurse Council in 2016. Members of this council need no experience or certifications, just the desire to learn more about holistic care and to share ideas and manifest a common vision of caring and healing. The greater the number holding a unified vision, the more powerful the manifestation of that vision; let us unite to realize a healing healthcare system moving nursing care to a new level. For more information or if you are interested in becoming a member of this council, please call **Carmen McDonald** at 856.342.3495 or email mcdonald-carmen@cooperhealth.edu.

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Compassionately Promoting Safe and Healthy Families

Rita A. Varano, MSW, LCSW • Kristie Roohr, RN, BSN

Despite consistently high historical data on the prevalence of child abuse and neglect in society, most people are not aware of the complexities of the child welfare system designed to help keep kids safe and remain in a permanent home. Similarly, many people do not understand why removing a child from their parent – even after abuse – is the safety plan of last resort; nor do people realize that nearly 50% of all abused children are returned to their parent usually within 18 months (Child Welfare, 2011). Though abuse is not a new epidemic in the medical field, research on supporting families with concerns of abuse or neglect in a medical setting is scant, if available at all.

As healthcare professionals working in an American College of Surgeons accredited, Level II Pediatric Trauma Center, we have chosen a career in which we are primary care givers and frequently have the most contact with abused children and their families. Therefore, it is essential to our role as direct caregivers that we

“These are incredibly time-consuming cases and they cost money, but when we do it right, the kids are protected, the outside systems work better, and social services are much more likely to make the right decisions. If it’s a criminal case, it is more likely to proceed in an orderly way. And just as important, if we do it right, people who haven’t abused their kids are not going to be accused of abuse and we’re not going to be spending money putting kids in foster care who don’t need to go into foster care.”

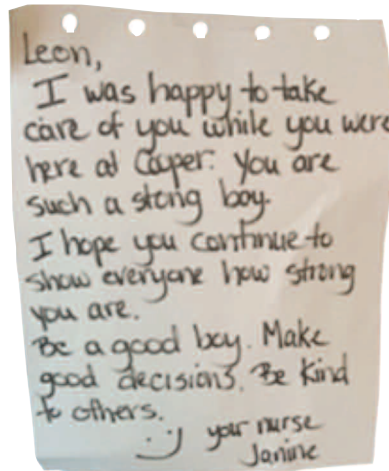
— Carole Jenny, MD, MBA, FAAP
Director, Child Protection Program
Hasbro Children’s Hospital, Providence, RI
(NACHRI article)



learn more about family resiliency and how to offer trauma-informed, pediatric care that promotes positive change. Child abuse and neglect is one of those situations where it is often more difficult to maintain a neutral position and provide such care. "Caring for patients and families who may have been involved in causing the child's injury creates an appreciable paradox for the nurse... despite the inner conflict it causes the nurse, the family continues to hold a central role in the child's life" (Moyer et al, 2015). Moyer et al (2015) discusses at length why it is important for direct care staff to engage child-welfare involved families in the child's medical care and develop a therapeutic alliance. At Cooper University Hospital, we are fortunate to have a child protection team, the Children At Risk Evaluation Team (C.A.R.E. Team). The C.A.R.E. Team is an inpatient consultative service available to assist staff when children are admitted to the hospital with concerns of abuse or neglect. The C.A.R.E. team consists of Dr. Kathryn McCans, Medical Director, who is a board certified pediatrician trained to concerns of abuse, as well as, Rita Varano, LCSW, a clinical social worker with extensive experience working with child-welfare involved families.

The C.A.R.E. Team encourages staff to use a resiliency-based approach when working with child-welfare involved families. At times, due to the adversarial nature of child welfare, these are often the most difficult families to engage in medical care. Despite any misgivings one might have for the family or child welfare, it is important to recognize the sense of vulnerability that child welfare causes a parent, and validate the reality that someone overseeing our parenting is difficult.

The C.A.R.E. Team also suggests that staff help families affected by abuse or neglect acknowledge how hard it is to have a hospitalized child and remind parents they are still essential to their child's recovery regardless of the causes of the injury. It is useful to advise parents that staying with a routine and being predictable often help with a child's recovery. Parents should continue to change and feed their child as well as read to their child and take their child to the play room to help support their child's recovery. Modeling positive child-engagement strategies such as the note to the right, written by a PICU nurse to a patient during his hospital stay and offering tips for parents once rapport is established, also helps promote healing. And, when a parent is not permitted at



bedside due to legal restrictions, advise parents to call the floor regularly for updates and find ways to get their input about their child. Next, documenting parent-child interactions at any point, noting suggestions you offered, will help child welfare expeditiously recognize the extent of need in the family. Some staff might feel surprised this type of support is needed, but research shows that these approaches to care are needed, effective and, at times, difficult to offer (Moyer et al 2015; Child Welfare Gateway, 2011; and, Lietz and Strength, 2011).

Family resiliency research also suggests that immediate orientation to child welfare has positive outcomes for families experiencing the removal of a child and helps make the child welfare process feel less stigmatizing and more empathetic to those involved (Children's Bureau, 2011). Therefore, remind parents that they have both rights and responsibilities. Ensure

that parents have their child welfare worker's name and telephone number, and suggest that they call their worker consistently; the same day and time each week, and be sure to document the call. Similarly, remind parents that they have control over how they interact with child welfare and note that their interactional style will influence how child welfare engages with their family. Furthermore, encourage parents to initiate conversations about child welfare intentions early on in the child welfare process. Prepare families that in some cases children are temporarily moved to another family while parents make some changes, and encourage parents to identify family or friends that can help care for their child while parents get help. The goal of this type of support is to help the family develop a sense of resiliency, rather than waste time negating the realities of the situation.

