Cooper University Hospital

Aster Awards Excellence In Medical Marketing 2010

Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/ SUMMER 2012 ▪ VOLUME 6, ISSUE 1

The Flight Environment

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Professional Calendar

UPCOMING ANNUAL CONFERENCES:

- **Clinical Connections: Emergency and Trauma Care**
  September 11, 2012
  7:30 am to 2:45 pm
  Crowne Plaza Cherry Hill, NJ
- **Annual Medical-Surgical and Oncology**
  November 1, 2012
  7:45 am to 3:45 pm
  Crowne Plaza Cherry Hill, NJ
- **Achieving Excellence through Evidence: Apply Research and Evidence**
  December 3, 2012
  Crowne Plaza Cherry Hill, NJ

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Cooper University Hospital

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

Cooper adopted the Planetree philosophy that guides our Cooper staff in personalizing, humanizing and demystifying care for patients and their families. In addition, it serves as a framework for the interdisciplinary and collaborative approach we should share with each other. As we reenergize the focus around core values and have recently defined our service expectations, we establish who we are as a unified team of healthcare providers.

In March 2011, over 400 nurses voted on the final draft of the Cooper University Hospital's Nursing Professional Practice Model (PPM). This model was developed by our direct care nurses around the Planetree® philosophy which reflects a commitment to patient and family-centered care. A nursing professional practice model provides a framework for how nurses practice, collaborate, communicate and develop professionally to provide safe high quality patient care.

As with Planetree®, Cooper's unique schematic model depicts a tree. This tree is made up of individuals, all shapes and sizes, that are interconnected. The roots are the foundation and represent nursing's values, professional relationships and shared governance structure. The trunk depicts the care delivery model which has a strong foundation in our patient and family-centered care approach. Our patients, families, and community are the branches and leaves of the tree.

This edition of *Bridges* will look slightly different from past editions. The pillars of service excellence (seen in the upper corners of each page), which were used to identify the article's content to a specific pillar, will be replaced by the PPM tree. Each article will now identify which part of the PPM it relates to. For example the "Transforming Care at the Bedside" article relates to the trunk of the tree in the PPM because it describes how nurses have the autonomy to make decisions at the unit level to improve the care delivery system in an effort to improve the patient experience and outcome.

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

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Cooper Bridges Mission Statement:

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

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

CARE DELIVERY

Cooper University Hospital's Nursing Professional Practice Model

Kathleen Yhlen, RN, MSN, NE-BC

Cooper's Professional Practice Model (PPM) is the conceptual framework for nurses, nursing care and interdisciplinary care. It depicts how nurses practice, collaborate, communicate and develop professionally to provide the highest quality patient care. Cooper's PPM illustrates the alignment and integration of nursing practice with the mission, vision, philosophy and values that nursing has adopted. The five components of Cooper's model include:

- Organizational values
- Professional relationships
- Management approach
- Rewards
- Care delivery model

Cooper's PPM was developed by direct care nurses and was finalized in March 2011 after over 400 nurses voted on the final draft. It was developed around the organization's adoption of the Planetree philosophy, which reflects a commitment to patient and family-centered nursing care. The Planetree philosophy guides Cooper staff in personalizing, humanizing and demystifying patients' and families' experiences, and it guides nurses in their interactions with colleagues.

Cooper's unique schematic model of a tree depicts a nursing practice that is living in the organization. Each part of the tree represents an essential component of nursing practice. All parts are connected, showing that each part relies on the others. The roots are the foundation, and these represent nursing's values, professional relationships and management approach. Nursing practice is grounded in Cooper's organizational values, which provide a roadmap for caring for patients, families and each other. Cooper's core values include:

- Excellence in patient and family-centered care
- Ownership
- Integrity
- Innovation
- Teamwork
- Respect

Nurses exemplify these values in their partnerships with all disciplines in the delivery of patient care. Through their professional relationships, nurses collaborate with all team members to achieve the best possible patient outcomes. The shared governance model provides the structure and processes that enable nurses to integrate these values and professional relationships into their practice. This model drives the operational, professional, education and research processes for nursing practice. Originally implemented in 1983, the revised (2010) shared governance model includes the following councils:

- CORE (Coordination, Outcomes, Recognition, Empowerment)
- Unit-Based Leadership
- Nursing Research
- Professional Recognition
- Nursing Quality and Patient Safety
- Advanced Practice Nurses
- Patient Care Informatics
- Nursing Practice

The trunk of the tree represents nursing's commitment to the Planetree care delivery model and rewards, which is Cooper's overarching care delivery model.

