Cooper University Health Care

Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/SUMMER 2013 ▪ VOLUME 7, ISSUE 1

Memory Boxes

COMFORTING THE GRIEVING

Table of Contents:

Professional Calendar

- **Advanced Critical Care Series I**
  October 8, 2013
  Crowne Plaza Cherry Hill, NJ
- **Annual Medical Surgical Conference**
  October 24, 2013
  Crowne Plaza Cherry Hill, NJ
- **Advanced Critical Care Series II**
  December 10, 2013
  Crowne Plaza Cherry Hill, NJ

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Cooper
University Health Care

World Class Care. Right Here. Right Now.

From the Chief Nursing Officer

Dianne S. Charsha RN, MSN, NEA-BC, NNP-BC
SVP Patient Care Services, Chief Nursing Officer

We have just completed the Magnet Site Visit preparation and survey process. During that time, we had a wonderful opportunity to review and evaluate our professional practice model with the nursing team at large. It was apparent that this model accurately reflects how we deliver care to our patients and families while supporting change and learning as a team of nursing professionals.

After we receive the Magnet Commission's decision, we will be transforming our current Patient Care Service Blueprint into a new nursing vision statement to guide our decisions and focus over the next five years.

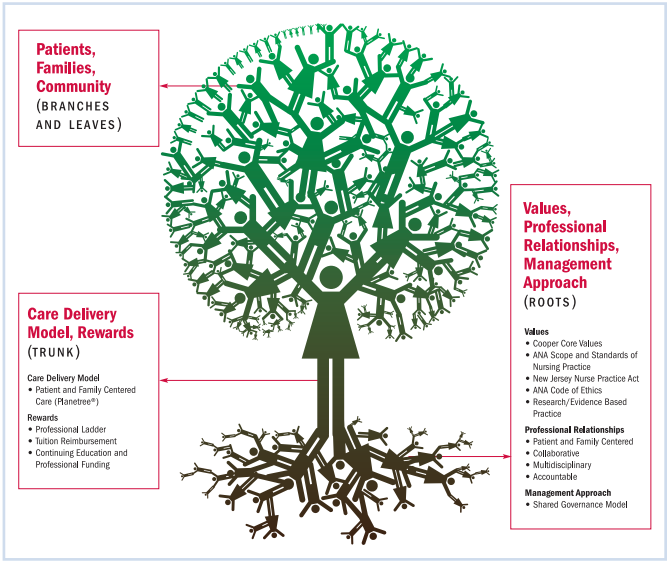
PCS Blueprint

Patient Care Services will build partnerships to foster innovative ways to deliver exceptional patient and family-centered care while being stewards of our resources.

As a result, we will bring forth new ways to explore and deliver high quality, cost-effective and safe care while broadening our boundaries of where and how we provide services to our patients and community.

We will welcome open discussion of concerns and ideas to improve performance through evidence-based practice and research. We will become masters of change by communicating and working together to enhance performance and solve problems.

We will accomplish this by nurturing a climate of trust and respect through transparency of goals with clear expectations in a culture of service and accountability. We will develop our talent and recognize and reward top performers.



Nursing Professional Practice Model

A vision statement draft, crafted from this blueprint, will be vetted through the unit based councils before being presented to the Nursing Shared Governance Councils and CORE Council for approval. Then this updated vision statement will be printed on our Professional Practice Model for Nursing Posters to be displayed in our departments.

I hope that you enjoy this Spring/Summer edition of *Cooper Bridges*. I think that you will find that most of the articles contained within these pages focus around our care delivery to patients, their families and our community.

Enjoy,

Dianne

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

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:
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CARE DELIVERY

On-Pump Versus Off-Pump Coronary Artery Bypass Grafting

Andrea R. Lore, RN, BSN, CCRN

Coronary artery bypass grafting (CABG) is one of the most common surgical procedures performed in the United States, benefiting a substantial number of patients each year. According to the National Center for Health Statistics, 467,000 CABG procedures were performed in the United States in 2003 (Feng, Shi, Zhao & Xu, 2008). Over the past thirty years, CABG procedures have been primarily performed with the use of the cardiopulmonary bypass machine (on-pump) utilizing cardioplegic arrest. In the 1990s, interest surfaced in performing CABG without the use of the bypass machine (off-pump). This area of thought focused on decreasing postoperative complications related to the bypass machine (Shroyer et al., 2009).

In the interest of clinical practice, this topic is significant with the growing number of patients entering the hospital at advanced age. The great advancements being made each year in medical science have made it possible to live longer lives. Numerous studies are available on the advantages and disadvantages of on-pump versus off-pump CABG surgery. Surgeons are looking for the most effective treatment for patients in need of CABG surgery. One school of thought is that off-pump CABG will reduce certain postoperative complications including systemic inflammatory response, coagulation disturbances and potential embolization with air bubbles and/or particles after cannulation and mortality (Pawlaczyk, Swietlik, Lango & Rogowski, 2012). Today, the global percentage of surgeons performing off-pump CABG surgery is approximately 20%. New technologies and surgical instruments are now providing the opportunity for cardiothoracic surgeons to learn the specialized technique on the beating heart (Pawlaczyk, Swietlik, Lango & Rogowski, 2012).

A ground breaking and popular trial called the Randomized On/Off Bypass (ROOBY) trial has led the research community of on-pump verses off-pump CABG surgery. Conducted from February 2002 to May 2008 at eighteen Veterans Affairs (VA) medical centers this study looked at primary outcomes of on-pump verses off-pump surgery, most importantly, mortality at 30 days and one year post procedure. The researchers hypothesized that there would be no difference between the on-pump and off-pump surgeries in the case of mortality. This is the largest, controlled, single-blind, randomized trial conducted thus far in the United States comparing on-pump and off-pump CABG surgeries (Shroyer et al., 2009). Total sample size was 2203 subjects. At the end of the six year trial, the researchers did not find any general benefit to the use of off-pump in comparison to on-pump CABG surgery (Shroyer, et al., 2009).