In conclusion, patient health and safety is always a health care priority and we are not suggesting anyone deny the occurrence of child abuse or neglect. However, it is important to remain compassionate to all of our patients and for direct caregivers to realize that we are in a unique position to influence positive and timely change when abuse or neglect occurs. As such, it is important to plant the seeds of support for child welfare involved families while they are in the health care environment so that families aren't afraid to seek help – and know that research demonstrates that the seeds will grow.

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Credits: The note written to a family was written by PICU nurse Janine D'Auria-Rousseau and published with permission.

An Educational and Informative Night for Cooper's Advanced Practice Providers

Marlo DiDonna, CRNA, APN • Jane Ryan, PhD, RN

The advanced practice providers (APPs) had a wonderful evening in March at Seasons 52 Restaurant at our first Advanced Practice Provider Symposium. The night was hosted by Mallinckrodt Pharmaceuticals and was organized by the Advanced Practice Nurse (APN) Council. Two informative speakers provided lectures that sparked interesting conversation between colleagues. "Multimodal Analgesia Strategies" was presented by Jennifer Vecere and one of our own Cooper nurse practitioners, Nora Vizzachero, DNP, spoke on APN practice in NJ and doctorate education. The 40 attendees also had a chance to network and share pertinent practice topics in an open forum discussion.

Nurse practitioners, nurse anesthetists, clinical nurse specialists and physician assistants collectively make up our network of APPs. The APN Council was formed in 2012 with the intention of empowering APNs to collaborate with peers and to encourage professional growth, which thereby, can improve patient care by facilitating multidisciplinary partnerships.

Cooper University Health (CUH) System's APNs provide care throughout CUH in both inpatient and outpatient settings. In addition, they care for acutely ill patients and their families as well as stable patients in their communities. In conjunction with physician partners, nurse practitioners provide care for many vulnerable, medically fragile patients, many of whom are either uninsured or underinsured. Nurse practitioners care for patients throughout their life span and can be found in the Neonatal Intensive Care Unit, outpatient pediatric offices, Emergency Department, Urgent Care Centers, medical practices, Clinical Decision Unit, the Cancer Center, women's health, Trauma Intensive Care Unit, throughout surgical services and in end of life care.

CUH's certified registered nurse anesthetists (CRNA) have

been administering anesthesia in the main operating room (OR) and outpatient surgical centers for many years. The CRNA is present for the duration of a patient's surgery; securing the airway, monitoring vitals, administering medications and balancing fluid and blood administration. The goal for a CRNA is to carry a patient safely through surgery, and ultimately, to deliver the patient to the post-operative area without memory of the surgery and without major pain. Over the years, CRNAs have expanded their practice to many areas outside of the OR including the endoscopy suites, cardiac EP lab, neuro interventional lab and MRI suite just to name a few areas. And of course, CRNAs are vital to the trauma department, as they report to every trauma alert 24/7.

Our teams of APPs at Cooper are a valuable resource and positively impact the delivery of patient care throughout all areas of the health system. At a minimum, APNs hold master's degrees, but many have doctorates in nursing practice and PhDs. Both the New Jersey State Nurses Association and the American Association of Nurse Anesthetists are pushing its members to strive for these educational goals, and as a result, the entry level for some programs such as for CRNAs will be a doctorate of nursing practice by 2025.

The APN council hopes to continue these meetings quarterly in the future. If you are an APN who wants to become more involved either in planning a meeting or presenting a topic, we welcome your opinions and involvement! And if you are a nurse who is interested in exploring an APN specialty, please do not hesitate to contact a member of the council for mentorship opportunities.

Email comments to : DiDonna-marlo@cooperhealth.edu



Ethical and Legal Views of the Changing Healthcare System

Romagnia Hill, MSN, RN, CNOR

Ethical dilemmas are more common and complex in today’s technologic and cost-contained healthcare settings and nurses need ethical skills to help resolve ethical conflicts, which they may not recognize, especially in everyday practice (Varcoe et al, 2004).

Ethical Responsibilities

Nurses are guided in their everyday lives by their personal beliefs about what is right and good. The American Nurses Associations (ANA) Code of Ethics as stated in Burkhardt and Nathaniel (2008) consists of nine provisions divided into three areas that describe the fundamental values and commitments of nurses, the boundaries of duty and loyalty and the duties beyond individual patient encounters. The ethical principles that commonly guide nursing practice includes non-maleficence, beneficence, autonomy, fidelity, veracity and justice (Guido, 2006) see Table 1.

Nurses have responsibilities that exceed not only the specific healthcare needs of individuals, but broader health concerns such as lack of access to healthcare, world hunger, violation of human rights and inequitable distribution of nursing and healthcare resources (Burkhardt & Nathaniel, 2008). Nurses are obligated to advance the nursing profession by assuming the roles of leaders, mentors, or engaging in scholarly activities like research. Nurses can also get involved in civic activities related to healthcare through local, state and national initiatives (Burkhardt & Nathaniel).

Legal and Ethical Guidelines

Nurses are faced with ethical and legal issues in their daily practices. It is imperative that they understand the laws and standards that safeguard the interests of patients, themselves, their

institutions and society at large. Ramsey (Laureate, 2005) explained that nurses need to understand the standards of care to which they are held accountable and the rights they have as professionals and employees. Furthermore, nurses need to be familiar with the laws that pertain to their nursing professions. Healthcare professionals, including nurses, are more frequently named in litigations generated by patients. Becoming familiar with their state nurse practice act is one way that nurses can minimize their risks for liability while practicing ethically.