Nurses, together with all members of the healthcare team, strive to provide exceptional care and service to every patient, every day, in a patient-centered and family-focused environment. To fulfill its commitment to this care delivery model, Cooper rewards nurses with a professional ladder and tuition reimbursement for professional education. It also provides continuing education and funding for nurses to become certified in their areas of practice and participate in professional organizations. These rewards contribute to a culture of inquiry, excellence and quality nursing care.

The branches and leaves of the tree represent Cooper's patients, families and community. Patients and families come to Cooper when they are most vulnerable and experiencing pain, discomfort and anxiety. The healthcare team's goal is to personalize, humanize and demystify the care patients receive to achieve a healthier community.

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Transforming Care at the Bedside Through Innovation

Christina Hunter, RN-BC, OCN and Jennifer Kubat, RN, BSN

Transforming Care at the Bedside (TCAB) is a national program developed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement to implement changes that improve patient care on medical-surgical units and improve staff satisfaction. Cooper University Hospital Patient Services Department successfully applied for a TCAB grant for North/South 9 from the Robert Wood Johnson Foundation in September 2009. This is a three year commitment which includes development of a team dedicated to frequent meetings, information gathering and innovative ideas. The goals of the program are to improve the quality and safety of patient care, increase the retention of medical/surgical nurses, and improve the patient care experience and the overall effectiveness of the entire care team.

TCAB is not a traditional quality improvement program. The focus is on engaging frontline staff and unit managers of medical/surgical units.

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The ninth floor TCAB team is now entering the third year of this program, with staff nurses Jennifer

The goals of our program are to improve the quality and safety of patient care, increase the retention of medical/surgical nurses, and improve the patient care experience and the overall effectiveness of the entire care team.

Kubat RN, BSN, Stephanie Jennings RN, and Danielle Ballak RN leading the team. The group has hosted several "deep dives" and "snorkel" exercises which get the entire care team together to generate new ideas and strategies to improve patient care and the work environment. These exercises allow the entire team to fully engage in brainstorming new ways to improve quality.

After issues and ideas were identified and evaluated, the team strived to implement the easiest changes first. These initial changes helped to improve work flow and efficiency. The first projects N/S9 identified were:

- Clean up and re-organization of the unit
- Acquire a unit par level of 6 Flowtron machines
- Change the process for filling water pitchers to 6 a.m. and 6 p.m.
- Change the process for signing out chemotherapy to promote efficiency
- Provide a menu box on the unit to eliminate menus getting lost

Once the direct care nurses on the unit were able to see the first few successes that came from their suggestions, the team moved on to other opportunities to improve the patient care experience. For example, the "Keep in Touch" binder has been a favorite among the team. This binder is located at the nurses' station. Inside are note cards, sympathy cards and other greeting cards which the staff are encouraged to send to patients and their families. In the binder is also a log of card recipients so the staff will know if a sympathy card or a thinking of you note has been sent to the patient and or their family. On an oncology unit, the staff really bonds with the patients and their families due to the long and frequent hospitalizations that occur. This binder provides another way that our staff can reach out to help support our patients and their families.

The next project that was initiated was the "Closet of H.O.P.E.," which stands for "Helping Our Patients Endure." A storage closet on the unit was designated to keep a supply of toiletry items such as lip balm, soft tissues, shaving cream and hair barrettes to help keep patients comfortable. Additional items provide diversion during a long hospital stay and include: playing cards, puzzle books, DVDs, CDs, DVD/CD players and much more. A bake sale hosted by the ninth floor staff originally funded the closet. Staff members have embraced the idea of this project as evidenced by the fact that they purchase items to keep the closet stocked.

Other projects that were initiated and adopted by the TCAB team include:

- Placing the RN's name & phone number on the dry erase boards in the patient's room.
- Purchasing of foam liners for water pitchers to eliminate water accumulation from the sweating water pitcher.
- Providing a welcome letter for new admissions that includes important information regarding the unit and the patient's hospitalization.

The TCAB process has helped the 9th floor team identify areas on the unit that are in need of change, analyze ideas, develop innovative solutions, implement and evaluate changes.