On-pump surgery was the gold standard for many years. However, many studies show no significant statistical difference between on-pump and off-pump surgery in relation to mortality. Perhaps on-pump should continue to be the standard treatment, but off-pump should be considered when contraindications arise (Moller, Penninga, Wetterslev, Steinbruchel & Gluud, 2012).

Additionally, some studies have shown that off-pump surgery may be related to poor graft patency and revascularization when compared to on-pump surgery thus leading to increased mortality in the long-run (Wu, et al., 2011). Wu, et al. (2011), also noted that the long-term survival following on-pump or off-pump surgery had not been thoroughly studied past the five year period post procedure. Again, it was mentioned that further studies should be conducted. The purpose of this paper is to present the evidence available for off-pump and on-pump CABG surgery and the associated mortality associated with each technique.

The PICOT question asked for the purposes of this paper is: In patients receiving coronary artery bypass graft surgery (P), how does on-pump surgery (I) compared to off-pump surgery (C), affect mortality (O)?

Shroyer, et. al., (2009) presents the ROOBY trial, a controlled, single-blind, randomized study. The 2203 subjects were randomly assigned for either on-pump or off-pump CABG surgery. The primary short-term end point was a combination of death or complications before discharge or within 30 days after surgery. The primary long-term end point was a combination of death from any cause, a repeat revascularization procedure or nonfatal myocardial infarction within one year after surgery. This trial showed no significant difference in the early outcome of death or complications. This trial also showed one year outcomes, completeness of revascularization, and graft patencies were significantly worse with off-pump than with on-pump. Interestingly, mortality rates between the groups were not statistically significant.

Moller, Penninga, Wetterslev, Steinbruchel & Gluud (2012), brought forth a systematic review from the Cochrane Library. Eighty-six trials (10,716 subjects) were included. Ten trials (4,950 subjects) were considered to be at low risk of bias. Combined analysis of all trials showed that off-pump CABG increased all cause mortality when compared to on-pump CABG (3.7% versus 3.1%). This systematic review did not demonstrate any significant benefit of off-pump compared to on-pump CABG regarding mortality, stroke or myocardial infarction. The study observed better long-term survival in the on-pump CABG group. However, off-pump CABG may be acceptable when contraindications exist for cannulation of the aorta and cardiopulmonary bypass. Further randomized clinical trials should focus on the most favorable treatment option in these patients.

Wu, et al., (2011) investigated through meta-analysis, the 7-year survival difference between off-pump and on-pump CABG surgery patients. The New York State Cardiac Surgery Reporting System was used to identify the 8580 patients. The National Death Index was also used to obtain patients' vital statistics. The researchers had previously studied the differences in mortality at the 3-year post surgery mark but it is unknown whether the relative survival of the two different surgical techniques during longer-term follow-up would be the same as previously observed. This study found that there is no statistically significant difference in 7-year mortality between the two types of CABG surgeries. Shroyer, et. al., (2009) with the ROOBY trial also showed no statistically significant difference in mortality between the procedures at 1-year follow-up.

Pawlaczyk, Swietlik, Lango & Rogowski, (2012) looked at the older population in regards to on-pump and off-pump mortality. A meta-analysis of all published observational studies comparing results of on-pump and off-pump surgery in patients 80 years and older was performed. Fourteen studies were analyzed with 4991 total subjects. The rates of mortality were significantly higher in the on-pump CABG group. The results showed that off-pump CABG surgery may be an option and may optimize the outcomes in senior patients. Taking the Cochrane analysis into consideration, the older population may be the group with contraindications to aortic cannulation and cardiopulmonary bypass.

Feng, Shi, Zhao & Xu, (2008) performed a meta-analysis comparing on-pump and off-pump CABG in ten randomized trials (2018 subjects). These researchers found that off-pump surgery did not reduce 1-year mortality when compared to on-pump. This study found the rates of mortality, stroke, myocardial infarction or revascularization did not differ in either group. Wu, et al., (2011) had the same findings with the only difference being a 7-year survival versus 1-year as in this study.

In answering the PICOT question posed for this paper: In patients receiving coronary artery bypass graft surgery (P), how does on-pump surgery (I) compared to off-pump surgery (C), affect mortality (O)? The answer, based on the studies reviewed, is there does not seem to be a difference in the mortality rates between the two procedures. One must take into consideration other factors that these studies looked into that are present in patients receiving these surgeries. Factors such as: advanced age (80 years and older), graft patency at one year and longer, completeness of revascularization, rates of stroke, myocardial infarction, renal failure, et cetera. When looking at mortality alone, with none of these other factors, the studies agree that there is no statistically significant difference between the procedures. Of course, further randomized control trials are needed to compare the two procedures on different populations of patients.

In this author's current practice, both methods are utilized. An examination of the evidence will help the author to better educate patients on the two techniques available to them and what factors may influence their choice. If a patient is of advanced age, greater than 80 years old or has extensive known aortic calcification, the off-pump technique may present better results. For other populations of patients, the on-pump procedure may give them better long term results when looking at all factors, not just mortality. The global percentage of surgeons performing off-pump CABG surgery is estimated at 20% indicating that many hospitals are able to offer both techniques. A change that may happen is that patients may find that they will need to travel in order to receive the off-pump procedure if it is not available at the hospital of their choice. This will obviously cause a rise in travel cost and perhaps insurance cost to the patient and their family in order to receive the procedure they choose. This may cause a moral and financial dilemma for the patient when choosing which technique may better suit them.