Ways to Avoid Moral Distress

Moral distress as defined by Jameton is the “disturbing emotional response which arises when one is required to act in a manner which violates personal beliefs and values about right and wrong” cited in Burkhardt and Nathaniel (2008). One way of dealing with moral distress is to apply the 4 A’s Model to clinical settings. The “4 A’s” Model developed by the American Association of Critical Care Nurses (AACN, 2006) consists of four basic steps applicable to any nursing practice area.

- 1. **ASK:** self-awareness and self-reflection are utilized during this stage.
- 2. **ACT:** one prepares to act personally and professionally by implementing strategies to initiate the desired change.
- 3. **AFFIRM:** confirm that one is experiencing distress, commit to take care of self, validate feelings and perceptions with others and review professional commitment.
- 4. **ASSESS:** sources of distress can be the environment or personal. Analyze the risks and benefits involved, determine the severity of distress and assess readiness to take action.

Conclusion

Unidentified and unresolved ethical dilemmas in clinical practice settings can lead to feelings of uncertainty, tension, frustration and moral distress. Today’s healthcare environment, in conjunction with economic constraints can create situations that are overwhelming, making it difficult to uphold the basic duties of patient advocacy and high ethical principles.

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TABLE 1 Ethical Principles	
PRINCIPLES	DEFINITIONS
Non-maleficence	An obligation not to inflict harm intentionally.
Beneficence	Engage in activities of goodness, kindness, or charity, including all actions intended to benefit others.
Autonomy	Right of all people to make choices and decisions freely based on their own individual values and beliefs.
Fidelity	Refers to faithfulness, particularly the duty to honor commitments made to others.
Veracity	Actions and beliefs that are based on the values of truth, accuracy, and honesty.
Justice	All people should be treated fairly, and available resources should be used equitably.

CRISIS RESOURCE MANAGEMENT: A Nursing Perspective

Gregory Staman, RN, BSN • Stacey Staman, RN, MSN, CCRN-K, TCRN

Overview

Crisis resource management (CRM) as a healthcare discipline traces its origins to the aviation industry. In the wake of catastrophic inflight accidents precipitated by human error, a codified training program to address cognitive and interpersonal skills for and between flight crew members was initiated by United Airlines in 1981. CRM was designed to enhance personnel interaction in the cockpit, particularly during high risk, high stakes events where poor communication and leadership held the potential for catastrophic results.

This training focused on individual and team use of interpersonal and cognitive skills designed to maximize clear communication, promote efficient and timely use of resources, capitalize on situational awareness and promote strong leadership and decision-making. As the merits of CRM training became apparent, it became an industry-wide gold standard by mid-decade, while also developing a strong following in US Military and nuclear energy sectors.

Certainly, there are strong parallels between the high-stakes environments mentioned above and the high-risk, low frequency events with the potential for great loss of life in healthcare. Dr. David Gaba, a practicing anesthesiologist and civilian pilot, saw clearly the parallels between aviation and medicine: high risk procedures, complex environments, 24/7 operation and disparate personnel assignments were identical factors present in both disciplines (Gaba, Fish, Howard & Burden, 2015).

Committed to creating positive change in the arena of anesthesiology following the devastating report “To Err is Human” (Kohn, Corrigan & Donaldson, 1999) released by the Institute of Medicine, Gaba developed and instituted the Anesthesia Crisis Resource Management curriculum at Stanford University, where it immediately generated interest in the medical community. In the last decade, CRM has been adopted across multiple disciplines within healthcare. In an effort to provide a clear and concise understanding of the eleven tenets of crisis management (as

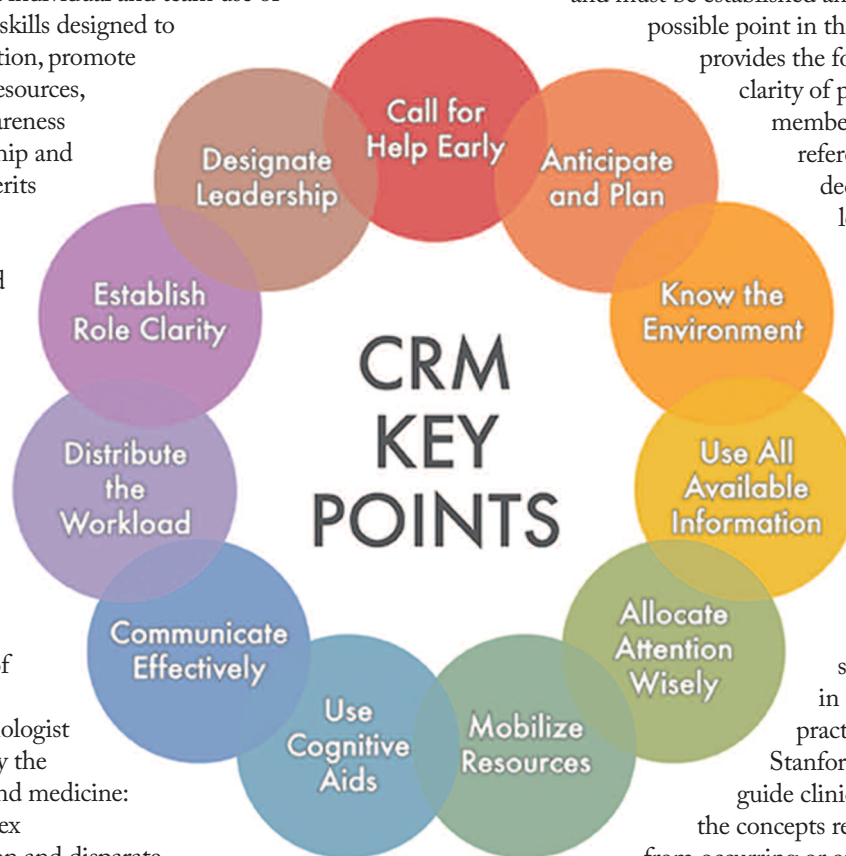
outlined in the Gaba model), Stanford developed the “CRM Flower” as a cognitive aid. This visual representation of the cognitive skills required of all individuals participating in critical events is easily conceptualized, and lends itself well to use as both an educational training tool and cognitive aid at the bedside.