- Giving each patient a patient information folder to use for patient education, the welcome letter, discharge instructions and the business cards of physicians and other healthcare providers.
- Establishing a unit quiet time. This is one hour during day shift that the lights are dimmed and the nurses have the opportunity to catch up on documentation in EPIC. During that time, the call bells are answered by the Nurse Associates and phone calls are triaged through the Unit Secretary.

One project the team decided to abandon was a role identification badge project that we did this past summer. Prior to creating and distributing a role identification tag, we surveyed patients and families asking two questions.

1. How do you identify your nurse and other members of the healthcare team?

2. Does this cause confusion in your care?

The summary of the responses indicated the patients and families felt they knew who the nurse and nurse associate were because their names were on the dry erase board in the room. We found the confusion was with identifying the physicians.

After the survey, the team distributed the identification tags that clearly stated the employee's title. We included the oncology physicians whose name tags reflected whether their role: attending, fellow or resident. After several weeks of wearing the tags, we re-surveyed the patients and families with the same two questions. The results were the same as the pre-survey: the patients knew who their nurses and nurse associates were, but had difficulty identifying physicians who were consulted and their actual title as far as student, resident, or attending. We decided to abandon this project since the name tags did not change the patient and family perception.

Through TCAB, nurses are empowered to share in decisions and the creation of an environment where the multidisciplinary team serves to improve patient family centered care.

The next project the team is working on is the reduction of red bag waste. The nurses have witnessed inappropriate waste by having red bag trash cans in the patient rooms. Staff find items like gloves, disposable gowns, newspapers and wrappers in the red trash can. The nurses want to implement using individual small red bags that will be stored in a mounted container on the wall. A red bag will be taken from the container when it is needed for biohazardous waste. The used bag will then be placed in the soiled utility room in the red bag trash can. So far the team has weighed their existing red bag trash waste and is ready to move forward with educating staff and implementing the pilot. After several weeks of having the new bags in place, the red bag trash will be weighed to determine if waste is in fact reduced.

The team will be completing their third year of TCAB in November 2012 and now are a subcommittee of our Unit Based Council. The TCAB process has helped the 9th floor team identify areas on the unit that are in need of change, analyze ideas, develop innovative solutions, implement and evaluate changes. When the three year commitment to the project is over, the direct care nurses are planning to continue to use TCAB methods to continue to improve their unit. Through TCAB, nurses are empowered to share in decisions and the creation of an environment where the multidisciplinary team serves to improve patient family centered care.

Email comments to **hunter-christina@cooperhealth.edu**

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CARE DELIVERY

Treating Morbid Obesity: *Is Bariatric Surgery Right for My Patient?*

Dawn Stepnowski, DNP, APN-C, CBN

Obesity is an epidemic that causes 400,000 deaths annually in the United States (CDC, 2010). It is a modifiable risk factor that is reported as the second highest cause of death, second only to smoking. As of 2010, the Centers for Disease Control and Prevention report obesity rates of 21-34% *(Figure 1)* in all 50 states (CDC, 2011), an increase of approximately 10% in every state since 2001 *(Figure 2)*. As the data shows, the epidemic is worsening. Only one in seven obese individuals will reach the USA life expectancy of 76.9 years (Buchwald, 2005).

As of 2010, the Centers for Disease Control and Prevention report obesity rates of 21-34% in all 50 states, an increase of approximately 10% in every state since 2001.

Overweight and obesity are classified according to body mass index (BMI). BMI is a calculation of height and weight [weight (kilograms)/height^2 (meters^2)]. Normal body weight for height has a BMI in the 18.5 to 24.9 range. Overweight is referenced with a BMI of 30-34.9. Obesity begins with a BMI of 35.0 and is defined as extreme or morbid obesity with a BMI of 40 or greater. A BMI of 40 equals 100 lbs of excess weight.

Is Bariatric Surgery Right for My Patient?

To answer this question appropriately, one needs to understand the basic qualifications for bariatric surgery. Individuals seeking bariatric surgery must meet certain BMI criteria: 35-39.9 with one obesity related comorbidity or greater than or equal to 40 for most bariatric procedures, or new criteria of 30-34.9 with one obesity related comorbidity for LapBand only. All individuals considering bariatric surgery must demonstrate a history of failed non-surgical weight loss, with many insurance companies requiring specific medically supervised documentation of the aforementioned attempted weight loss. All individuals are subject to a behavioral assessment which includes psychiatry or psychology and nutrition.