The available studies indicate there is no statistical significance in the mortality rates of on-pump versus off-pump CABG surgery. However, when one is presented with the reality that they need CABG surgery, more factors must be looked at when choosing a technique. It is not a decision to enter into lightly. One must be properly educated and presented all the facts before making a life altering decision. Nurses play a key role in educating the patient and their family on all existing options. The studies used for this paper are only a sample of the research that is available to the public for review. Of course, one must have the means to understand and interpret the data as well as be able to obtain it from a reputable source. Nurses are the eyes, ears, and voice for their patients. This is why nurses must be up to date on their specialty and current research.

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PATIENTS / FAMILIES / COMMUNITIES

Post-Discharge Telephone Calls to Improve Patient Satisfaction

Rowena Ripa, RN, MSN, PCCN and Kathleen Polimeni, RN, MSN, PCCN

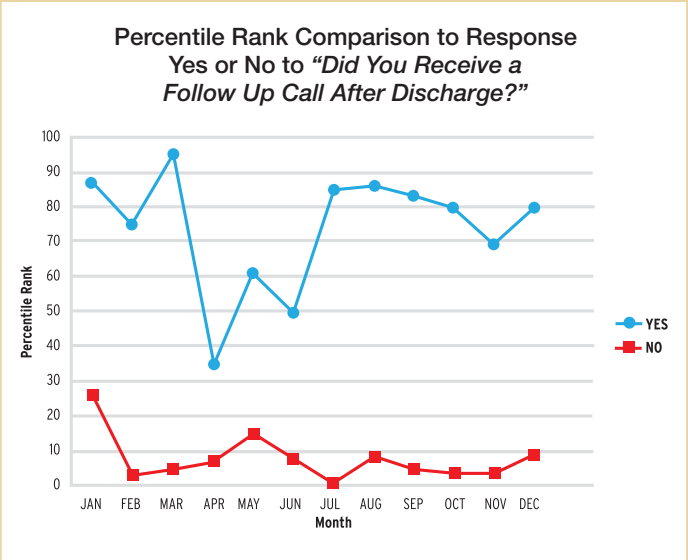
Patient satisfaction is an important indicator of quality of care and healthcare facilities are interested in maintaining high levels of satisfaction in order to stay competitive in the healthcare market (D'Amore, Murray, Powers & Johnson, 2011). With Medicare's new value based purchasing (VBP) set to begin impacting payments to most acute care hospitals in October 2012, payment is being rewarded by quality of care and how patients rate the care and experience received while in the hospital. Nursing care has a prominent role in patient satisfaction and it is essential that nurses continue to find ways to measure and improve patient satisfaction (Wagner & Bear, 2009).

A New Approach

One way to proactively address this issue is to implement a practice of routinely checking back with patients who have been discharged to ensure their recovery is on track, potentially boosting quality and improving customer service. Some patients are unlikely to initiate calls themselves when they have questions after discharge, emphasizing the need for hospital personnel to initiate contact (Cochran, Blair, Wissinger & Nuss, 2012). Experts maintain that not only does this type of follow up enable a healthcare institution to intervene for potential clinical issues but patients also perceive the call as a heightened level of caring and appreciate someone checking to see how they are doing (Gus, Leland & Castillo, 2012).This type of follow up also allows an opportunity for service recovery, as clinical quality goes hand in hand with service excellence. While a short telephone conversation might be viewed as a minor clinical intervention, this activity coordinates care during the transition from the hospital setting. Patients who receive a telephone call are more likely to be compliant with their discharge instructions. These patients are also more likely to rate their experience and patient satisfaction higher than those who do not receive a call. For maximum value, experts recommend a call back within 1-4 days of discharge (With patient satisfaction under increasing scrutiny, consider patient callbacks, 2011).

Figure 1 depicts data collected from Cooper University Hospital for the year 2012 indicating that patients who received a post discharge phone call gave a higher percentile rank for patient satisfaction.

FIGURE 1 2012 Post Discharge Calls



Post Discharge Program

In September 2010, Cooper University Hospital (CUH) in conjunction with the Patient Family Centered Care Department initiated a Registered Nurse (Post Discharge Coordinator) led post-discharge telephone call program to facilitate telephone contact with patients after discharge to review discharge instructions, evaluate understanding of instructions and evaluate the patient's hospital experience.

Initially, a script was created through evidence based research, input from outpatient areas already calling patients post procedure and Press Ganey the vendor used at CUH to obtain patient satisfaction data. Next, a report was created which populates a patient discharge list. Then, a database was created for documentation, trend analysis, follow-up and measurable goal directed initiatives.

The information collected through the database demonstrated a need to address clinical issues and questions and

concerns by escalation and distribution to the appropriate parties. One of the clinical issues noted was the need to assist patients with their follow up appointments. The course of action taken to facilitate these appointments included assistance from the CUH's Call Center. The Post Discharge Coordinator RN is able to directly notify the call center and supply the needed pertinent patient information. The call center then contacts the patient within 24 hours to schedule the appointment.

Other clinical issues identified were patient questions regarding home care, medications and prescriptions. Home care issues are resolved by the Post Discharge Coordinator RN by contacting and collaborating with either the home care agency or home care registered nurse. Medication questions are usually answered immediately during the post discharge call. If unable to address the medication question, the Post Discharge Coordinator RN will contact the appropriate physician office or nurse practitioner to obtain the answer. This process is also used for prescription issues. Closed loop communication is used and patients are always given an explanation of the resolutions or plan of action. All these services assist an already stressed patient from having to worry and wait for answers.

If a patient offers complaints, compliments and suggestions for improvements the Post Discharge Coordinator will document these findings in I-Sight. The I-Sight tracking tool used by CUH logs patient complaints and compliments and notifies the involved department. This provides opportunities to celebrate compliments and investigate complaints.