Current literature regarding crisis management in the clinical setting points to a noted deficit in clear communication, resource management and leadership skills that incorporate attention allocation and role clarity. Adequate control of the clinical event by clearly defined leadership is paramount to a successful outcome, and must be established and articulated at the earliest

possible point in the crisis. Decisive leadership provides the foundation for stability and clarity of purpose, and provides team members with a focal point of reference for task assignment and decision making. A strong leader synthesizes all aspects of the CRM rubric and focuses the team towards the most favorable series of outcomes.

It should be noted that CRM, in the context of medicine, is not the sole prerogative of an individual team leader. The eleven key components are valuable tools that all members of the healthcare continuum should recognize and embrace in the course of their clinical practice. The true value of the Stanford model lies in its ability to guide clinicians in an understanding of the concepts required to prevent events from occurring or escalating to the point of criticality.

Traditional nursing education provides a basic knowledge of physiology and nursing skills. CRM highlights the difference between “knowing” and “doing”. This gap is due in part to the lack of opportunities healthcare providers have to practice what they actually do as part of a team. CRM builds on these foundations and adds the method of managing situational emergencies. Education on CRM not only focuses on providing increased nursing responsibility for patient care and nursing autonomy, it can increase collaboration by promoting team building (Rudy, 2007). The primary objective is to better prepare staff to function in



emergencies, and prevent errors that often result when performing under pressure. The key points of CRM are:

Call for help early: Appropriate management of any critical event is not accomplished in a vacuum, and the early request for assistance is not a sign of weakness or incompetency. Additional personnel at bedside provide added physical, psychological and academic support to the situation at hand, and are integral to the successful resolution of the critical incident.

Designate leadership: Strong leadership will coalesce and strengthen the overall team, and those taking a leader position must be readily identifiable and recognized as in command by all participating team members.

Anticipate & plan: Consider all contingencies and pre-plan for emergencies when possible; identify interventions and designate responsibilities. Know your available resources including equipment, staff, etc.

Know the environment: A critical event can occur anywhere within the clinical setting. Become comfortable with the physical benefits and limitations of the areas within which you practice on a daily basis.

Use all available information: There are abundant resources available to a clinician during crisis situations. Do not discount the ability of other team members to provide critical information, utilize sources of objective patient data when possible, and integrate information from all sources equally and without prejudice.

Allocate attention wisely: Stay focused on the task(s) at hand that directly affect successful patient outcomes. Learn to “see the forest through the trees,” and prioritize needs and events in the order of importance.

Mobilize all available resources: Fully engage all assets. Ask for help early and elicit support from clinical providers not specifically assigned to your team, if able. Do not wait to activate clinical pathways. If possible, identify and operationalize ancillary service lines in preparation of a perceived worsening scenario.

Communicate effectively: Use closed-loop communication to clearly convey information. Speak to team members by name (if able) and maintain eye contact when giving orders or asking for assistance. Ask for confirmation of understanding and ownership. If accomplishing a given task, verbalize the undertaking and completion to the person who assigned the task to you (i.e.; 1cc Epinephrine 1:10,000 drawn and administered as ordered)

Distribute the workload: Be mindful of task saturation. Allocate resources appropriately and spread complex tasks among team members, based on competency and scope of practice. Team leaders should not be task providers!

Establish role clarity: Encourage the team to self-identify and verbalize their status and role within the response. Enter into the event by clearly stating your name and title. Do not assume that others involved in the event know who you are or your level of expertise.

Use Cognitive aids: Engage the use of cognitive aids as rapidly as possible. Assign a “reader” to verbalize steps outlined in clinical checklists, ACLS/PALS manuals, online resources, etc. Team leaders must be mindful of the needs to “keep eye on the team” and not be distracted by personal use of cognitive aids.

CRM at Cooper University Hospital:

The key to mastering any skill is the opportunity to practice and perfect through the use of feedback; CRM application is no exception. At Cooper University Hospital (CUH), the PCS clinical educators have begun to introduce CRM principles through an already established code review program; Pediatric Code Review and Crisis Management for the RN/ LPN Course. This four hour program is designed to prepare the nurse for a Code White or medical crisis situation. The first portion of the course reviews how to check a code cart, the contents of a pediatric and adult code cart, primary and secondary ABCD assessment, the nurse’s role before, during and after the code team arrival, documentation and CRM principles. The second portion is conducted in the Simulation lab. Training occurs in a safe, harm-free, confidential learning environment. Utilizing a hands-on approach, several common and uncommon crisis situations are created using Sim-patients. Working in small teams, the students manage each patient case, allowing them to practice their response to these emergent situations.