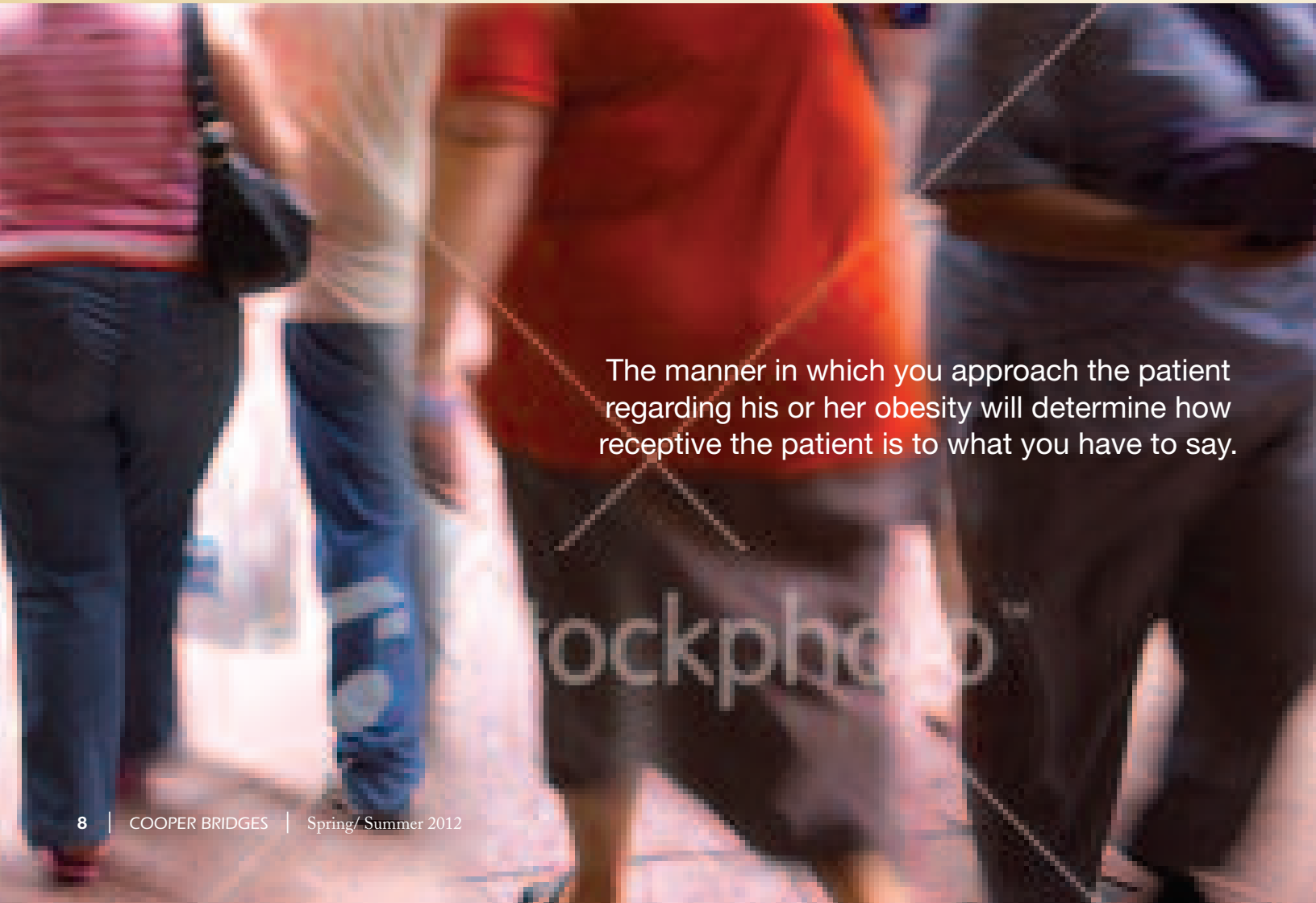


Figure 1: Obesity Rates 2010

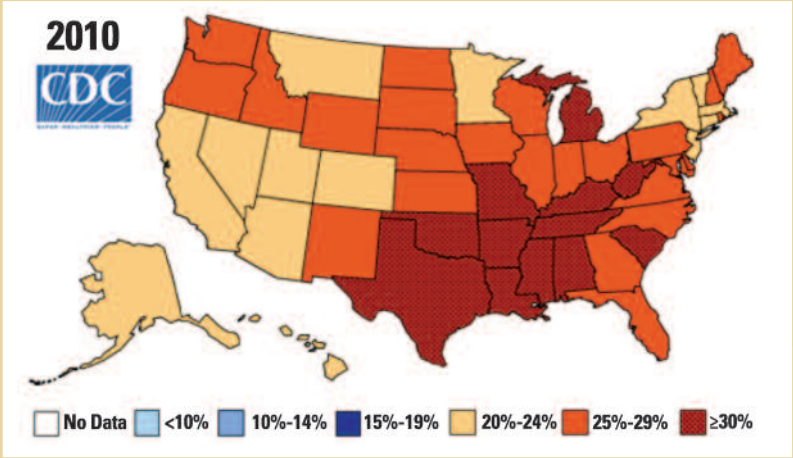
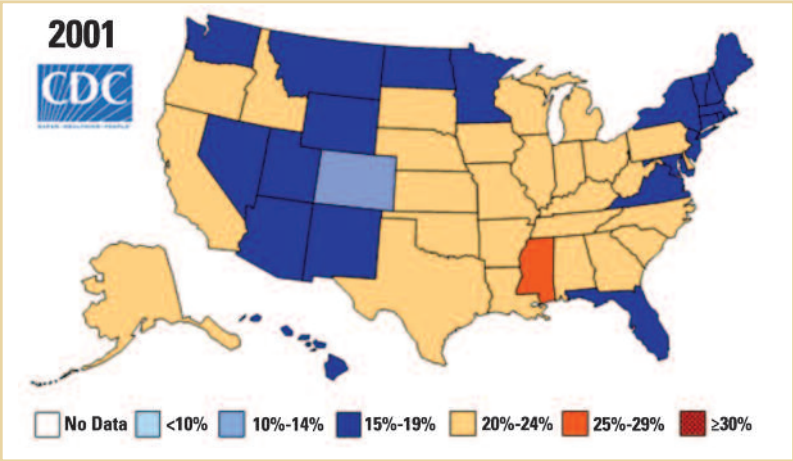


Figure 2: Obesity Rates 2001



Obesity is an epidemic that causes 400,000 deaths annually in the United States. It is a modifiable risk factor that is reported as the second highest cause of death, second only to smoking.

Bariatric surgery candidates should be educated on the various surgical options and required lifestyle changes, for which the candidate must demonstrate understanding. Individuals must be evaluated by a bariatric surgeon and determined a good surgical candidate, considering surgical history, medical evaluation and the full behavioral assessment.

Another aspect to consider is whether the risk of not intervening with bariatric surgery is greater to the individual's overall health and quality of life than the risk of having a bariatric procedure. BMIs greater than 35 are associated with obesity related medical conditions such as diabetes, hypertension, sleep apnea, hyperlipidemia, GERD, nonalcoholic steatohepatitis and osteoarthritis (MacDonald, 2002). Sowemimo et al (2006) demonstrated an 82% reduction in mortality of patients who had undergone bariatric surgery compared to those patients who did not have surgery. Bariatric surgery has demonstrated low rates of morbidity and mortality associated with it compared to mortality risk associated with untreated obesity (NIH, 1997).

Another aspect to consider is whether the risk of not intervening with bariatric surgery is greater to the individual's overall health and quality of life than the risk of having a bariatric procedure.

Once risk is assessed, the task becomes distinguishing which bariatric procedure is right for the individual. Bariatric surgery offers either restriction or a combination of both restriction and malabsorption. The two most common restrictive operations are the adjustable gastric band *(Figure 3)* and the gastric sleeve *(Figure 4)*. The most commonly performed combination procedure (restriction and malabsorption) is the roux-en-Y gastric bypass *(Figure 5)*.

What Factors Determine which Operation is the Best Choice?