Nursing Units Involved in the Program

Presently, all patients discharged to home from the adult inpatient units, North/South 10, North/South 9, North/South 8, North 7, Pavilion 6, Pavilion 7 and the recent addition of the Mother/Infant units, receive a post-discharge telephone call. In July 2012, the direct telephone number of the Post Discharge

Coordinator was added to the electronic health record discharge form. This permits any patient discharged from Cooper, including outpatient areas and procedural areas, the opportunity to call the Post-Discharge Coordinator RN with questions and/or concerns.

Post-discharge telephone calls are a systematic way to manage patients over the continuum of care and improve patient experiences. The calls provide opportunities, insight, confirmation of strengths and areas for growth and improvement. This nurse-driven strategy functions to develop excellence in nursing care, better patient outcomes and higher patient satisfaction.

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CARE DELIVERY

Memory Boxes: An Effective Intervention to Improve End-of-Life Care in the ICU at Cooper University Hospital

Colleen Agostini, RN, CCRN-CSC-CMC

Nurses are a vital part of the hospital experience for patients and their families. They are teachers, healers and many times a source of comfort for sick patients and their families. Nurses also help patients and families to cope with life-altering illnesses that sometimes lead to death. Few professions intimately affect peoples' lives in the same way that nursing does. There are occasions in life that are so significant that people tend to always remember how they felt and how they were affected when it happened. The death of a loved one is often one of those times that people never forget who was there, their last moments with that person and what other people around them did to help them "get through" that moment. Nurses greatly impact patients and families going through this experience.

Nursing the Dying

As a caring profession, nurses tend to have an inherent desire to help others. End-of-life care can be very distressing for nurses who want to emotionally support families but don't know what to say or do. It is essential for nurses to have education and skills to help support patients and families going through the experience of death. When a patient is dying and a family is grieving, nurses can offer kind words and encourage the family to be with their loved one. But sometimes kind words and encouragement may not feel like enough. Nurses have to find other creative ways to support families. One way to help families cope and nurses to feel comfortable in the care they provide is to focus on the positive aspects of a person's life while they are dying.

The Intensive Care Unit (ICU) is a place where nurses often care for dying patients and grieving families. Statistics reveal that 10 to 20 percent of patients admitted to ICUs will die. While that doesn't sound like a large number, it is rather significant when one considers 1 or 2 people die for every 10 people admitted to the ICU. Nurses in the ICU often feel powerless in these situations,

Nurses have to find other creative ways to support families. One way to help families cope and nurses to feel comfortable in the care they provide is to focus on the positive aspects of a person's life while they are dying.

feeling that they may have failed to facilitate a peaceful death for their patients and provide adequate emotional support for the families. It is a difficult situation for everyone involved.

Comforting the Grieving

One solution was to search nursing literature for ideas other organizations had successfully implemented. The ICU Memory Box was inspired by an article obtained from the journal Critical Care Nurse 2010. The article discusses how end-of-life care can be "unsettling for both patients' families and staff" and focuses on the implementation of interventions to support both families and nurses through the end-of-life care experience. The nurses in this article developed an envelope that contained items for the nurses and families to assist with end of life care. While trying to recreate the envelope filled with family support tools, the author found a photo box and knew that would be a nice alternative, a Memory Box.

caption

A sample memory box was presented to the CUH ICU Unit Based Council in 2010. After an overwhelming positive response from all the members, the decision was to move forward and make the Memory Box a reality in the unit. There were a couple of barriers identified with implementing the boxes. Funding was the most significant issue. Sue Gould, Associate Clinical Director of the ICU, helped to facilitate the acquisition of a $1500 Cooper Cares Grant. This grant was a one-time monetary award for a cause which improves patient care at Cooper Hospital. In 2011, Mary Jo Cimino, ICU Clinical Director, received approval to integrate the cost of the supplies into the unit budget for subsequent years. Another challenge for developing the boxes was the time needed to obtain the supplies and to assemble them. There are several supplies purchased from different places, making it very time consuming to collect them all. Essentially, at this time, the supplies are covered by the unit budget and the boxes are put together voluntarily by one of the ICU nurses. Recently, a local church volunteer is helping assemble the boxes, which has proven to be a great help.

The Memory Box

The ICU Memory Box is a beautifully decorated box, approximately the size of a shoe box. A checklist included with the box offers ideas to enhance the end-of-life care process. It reminds the nurse to offer comforting measures such as a coffee tray from the Food and Nutrition Department, boxes of tissues, and perhaps a call to pastoral care if the family wants spiritual support. Inside the box there is a hairbrush and lotion which can be used by the family to comfort the patient if they choose. Nurses can facilitate a peaceful and pleasant environment by placing a scented envelope under the patient's pillow which works wonderfully with dimmed lighting and sounds from the relaxation TV channel in the room.

There are also items in the box that the nurse can offer to the family after the patient passes so they can take memories with them. There is a decorative paper, usually with a sunset on a beach, or the sky with a subtle rainbow in the background, that has the "Footprints Prayer" printed onto it. The patient's hand print can be traced onto the paper for the family to take home and keep forever. A small stringed purse can hold a lock of the patient's hair. A small butterfly wind chime and a candle marked "with caring thoughts from the Cooper ICU Staff" are also in the box. Finally, there is a sympathy card, which the nurse removes before

Memory Box Contents

- Decorative box
- Tissue paper
- Scented envelope
- Purse-string sachet (for lock of hair)
- Printed prayer for handprint
- Wind chime
- Lotion
- Brush
- Candle
- Sympathy card

The Memory Box has created special connections between the patient and the family, and the family and the nurse. There are no words needed to understand the expression of sympathy or the level of support that exists when the nurse gives the Memory Box to their patient's families.

presenting the box to the family. This card can be signed by the nurses, doctors, and techs involved in the patient's care and mailed to the family a few days later.