Following each scenario, a non-threatening, non-judgmental faculty-guided debriefing occurs. This session allows for individual and group self-reflection of their performance and management of the situation. Debriefing of each scenario focuses on key clinical objectives and utilization of CRM principles by team leader, allowing for actual learner to occur. Student feedback from this revised program has been very positive; with participants strongly recommending this type of training for all staff nurses.

Summary

All team members should be knowledgeable and skilled in CRM principles to enhance team effectiveness and improve patient outcomes. Simulation is an effective tool for focused instruction on team-based behaviors (Petrosoniak, 2013). The insertion of CRM skills into simulation involving crisis situations provides the student with an opportunity to practice CRM principles during high risk; low frequency events. The described model is one strategy to introduce CRM principles and improve decision-making and leadership skills to nurses.

Email comments to staman-stacey@cooperhealth.edu

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Utilization of a Progressive Mobility Program in Critical Care Units

Jamie Rubino, DPT, PT • Jaclyn Wiggin, RN, BSN, CMSRN

Research suggests that patients who have been hospitalized in a critical care setting resulting in prolonged immobility experience great challenges both short- and long-term. Gosselink et al. (2008) report that extended immobility may cause, “deconditioning, muscle weakness, dyspnea, depression and anxiety;” these impairments often lead to extended hospital stays which increase health care costs and decrease quality of life after discharge. In an effort to combat these effects, the nurses, critical care technicians, respiratory therapists (RT) and physical/occupational therapists (PT/OT) in Cooper University Hospital (CUH)’s Cardiac Care and Intensive Care Units (ICU) are performing early and progressive mobilization of critically ill patients. Typically this occurs once hemodynamic stability has been achieved; regardless of being on mechanical ventilation or receiving low-dose vasopressor infusion therapy, early mobilization can be initiated. The aims of early and progressive mobility include improving respiratory function, reducing the harmful effects of immobility, increasing levels of consciousness, increasing functional independence, improving cardiovascular fitness, increasing psychological well-being and reducing the risks of pulmonary complications (Stiller, 2007). Other benefits reviewed by Stiller include decreasing duration of ICU stays, hospital stays and time on mechanical ventilation; all factors that may benefit not only the patients, but also the hospital itself.

There are four primary teams that are essential in a successful progressive mobility program (PMP): physicians, nurses, RT and PT/OT. These groups are responsible for collaborating daily to determine each patient’s expected level of mobility. Physicians are responsible for ordering the expected level of activity (i.e. bed rest, up ad lib) and any precautions (i.e. weight bearing status), as well as for consulting physical/occupational therapy. They are also responsible for routinely evaluating sedation requirements and decreasing doses when appropriate. Once the order for activity has been received, it is the responsibility of both the nurse and PT/OT, with support from the RT, to carry out the PMP activities as tolerated by the patient on a daily basis. Since physical therapists are most knowledgeable regarding biomechanics of movement, their assessments of functional mobility are extremely valuable.

The PMP that CUH is using was developed by Hill-Rom. A multi-disciplinary group from CUH gathered with a representative from Hill-Rom to plan the program’s initiation. Hill-Rom’s PMP consists of 5 levels: breathe, tilt, sit, stand and move (Hill-Rom Brochure, 2013). Several factors are taken into account to determine if a patient is appropriate to participate in the PMP, such as ventilator settings, oxygen saturation, respiratory rate, presence of cardiac arrhythmias/ischemia, heart rate, mean arterial pressure (MAP), systolic blood pressure, vasopressor use

and sedation scores. Each of the five levels offers increasingly more difficult mobility activities. A patient moves forward once activity in the current level is tolerated.

Levels one and two (breathe and tilt) are focused on minimal movement, often with assistance from the Total Care Sports Bed (i.e. continuous lateral rotation therapy, chair position, foot board extension/retraction). Range of motion (ROM) of all joints should be performed two to three times daily with the patient providing as much assistance as possible. Printed lists, with pictures of each exercise, have been laminated and are placed with the data collection sheets for each patient to provide a reference for nurses. When family is available, education is provided on how to assist the patient with passive or active-assistive ROM and how to instruct the patient to perform active ROM.

At level three, the patient should be able to complete active-assisted to active ROM three times daily. Activities of daily living should be encouraged regularly. The Total Care Sports Bed should continue to be utilized, however dangling at the edge of the bed may be initiated and PT/OT should be consulted as appropriate.

Once the patient tolerates level three activities it is appropriate to attempt standing and pivot-transfers to a chair as level four states, utilizing

equipment as needed for patient and staff safety. As the patient’s strength improves, level five activities such as standing, marching in place, and ambulating to a chair can be initiated. Once the patient can tolerate these dynamic standing activities, the expectation is that ambulation distance is increased as appropriate.

CUH purchased specialized safe patient handling equipment from Hill-Rom for use hospital-wide to aid with transferring and ambulation. The equipment is designed to reduce caregiver injury and improve patient outcomes (Hill-Rom, 2016). For patients who are dependent and can only tolerate in-bed mobility, every bed in the critical care units is a Total Care Sports Bed. These specialized air-flow mattresses allow for continuous lateral rotation therapy, along with other inflation modes and tilting, all of which allow for safe repositioning of patients while in bed. When the patient is strong enough to tolerate standing and sitting in a chair, the bed has the mechanical function to turn into a chair and tilt forward for standing. The Sabina sit-to-stand (see Figures 1 & 2) lift is used for getting patients out of bed to chair while they are only able to partially weight bear. With this tool, the patient can be moved to a bedside chair or commode while giving them standing practice. Once strong enough for full weight-bearing exercises and ambulation, walkers, wheelchairs, IV poles and carts on wheels are available to support the patient.