There are many factors that contribute to an individual's obesity. Generally, excess calorie consumption and decreased mobility or exercise top the list. There are presently only 2 drugs approved for long-term treatment of overweight patients, and their effectiveness is limited (Bray, 2011). For an individual's success with long term weight loss for medical or surgical weight loss, it is imperative that lifestyle changes be made which include healthy dietary modifications and exercise. For dietary changes to be most effective with bariatric surgery, the choice of surgery type is important. Understanding what the individual's food preferences are before surgery can help alter the cycle of poor behaviors; it can also help the patient choose the appropriate surgical procedure.

Remember that adjustable gastric banding and sleeve gastrectomy are only restrictive operations. The new anatomy will help to achieve fullness with a smaller portion of solid food. If poor choices of high calorie liquid foods (milkshakes, candy, alcohol) are made routinely, the individual will not lose weight or might even gain weight despite having bariatric surgery. Alternately, combination procedures such as the gastric bypass can deter this type of poor eating behavior. Gastric bypass alters the absorption of high calorie sugary foods which makes it difficult for most patients to tolerate them without experiencing abdominal pain, nausea or diarrhea [dumping syndrome].

Gastric bypass and sleeve gastrectomy show some increased benefit for patients who have diabetes and other metabolic disorders due to the metabolic effects of the operations. Recent studies have shown that serum leptin levels decreased, adiponectin increased and insulin sensitivity improved following

Figure 3: Adjustable LapBand

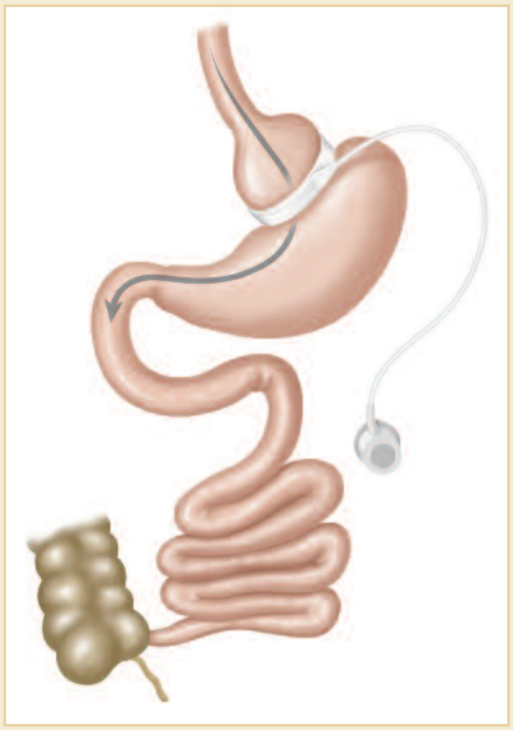
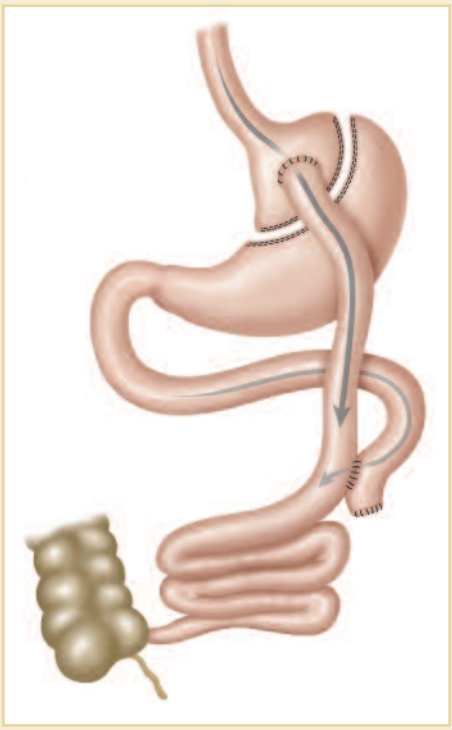


Figure 4: Vertical Sleeve Gastrectomy

Figure 5: Roux-en-Y Gastric Bypass



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both gastric bypass and sleeve gastrectomy (Woelnerhanssen et al, 2011; Madan et al, 2006). Gastric bypass is the operation of choice in individuals who have gastroesophageal reflux disease and Barrett's esophagus since it greatly diminishes the acid exposure to the lower esophagus (Houghton et al, 2008). There are some medical diagnoses that may eliminate a type of surgery as a choice for patients. A consult with a bariatric surgeon will determine which options are available to your patient (Kuruba, Koche & Murr, 2007).