Implementation of the Memory Box

When the ICU first started using the Memory Boxes, there were questionnaires for the nurses to provide feedback. It was important to know if families who received the boxes had a more positive experience and if the nurses offering the boxes felt more satisfied in their ability to provide emotionally supportive care. The comments related to the Memory Boxes were largely positive. Most often, families were profoundly grateful to have the boxes as they were leaving with a very personal remembrance of their loved one. The box is also useful as the family can place personal items such as the patient's eyeglasses or rosary beads in the box to keep everything together. Nurses most often commented that they too felt better about their provision of care and support. By offering the Memory Box, nurses were better able to comfort families at a time when words are often inadequate. It has helped nurses and families to improve the final moments that families spend with their loved ones.

The Memory Box has created special connections between the patient and the family, and the family and the nurse. There are no words needed to understand the expression of sympathy or the level of support that exists when the nurse gives the Memory Box to their patient's families. Sometimes, this is exactly what is needed to help patients, families, and nurses through grieving and the end-of-life process.

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CARE DELIVERY / EBP

Pediatric Pain Management

Michael Lin Pizzuto RN BSN CPN

As healthcare providers to the youngest population, nurses strive to prevent and control pain. One of nursing's goals is to focus on minimizing pain for their patients. Infants and children are exposed to a myriad of potentially painful procedures including intravenous (IV) therapy and blood draws while they are hospitalized. Procedures are painful and can be anxiety provoking, leading to fear and distrust of the healthcare team. Studies have shown that pain in young children can have lifelong psychological effects, and memories of pain can lead to delayed medical care for people in their later years (Weisman, Berstein & Shechter, 1998). Nurses play a critical role in reducing or alleviating pain and gaining the trust of infants and children during hospitalization. Implementing a multi-disciplinary approach to pain relief is one method to ensure that unnecessary pain does not occur.

Pediatric Pain Management Committee

Cooper University Hospital's inpatient pediatric unit and pediatric intensive care unit set a goal to minimize pain for their patients. A multidisciplinary Pain Management Advisory Committee formed and agreed to work collaboratively on the following three areas:

1. Implementing use of pharmacological products such as LMX4, ethyl chloride topical numbing spray and TootSweet 24% sucrose solution
2. Positioning children for comfort during procedures
3. Including Child Life specialists during procedures

The committee set the goal that pediatric patients would be offered and administered pharmacological and non-pharmacological pain management for invasive procedures (IV starts, blood draws, LPs, etc.) performed by the multidisciplinary staff (nurses, phlebotomists and physicians).

Review of Literature

The Pain Management Advisory Committee members conducted a literature search on methods of controlling pain in children during procedures. One study reported significantly fewer infants crying who received swaddling, side position, shushing, swinging, and sucking when receiving an immunization (Harrington, Logan, Harwell, Gardner, Swingle, McGuire & Santos, 2012). Gibbins and Stevens (2001) concluded that giving infants a pacifier dipped in a sugar water solution helped distract and decrease distress in infants. Non-nutritive sucking helps infants cope with pain (Gibbins & Stevens, 2001). Baxter, Leong and Matthews (2009) stated that a device that produces vibration also can decrease pain perception by stimulating temperature and nerve endings so that the child's brain focuses on more than just the pain of the injury. As described in the studies, evidence supports using multiple modalities of pain control measures and non-pharmacological and pharmacological products to minimize pain in children.

Educating the Multidisciplinary Staff

Next, the committee decided that education was the first step toward reaching its' goal. The pediatric clinical educator provided education that included discussing available products, using Child Life services for procedures and documenting the products used and patient outcomes. Nurses and physicians received education through in-services provided by the Pain Management Advisory Committee.

Data was collected on the percentage of patients who were offered and/or accepted comfort measures for painful procedures. The data included: type of procedure, pharmacological measure used, positioning and participants. The percentages of patients

who received pharmacological interventions prior to procedures vs. those who did not were compared monthly and shared with staff to continue to improve the provision of comfort measures.

Implementation of Pain Control Measures

The nurses on the committee identified barriers to the use of pharmacological interventions: including the lack of knowledge of proper use, availability, and convenience of medication. The inpatient pediatric nurses suggested that guidelines for the different products be laminated and kept at the nurses' station for ease of reference. The staff identified difficulty in finding products such as Ethyl Chloride on the pediatric units so nurses put it in the treatment rooms to increase its use during procedures. The clinical educator created a reference for direct-care nurses on its use. The nursing staff also recommended stocking TootSweet on the phlebotomy cart to promote its use for blood draws, including heel sticks, for infants four months old and under.

It's only natural for children to have misconceptions and apprehensions when exposed to the medical setting. Many children cry as soon as they see a "white coat" enter their room, which makes it extremely difficult to treat them. Nurses can account for terrified children in their own experiences as well. Some children cling to their mothers for dear life, while others throw tantrums in their beds. It is important to manage their expectations so their fears can be put to rest (Madhok, 2011). At a committee meeting it was suggested to promote the increased use of the pediatric treatment room for painful procedures such as phlebotomies. The committee decided to actively promote this practice, particularly with toddlers through early school-aged children.

Used with permission

The committee continued to work to improve care, investigating other non-pharmacological pain relief products. The Child Life Director presented a new product called the Buzzy. This device can relieve procedural pain in children ages four and over, which is a group of patients that had presented pain control challenges. A Buzzy is a bee-shaped vibrating box with a unique ice pack. It desensitizes the body's own nerves, thereby dulling or eliminating sharp injection pain. The combination of cold and vibration decreases venipuncture pain significantly more than a vapocoolant spray (Baxter, Choen, McElvery, Lawson & Von Baeyer, 2011).