In an effort to provide easily-accessible information to the parties involved in initiating and carrying out the PMP, a printed

When performed appropriately, the benefits of early and progressive mobility often outweigh the risks.

exercise sheet is placed at each room and documentation is completed in the electronic medical record (EMR). The exercise sheet outlines the parameters a patient must meet to initiate mobility, as well as the functional expectations of each level and goals that are to be met prior to advancing to the next level. Documentation in the EMR collects information including oxygen delivery system, date of intubation/extubation, use of sedation, barriers to advancing in the PMP, whether or not PT is involved and date of discharge from unit. It also provides a list of activities (divided into PMP levels) for staff to check if accomplished. The outcome measures chosen by the multidisciplinary group to be recorded include critical care unit length of stay, readmission into the critical care unit, mechanical ventilation days, presence of ventilator-associated pneumonia and days until first out of bed activity.

Although research shows improved outcomes in patients who receive progressive mobility, there still may be questions about how patients and their families feel about this type of care. In a survey collected from 55 patients and 47 family members at University of Colorado Anschutz Medical Campus the majority of those surveyed were generally satisfied with mobility in the critical care setting (Sottile, 2015). The questionnaire included questions on necessity, difficulty, exertion, benefit, enjoyment, frequency, discomfort and satisfaction. The survey found that although family members rated PT as being of a higher necessity than patients did, patients found the sessions more enjoyable than family predicted. As may be expected, the survey revealed that PT was more difficult and less enjoyable for patients who were intubated for longer periods (>14 days). Functional outcomes were better for patients who enjoyed PT and found it to be slightly or moderately difficult rather than significantly difficult.

When performed appropriately, the benefits of early and progressive mobility often outweigh the risks. Adverse events during patient mobilization have been found to happen in $\leq 4\%$ of mobility occurrences (Hodgson, 2014). Hodgson et al reported on a 23-person multidisciplinary group that, after performing separate systematic literature reviews, developed safety criteria to serve as a guide for the mobilization of patients in a critical care setting. Once consensus was achieved on all criteria, three levels of risk were identified for each of four categories: respiratory, cardiovascular, neurological, and medical/surgical. The low-risk criteria of each category indicate that a patient is appropriate for mobility. The medium-risk criteria indicate that while it may still be appropriate for a patient to be mobilized, extra consideration and discussion is warranted to ensure safety. The high-risk criteria indicate that the risk of an adverse event occurring is high and



Fig. 1 Sabina Lift



Fig. 2 Sabina Lift

may outweigh the benefits of mobility.

It was agreed upon by the group members that if a patient presents with one high-risk criterion, this would take priority in decision making even if all other criteria presented little risk (which would thus limit mobility). See Table 1 for an outline of high- and medium-risk criteria for each of the four categories. It is worth noting that presence of femoral dialysis catheters, venous/arterial femoral catheters, ventricular assist devices, low-level MAP support and endotracheal or tracheostomy tubes are considered low-risk for mobilization of critical care patients. This research is important because it provides more guidelines and risks to consider when developing a protocol to use on our patient population.

As with many endeavors, barriers have been identified that may prohibit or slow effectiveness of CUH's PMP. In order to successfully implement the PMP, education was offered to nurses before the program was launched. This education outlined details of the program, the benefits and risks involved and the roles of each team member. However, since the program has been launched other members of the interdisciplinary team have expressed desire for education and more learning opportunities have been identified. This issue is actively being addressed in order to gain more compliance moving forward. In addition to this, a protocol is being developed that will outline the roles of each team member, safety parameters to guide progression of mobility in and out of bed and how to keep an accurate recording of mobility in the patients electronic medical record. With these records we can track progress and identify areas for

improvement in the future.

Barriers aside from safety that are being addressed are those related to sedation practices, presence and placement of lines, and priority level (Barber, 2014). CUH's physicians and nurses are performing daily total interruption of sedation as appropriate, often referred to as "sedation vacation," and the need for sedation is addressed frequently throughout the day and night based on patient responses. The regular lowering of sedation means patients are alert sooner and more frequently which will lower the incidence of delirium and improve functional mobility simply by creating more time awake. Mobility exercises can be performed both passively and actively during sedation vacations, thus lowering the incidence of prolonged bed-rest with any resulting impairments.

Communication across all disciplines is important to ensure that appropriate mobility/activity orders are placed for each patient and there must be accountability with following through with these orders (Barber, 2014). Lastly, strained resources present a problem at times, such as sufficient staffing and equipment to carry out mobility exercises (Barber, 2014). Other barriers

identified are patient-specific and include lack of patient cooperation, patient age and prior level of function, co-morbidities, severity of illness, limited endurance/tolerance and strength, body weight, pain and vital signs (Perme, 2008). A tailored protocol based on CUH's specific critical care population will address the majority of these barriers and is something that will be developed in the near future.

Fraser et al. (2015) report that prolonged immobility leads to higher hospital costs, marked physical weakness, loss of function,

increased incidences of mortality and higher rates of readmission within thirty days of discharge. Early mobility is safe and feasible when performed appropriately and is associated with less delirium and improved patient outcomes; when a PMP is used, sedation is used less frequently and functional status improves (Fraser, 2015). It does not require extra staff or equipment. The Cardiac and Intensive Care Units are proud to participate in Cooper Hospital's progressive mobility initiative.

Email comments to wiggin-jaclyn@cooperhealth.edu

TABLE 1

	HIGH-RISK CRITERIA	MEDIUM-RISK CRITERIA
RESPIRATORY <ul style="list-style-type: none"> • Intubation status • Ventilator parameters 	<ul style="list-style-type: none"> • Oxygen saturation <90% • High Frequency Oscillation Ventilation mode • Prone positioning 	<ul style="list-style-type: none"> • FiO₂ >0.6% • Respiratory rate >30 bpm • PEEP >10 cmH₂O • Ventilator dysynchrony • Nitric acid or prostacyclin therapy
CARDIOVASCULAR <ul style="list-style-type: none"> • Devices • Arrhythmias • Blood Pressure 	<ul style="list-style-type: none"> • IV antihypertensive therapy agents (for hypertensive emergency) • MAP below target range with symptoms or despite support • MAP greater than the lower limit of target range with high levels of support • Bradycardia requiring pharmacological intervention or emergency pacemaker • Transvenous/epicardial pacemaker with a dependent rhythm • Tachyarrhythmia with ventricular rate >150 bpm • Femoral intra-aortic balloon pump • Femoral or subclavian access for ECMO • Cardiac Ischemia 	<ul style="list-style-type: none"> • MAP greater than the lower limit of target range with moderate levels of support • Severe pulmonary hypertension • Bradycardia not requiring pharmacological intervention or pacemaker • Tachyarrhythmia with ventricular rate between 120-150 bpm • Central vein access for ECMO (with single, bicaval, dual lumen cannulae) • Continuous cardiac output monitoring device (i.e. pulmonary artery catheter) • Shock with lactate level >4 mmol/L • DVT/PE • Severe aortic stenosis
NEUROLOGICAL <ul style="list-style-type: none"> • Sedation level • Delirium • Intracranial pressure 	<ul style="list-style-type: none"> • Richmond Agitation-Sedation Scale (RASS) <-2 (deep sedation, unarousable) or >+2 (very agitated, combative) • Intracranial hypertension out of target range despite active management • Open lumbar drain • Spinal precautions (without clearance or fixation) • Active seizures 	<ul style="list-style-type: none"> • RASS -2 or +2 • Delirium with or without ability to follow simple commands • Intracranial pressure without hypertension or active management • Craniectomy without bone flap • Subgaleal drain • Acute spinal cord injury • Subarachnoid hemorrhage with unclipped aneurysm • Vasospasm after aneurysm is clipped
MEDICAL/SURGICAL <ul style="list-style-type: none"> • Lines • Surgical precautions • Medical Conditions 	<ul style="list-style-type: none"> • Unstable fracture (specifically spinal column, pelvis, or lower extremity) • Large and open surgical wound (i.e. on chest, abdomen) • Known and uncontrolled active bleeding • Femoral sheaths 	<ul style="list-style-type: none"> • Suspicion of bleeding • Increased risk of bleeding • Fever despite management • Active hypothermia management

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First Annual Choose to Lose Bariatric Walk

Josie Raum, MS, RD • Sheree Pinckney, MSN, APN-C

The weather could not have been more perfect as a crowd of people in white shirts gathered underneath a big white banner. Nearly 75 people, a mix of patients and staff, began our first steps for our first ever 5K walk around the Cooper River Park in order to raise awareness of bariatric disease and treatment.

To local park-goers and passersby, it is not apparent that as a group, these walkers had collectively lost hundreds of pounds through bariatric surgery. Nor would anyone know that the man carrying his cane, but without the assistance of the cane, could barely walk from his car to our office a little more than a year ago. Now, our patient, E, speeds ahead of the group, and triumphantly points his cane in our direction as we shout “Way to go E! You are moving!!” At one of our water stations, our dietitian, Joshua handed out a cup of water to B. B had lost 150 pounds and can now move around and experience life like never before. He took in the view, sipped his water and started up at a great pace along south park drive. B came to us, greater than 300 pounds, determined to get healthy. He had hypertension, on the border of being diabetic and was diagnosed with sleep apnea. At his nutrition appointments prior to surgery he committed to changing his diet and even started jumping on his stationary bike when he would watch TV, instead of just sitting on the couch. His efforts before surgery, as well as his post-operative weight loss allowed him to shed his co-morbidities. He no longer takes medication for his diabetes and does not need to use his CPAP any longer.

Some patients did not choose to walk, but instead, run! L finished the 5K in only thirty five minutes and waited underneath the main banner to congratulate her fellow finishers as they crossed the finish line. Since the 5K, she has participated in more races and recently completed the Norcross Run the Bridge 10K. She is an avid spinner as well as a runner and has fully embraced her new life and body.

Going for a walk may seem like a simple task, but for many Americans who suffer from obesity, it is anything but easy. Limited mobility due to joint pain, back pain and a variety of other aches that come from moving around can cause people not only to be discouraged but feel isolated as well. Patients will come to us with goals such as wanting to play in the park with their grandchildren, walk the college campus where their child attends, or just be able to tie their shoes easily. Bariatric surgery opens up a new door to our patients to be able to fully participate in life again! They no longer have to shy away from going to an amusement park with their family because they cannot walk to the park or fit on the ride. They now are creating memories that many people with normal mobility would take for granted.

The Cooper Bariatric Choose to Lose Walk celebrated all of these experiences and triumphs that our patients can now claim as their own. Bariatric surgery helped make activity and exercise a true walk in the park!

Email comments to Pinckney-Sheree@cooperhealth.edu



Professional News

DEGREES:

Kimberly Hummel, MSN, RN, graduated with her MSN from University of Phoenix.