Buzzy Pain Relief System

After education, implementation and data collection, the pediatric clinical educator along with the committee developed a written pediatric pain policy. The committee's goal became the policy's purpose statement. This policy outlines the best evidence based nursing practices for pediatric pain management which includes:

1. Assessing pain using validated pain scales such as FLACC, Faces and 0-10
2. Outlining interventions for pain relief, including information on the products LMX4, TootSweet and ethyl chloride spray
3. Assuring patient and family education

The committee re-named itself the No Pain Campaign Committee and decided to ramp up efforts to reduce pediatric pain. The committee selected pain as a performance improvement project with a short-term goal of 80 percent and long-term goal of 100 percent. The multidisciplinary staff complete tally sheets to evaluate compliance with pain relief measures. Ten months after the committee began work, pharmaceutical use for procedural pain relief increased to 86%, a dramatic increase from 56% at the committee's inception, indicating a positive trend.

Expansion to Other Units

Committee membership expanded to include other areas serving pediatric patients. Representatives from the Pediatric Emergency Department, Post Anesthesia Care Unit, Outpatient Pediatrics and the Neonatal Intensive Care Unit (NICU) were invited to attend committee meetings. The NICU saw significant changes with the implementation of non-pharmacologic interventions. NICU nurses began using TootSweet and developmentally appropriate methods of pain control, including quiet, snuggling, positioning and clustering of care. The NICU also began educating parents about pain control, using the words "pain" and "no pain" more frequently and developing a pain brochure.

Outcome

It is an expectation that comfort measures be provided to all pediatric patients. Nurses believe in introducing and explaining a procedure to a child before it is performed whenever possible. As a child interacts in the medical setting and with the equipment, experiences become less frightening. Anxiety and pain are often tied together, but through education and play both can be reduced (Madhok, Scribner-O'Pray & Teele, 2011). Nurses and residents can also rely on the resources of Child Life specialists to provide the non-pharmacological modalities. Child Life specialists are experts in child development. They offer emotional support to patients and families and promote optimum development of children.

The result of new knowledge translated into nursing practice was an upward trend in patient satisfaction survey results. The committee met the goal to minimize painful procedures for their patients and saw an increase in patient satisfaction with pain control. Pediatric nurses and physicians not only have the responsibility to provide the best care possible to their youngest patients, but to reduce their fears and anxieties at the same time. Nurses can accomplish the goal to reduce painful procedures by utilizing a multi-disciplinary approach to pain management.

Email comments to **pizzuto-michael@cooperhealth.edu**

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RESEARCH / EBP

Effectiveness of Faculty Mentoring in Retention of African American Nursing Students: An Action Research Study

Dianne Hyman MSN, RN, Cooper Cancer Institute

Significance: African American nurses are severely underrepresented in the nursing profession. By the year 2050, at current growth rates, nearly half of the U.S. population will be minorities. In the 2008, National Sample Survey of Registered Nurses, minority nurses accounted for only 16.8 percent of registered nurses. Of those minority registered nurses, 5.4% were African American (Devita & Pollard, 1996). Diversity in the nursing workforce needs to reflect the diversity of the population. Strategies to retain and matriculate minority nurses should be a priority for nursing institutions.

Purpose: The purpose of this study was to improve learning outcomes and the retention of minority nursing students by implementing faculty mentors to serve this at risk student population. Secondary study purposes included identifying barriers contributing to poor retention rates, providing workshops and programs to improve skill sets to aid in the retention of the students while fostering a mentorship relationship.

Method: The study investigators established the Educate, Support and Retention Project (ESR) to implement the goals of this study. An open ended questionnaire determined minority student needs and interest in a faculty mentorship program. Nursing students included nine African American nursing students from Associate Degree and Baccalaureate Programs.

Results: Content analysis of the questionnaires revealed that the nursing students identified motivation and support, organizational skills, time management and enhanced study skills as the top four areas of need. In addition, formulating a mentor/mentee relationship with the faculty was supportive of the minority nursing student. Each of the nursing students mentored during the course of this study completed the school year.

Conclusion/Implications for Education: Minority nurses have numerous barriers that contribute to retention in nursing school. Nursing academia has an obligation to improve learning outcomes, retention and matriculation of minority nurses. Nursing academia should consider instituting programs such as the ESR Project in nursing curricula and implement faculty as mentors to enhance the diversity of the nursing profession.

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

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Professional News *(continued from page 16)*

Kramer, N. (2012). [Abstract]. Examination of parents of children who have had hypoxic-ischemic encephalopathy at birth: A mixed methods study. Proceedings from the 24th Annual Scientific Sessions of the Eastern Nursing Research Society: From Cell to Society: The Intersection of Nursing Research Practice and Policy.

Parone, D., Stauss, M. Reed, C., Sherman, B., Smith, L., Johnson, R., Milcarek, B., Hunter, K. (2013). A comparative study of two nebulizers in the emergency department. JEN, Article in Press

Suokhrie, L., Reed, C.-R., Emory, C., White, R., Moriarity, C., Mayberry, J. (2013). Differences in automated blood pressure measurement in hospitalized psychiatric patients. Journal of Psychosocial Nursing & Mental Health Services, 51(3), 32-37.

PROFESSIONAL ACCOMPLISHMENTS:

Dianne Charsha, RN, MSN, NEABC was reappointed to the Board of Directors for the Organization of Nurse Executives, New Jersey.

Janice Delgiorno, MSN, CCRN, ACNP-BC, Stacey Staman, RN, MSN, CCRN and **Mary Stauss, RN, MSN, APN, CEN** are contributing authors for the 2013 ATCN textbook.

Karen Gruber, RN, BSN, CEN was appointed to the ONE NJ Advocacy Committee

Correinne McKenna, RN, MSN was inducted into the Sigma Theta Tau International Honor Society of Nursing.

Barbara Sproge, MSN, RN, OCN, CHPN is the President of the South Jersey Chapter of the Oncology Nursing Society. She is also a peer reviewer for the Journal of Palliative Medicine.