Gina Brouster, BSN, RN, graduated from Rowan University with her BSN and with Summa Cum Laude honors.

Tom Repici, MSN, RN, graduated from University of Medicine of New Jersey with a MSN.

Rachel Vanderslice, BSN, RN, graduated from Penn State University with a BSN.

Kathleen Motter, BSN, RN, graduated from Rowan University with a BSN.

Tina Thomas, BSN, RN, graduated from Rowan University with a BSN.

Jennifer Bonafiglia, MSN, RN-BC, OCN, graduated from Rutgers University-Camden with a MSN in Adult/Gerontology Primary Care Nurse Practitioner.

Alena Pascucci, BSN, RN, graduated from Widener University with a BSN

CERTIFICATIONS:

Elaine Helmer, BSN, RN, has received her post-graduate nursing certificate in Complementary and Integrative Therapies (CCIT) from Drexel University.

Kim Damian, BSN, RN, CCRN, obtained the certification in critical care nursing.

Shannon Taylor BSN, RN, CCRN, obtained the certification in critical care nursing.

Christina Smith, MSN, RN, NE-BC, CPHQ, became certified in Health Care Quality through the National Association for Healthcare Quality.

Janice Delgiorno, MSN, RN, TCRN, obtained the certification in trauma nursing.

Stacey Staman, MSN, RN, CCRN, TCRN, obtained the certification in trauma nursing.

Michael Piotti Jr., BSN, RN-BC, CEN, obtained certification in emergency nursing.

Marc Cucetta, RN, CEN, obtained certification in emergency nursing.

Kathleen Koestler, BSN, RN, CEN, obtained certification in emergency nursing.

Erika Orfe, BSN, RN, CCRN, obtained her certification in critical care nursing.

Robert Strayer, PhD, APN-C, CCRN, CBN, obtained his certification in bariatric nursing

PRESENTATIONS:

Anthony Angelow, MSN, APN, ACNP-BC, AGACNP-BC, ACNPC, CEN, presented "A Bump on the Head Can Put Your Sodium to Bed" and "Bugs and Drugs: Infectious Disease and Antimicrobial Therapy" at the NJENA Emergency Care Conference in Atlantic City, NJ, March 2016

Janice Delgiorno, MSN, CCRN, TCRN, ACNP-BC, presented "Dancing With Death: Designer and Club Drugs" at the NJENA Emergency Care Conference in Atlantic City, NJ, March 2016

Janice Delgiorno, MSN, CCRN, TCRN, ACNP-BC, and Elizabeth Lee, RN, presented "My Back Is Broken: Case Studies in Spinal Trauma" at the NJENA Emergency Care Conference in Atlantic City, NJ, March 2016

PUBLICATIONS:

Catherine Hassinger, BSN, RN, CGRN, and **Patricia Passarelli, MSN**, published an article in EndoPro Volume 1(1). January/February 2016, P.38.

APPOINTMENTS:

Romangia Hill, MSN, RN, CNOR, was appointed to a 3 year position on the CNOR Form Review Committee of the Competency and Credentialing Institute.

AWARDS:

Devyn Berry, RN-BC, Selma and Martin Hirsch Award for Excellence in Medical Surgical Nursing

Jacqueline Bockarie, RN, BSN, Barbara and Jack Tarditi Award for Excellence in Nursing Mentorship

Lisa Butler, BSN, MSN, APN, Moorestown Axillary Award for Excellence in Advanced Practice Nursing

Kathrina Chapman, RN, CCRN, MICN, Award for Excellence in Trauma Nursing

Shannon Clapper, RN, Cooper Heart Institute and The Heart House Award for Excellence in Cardiovascular Nursing

Wendy Colindrez, EMT, Barbara and Jack Tarditi Award for Excellence in Service (Non-nursing)

Sean Deiter, RN, BSN, Shaina Horton Memorial Award for Excellence in Service

Tasha Herbert, RN, BSN, Charlotte Tobiason Memorial Award for Excellence in Obstetrical Nursing

Adrian Hernandez, RN, BSN, RNC-NIC, John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing

Kasey Massa, MSW, LSW, Women's Board of Cooper Hospital Allied Health Professional Excellence Award

Jennifer Nazarethian, RN, BSN, Ruth Parry/ Moorestown Axillary Award for Excellence in Geriatric Nursing

Charlotte Nussbaum, MD, Excellence in Nursing-Physician Partnership Award

Alice O'Brien, RN, ONC, HP(ASCP), Rose Smith & Sue Zamatis Memorial Award for Excellence in Oncology Nursing

Jonelle O'Shea, RN, MSN, Barbara and Jack Tarditi Award for Excellence in Nursing Research

Patricia Passarelli, RN, Carol G. Tracey Compassion Award

Giacinta Roupas, CRNA, MSN, Philip and Carole Norcross Award for Nurse Leadership

Janine Rousseau, RN, BSN, CPN, Dr. Ronald Bernardin Memorial Award for Excellence in Pediatric Nursing

Michelle Shannon, RN, BSN, CCRN-CMC, William and Eileen Archer Award for Excellence in Critical Care Nursing

Mary Alice Smith RN, CNOR, Philip and Carole Norcross for Excellence in Perioperative Nursing

Megan Staerk, RN-BC, BSN, Lynn Nelson Award for Excellence in Emergency Nursing

Jeanette Trotman, RN, BSN, Women's Board of Cooper University Health Care Award for Excellence in Ambulatory Nursing