Mary Stauss, RN, MSN, APN, CEN received the 2013 NJENA Advanced practice award at the 35th Annual Emergency Nursing Conference in Atlantic City, NJ.

Mary Stauss, RN, MSN, APN, CEN was appointed to the Emergency Nurses Association Clinical Practice Guidelines Committee

Malikah Taylor, RN, BSN received the Outstanding Senior award from the Rowan University College of Science & Mathematics at the Dean's Senior Recognition Ceremony on May 3, 2013.

PATIENTS / FAMILIES / COMMUNITIES

REFLECTIONS

Building a Academic-Community Global Partnership to Address Health and Wellness Needs of the Haitian Population

Sharon Byrne, DrNP, APN, NP-C, AOCNP, CNE

As stated by the Institute of Medicine in "America's Vital Interest in Global Health" (2012, p.1), "the failure to engage in the fight to anticipate, prevent, and ameliorate global health problems would diminish America's stature in the realm of health and jeopardize our own health, economy, and national security". In order to address that challenge on a small scale and address global health problems that move across national borders, a weeklong medical mission occurred in June 2012. Four Family Nurse Practitioner (FNP) students and two Faculty Preceptors, all Explorers Sans Frontiers (ESF) volunteers, had the opportunity to diagnose and develop a treatment plan in a resource limited environment, and educate the Haitian community regarding chronic and acute health issues. The team compatibility, skills, dynamics, and culture made for an amazing experience.

As an Advanced Practice Nurse in the Department of Medicine, Division of Hematology/Oncology, Cooper University Hospital, I coordinated this effort related to my role as an Assistant Clinical Professor and Director of the FNP Program, Drexel University College of Nursing and Health Professions. The team was able to successfully support the health education and medical care needs of over 650 persons by setting up clinics in four different sites in Haiti including two tent cities in Port-Au-Prince, the Haitian American Caucus in Croix Des Bouquete and the rural mountain area of Petite Gouve. Partnering organizations in Haiti included Life is Good, the Haitian American Caucus (HAC) and Amanda Marga Universal Relief Team (AMURT).

Based upon the evaluation of the ESF leadership team and that of Drexel University faculty and students, this mission was an educational, life altering and spiritual experience for both the US based team and those in the Haitian community. Through the eyes of the patients, the team contributed to the holistic primary care needs and lives of people who live in poverty on a daily basis. They lack access to medication, food, water, nutrition and preventative healthcare services. The patients in these communities often present in an acute state for illnesses that in comparison to western countries is chronic and often maintained with traditional medicine. The Haitian community is very resilient, strong willed and spiritual but their hope that life will get better does not appear in congruence with the country's infrastructure at this time.

Overall, the mobile clinic days proceeded smoothly. Diseases and infections treated included disorders ranging from Essential Hypertension, Hypertensive Crisis, Uncontrolled Type 1 and Type 2 Diabetes, Diabetic Ketoacidosis (DKA), Depression, Anxiety, Anemia, Gastrointestinal Reflux Disease, Pelvic Inflammatory Disease, Typhoid Fever, Chronic Pain, Vaginal and Sexually Transmitted infections, Urinary Tract Infection, Allergic Rhinitis, Intestinal Parasites, Tinea Capitis and Malnutrition. The team made every attempt to provide education, recommend non-pharmacological alternatives and support for Therapeutic Lifestyle Changes, (TLC).

caption

A number of patients were seen and referred to established local health clinics in the surrounding community and three were provided with transportation and funds through ESF for immediate acute care needs. Evenings for the mission team concluded with a debriefing and a mindfulness exercise led by ESF Director of Mental Health and Wellness. In addition, the team relaxed while listening to the guitar playing and vocals of two of the Haitian based ESF team Translators.

The aim of ESF which is "to build cultural connections one person and one community at a time through health and wellness" was sustained throughout the medical mission. Personally, working directly with this organization, I have been to Haiti more than 15 times, allowing me to be immersed within a very unique culture, live within the community served, be challenged in a resource limited environment and serve as an advanced practice nurse within the global health model. Because of my work at Cooper University Hospital with the underserved community of Camden City and the surrounding area through the Cancer Screening Project in the Division of Hematology/Oncology over the past 5 years, I had dreamed of going on a more extensive medical mission, I felt honored to share my first encounter abroad with my peers and students on the Drexel-ESF team and those patients served in the Haitian community. "The experience changed my life and hopefully we changed their lives for the better". Plans are under way to continue this joint venture on an annual basis with missions planned in March and June of 2013.

Email comments to **byrne-sharon@cooperhealth.edu**

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Professional News

AWARDS:

2013 CUH Nursing Award Recipients

The UC/CADV Award for Excellence in Cardiovascular Nursing Practice: **Margaret Salerno, RN, BA**

The Selma & Martin Hirsch Clinical Excellence Award (Staff): **Jennifer Toomey, RN**

Cooper Nursing Alumni Clinical Nurse Excellence Award in Memory of Emily Watkins: **Deborah Byrd, RN**

Carol Tracy Compassion Award: **Coreen Mitchell**

The Ruth Parry Memorial Award for Excellence in Geriatric Nursing Practice: **Lisa Durso, RN**

John Henry Kronenberger Memorial Award for Neonatal Nursing Practice: **Dale Beloff, RNC**

The Philip & Carole Norcross Award for Excellence in Nurse Leadership: **Kathleen Yhlen, RN, MSN, NE-BC**

The Barbara & Jack Tarditi Family Award for Nurse Mentorship: **Lynette Jones, RN, BC, BSN**

The Barbara & Jack Tarditi Family Excellence Award for Nurse Research: **Dominic Parone, RN, BSN, CEN, CFRN**

The Sue Zamitis and Rose Smith Award for Excellence in Oncology Nursing Practice: **Patricia Kerfoot, RN**

The Women's Board Award for Excellence in Outpatient Nursing Practice: **Leslie Ditullio, RN**

Ronald Bernardin Memorial Award for Pediatric Nursing Practice: **Amanda Glass, RN, BSN**

The Philip and Carole Norcross Award for Excellence in Perioperative Nursing Practice: **Teresa Wolf, RN**

The Lynn Nelson Memorial Award of Excellence: **Donna Schultice, RN, CEN**

Excellence in Trauma Nursing Practice: **Doris Bell, RN-BC**

The Barbara & Jack Tarditi Award for Excellence in Patient Care (Non-nurse): **Lauran Fernandez**

Excellence in Critical Care Nursing: **Suzanne Butler, RN, BSN, CPBN, CCRN**

Charlotte E. Tobiason Memorial Award for Excellence in Obstetrical Nursing Practice: **Susan Lieberum, RNC, IBCLC**

Shaina Horton Patient Centered Care Award: **Linda Sullivan, RN, BA**

Nurse of the Year: **Suzanne Butler, RN, BSN, CPN, CCRN**

March of Dimes Pediatric Nurse of the Year **Suzanne Butler, RN, BSN, CPN, CCRN**

DEGREES:

Comfort Ahwin, RN, BSN graduated from Grand Canyon University with her BSN.

Deneen Clemons, BS, BSN received her BSN from Thomas Edison State College.

Sandra Crosson, RN, BS, received her BSN from Immaculata University.

Lisa Golger, RN, BSN received her BSN from Thomas Edison State College.

Colette Irving, RN, BSN received her BSN from Grand Canyon University.

Fatmata Kamara, RN, BSN received her BSN from Rutgers University.

Amanda Levy, RN, BSN, received her BSN degree from Wilmington University.

Eugene L. McEady, RN, BSN, CCRN-CMC received her BSN from Grand Canyon University.

Correinne McKenna, RN, MSN received her MSN from Walden University.

Christina Marcano, RN-BC, BSN is graduating from Drexel University with her BSN.

Jenny Ramos, RN, BSN received her BSN from Grand Canyon University.

Lori Schemeley, RN, BSN received her BSN from Grand Canyon University.

Malikah Taylor, RN, BSN received her BSN from Rowan University.

Maryann Tilliger, RN, MSN, CASC, CPAN received concurrent BSN and MSN from the University of Delaware.

Janet Tridente, RN, MSN, CCRN received her MSN degree from Neumann University.

Cathy "Kate" Wood, RN-BC, BSN, MSN, ACNP-BC received her MSN and Acute Care Nurse Practitioner Degree from Thomas Jefferson University.

CERTIFICATIONS:

Natalie Boland, RN, CEN passed the Emergency Nursing certification exam.

Nancy DuBois, DNP, RN, CRNI, NE-BC passed the ACCN Nurse Executive Certification exam

Joseph A. Hutchins, RN, BSN, CEN, CPEN passed the Pediatric Emergency Nursing certification exam.

Wendy Kunkle, RN, MSN, CEN, CPEN passed the Pediatric Emergency Nursing certification exam.

Eugene L. McEady, RN, BSN, CCRN-CMC passed the Cardiac Medicine Certification (CMC) exam.

Christine Miller, RN, BC passed the Medical Surgical certification exam.

Stephen Onufer, RN, CEN passed the Emergency Nursing certification exam.

David Snelling, RN, BSN, CEN passed the Emergency Nursing certification exam.

Cathy "Kate" Wood, RN-BC, BSN, MSN, ACNP-BC passed the Acute Care Nurse Practitioner Exam

PRESENTATIONS:

Janice Delgiorno, MSN, CCRN, ACNP-BC and **Elizabeth Lee, RN** Clinical Practice Manager in the Cooper Neurological Institute presented "Time is Brain, Case studies in Traumatic Brain Injury" at TRENDS in King of Prussia, PA.

Janice Delgiorno, MSN, CCRN, ACNP-BC presented "Thoracic Trauma" at TRENDS in King of Prussia, Pa.

Janice Delgiorno, MSN, CCRN, ACNP-BC presented 5 lectures at the American College of Nurse Practitioners Conference in Toronto, Canada.

Janice Delgiorno, MSN, CCRN, ACNP-BC presented 3 lectures at the Oregon Health Sciences University Annual Trauma Conference in Portland Oregon.

Kramer, N. (2012). Examination of parents of children who have had hypoxic-ischemic encephalopathy: a mixed methods study. Poster Presentation at Eastern Nursing Research Society Annual Meeting March 2012: From Cell to Society: The Intersection of Nursing Research, Practice and Policy.

Mary Stauss, RN, MSN, APN, CEN presented "Case Studies in Pediatric Trauma" at New Jersey Emergency Nurses Association 2013 Emergency Care Conference, March 15, 2013, Atlantic City, NJ

Mary Stauss, RN, MSN, APN, CEN presented "Hemodynamic Monitoring in the ED: A-lines & CVPs" at New Jersey Emergency Nurses Association 2013 Emergency Care Conference, March 14, 2013, Atlantic City, NJ

PUBLICATIONS:

Gregg, K., Houck, N., Irwin, R., Kramer, N., Stayer, D., Kattan, M., Wills, J., Zoucha, R., & **Turk, M.** [in press]. Fieldwork as a way of knowing: An Italian immersion experience. Online Journal of Cultural Competence in Nursing and Healthcare.

Baumann, B.,M., Patterson, R.,A,, Parone D., A., Jones, M., K., Glaspey, L., J., Thompson, N., M,. Stauss, M., P., Haroz, R. (2013), Use and efficacy of nebulized naloxone in patients with suspected opioid intoxication. Am J Emerg Med, 31(3), 585-8.

(continued on page 14)