Results of Surgery

The average long-term weight loss (at 10 years) from all bariatric operations is 47.5–68.2% excess weight (Angrisani, Lorenzo, & Borrelli, 2007; Buchwald et al, 2004)). Quality of life scales indicate improvement to the overall quality of life for obese individuals following bariatric surgery (Sargwer, Wadden & Fabricatore, 2005). Bariatric surgery is currently the most effective therapy available for morbid obesity and can result in improvement or complete resolution of obesity related comorbidities (Buchwald, 2005).

Health Consequences of Overweight and Obesity
Hypertension
Dyslipidemia
Type 2 Diabetes
Coronary Heart Disease
Stroke
Gallbladder disease
Osteoarthritis
Sleep apnea and respiratory problems
Some Cancers (endometrial, breast and colon)

Educating Obese Patients About Their Medical Condition

A discussion with your patient about his/her obesity can be a daunting task. By not addressing your patient's obesity, you send mixed messages to your patient about the need to address weight as it relates to actual or impending illness (Anderson & Wadden, 2004). However, opening the discussion of weight loss with your patient can save your patient's life. Decreasing overweight and obesity decreases obesity related comorbidities and improves quality of life (Galuska et al, 1999; Stafford et at, 2000; Simkin-Silverman et al, 2005). Having a basic understanding of available options for both medical and surgical weight loss, offering a handout materials as an initial primer for discussion, and facilitating a follow up discussion can be more to the point and just may be life saving. The manner in which you approach the patient regarding his or her obesity will determine how receptive the patient is to what you have to say. Keep the information simple. Offer basic information about obesity and link the information to other health problems, if appropriate. Offer suggestions to obtain additional help regarding obesity. And most importantly, be sensitive and non-judgmental. Obesity is a chronic disease, just like diabetes or hypertension, which needs a formal disease management plan to affect significant change.

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CARE DELIVERY

The Flight Environment

Joe Saloma, MA, RN, CEN, PHRN

"Air 2, on-scene request, Bridgeton, Cumberland County, LZ (landing zone) is Bridgeton Hospital," with that, the flight team is mobilized. Within a few minutes, the crew is at the landing zone and preparing for the patient. Questions go thru their minds, is it a medical or trauma patient? How sick is the patient? What will need to be done for the patient? Finally, the ambulance with the patient and the paramedics arrives. Simultaneously, the flight crew obtains the patient history, assesses the patient, and prepares the patient for the flight. The patient, an older gentleman, is having his seventh myocardial infarction (MI). Within 10 minutes, the patient is loaded into the helicopter and they are on their way to Cooper University Hospital. While in the air, the patient is continuously cared for, including medications, vital signs and subsequent electrocardiograms. The patient is met on the roof by the cardiac catheterization and emergency room teams, and is taken directly to the cath lab for treatment of his MI.

Air medical transportation has become the standard for rapid transfer of critically ill patients, whether it is a victim of a motor vehicle collision taken from the scene of an accident or a patient being transferred from a hospital to a tertiary care hospital. How did the use of helicopters become a vital resource for the most

Air medical transportation has become the standard for rapid transfer of critically ill patients, whether it is a victim of a motor vehicle collision taken from the scene of an accident or a patient being transferred from a hospital to a tertiary care hospital.

The helicopter can be thought of as trauma resuscitation bay and intensive care unit, all in one.

critical of patients? The answer can be found in military history. In 1917, the French were the first to use an airplane to transport injured soldiers. The use of airplanes for the transportation of casualties rapidly increased during World War II. The United States military was the first to use dedicated airplanes for medical evacuation of injured soldiers. The early flight teams consisted of a physician, or flight surgeon, up to six flight nurses and six technicians. In 1944, the use of the first rotor wing (helicopter) aircraft was by the US military in Burma. The air medical evacuation program was further developed and had significant influence on morbidity and mortality rates during the Korean and Vietnam Wars. Patients were flown from battle zones to mobile hospitals and hospital ships off shore.

The use of civilian helicopters for emergency medical services started in 1966 with the Highway Safety Act. Initially, the helicopters belonged to the military and the medical crew were doctors and nurses from local hospitals. As the Emergency Medical System (EMS) developed the composition of the air medical crew shifted from only hospital staff to a combination of pre-hospital and hospital staff. Currently, the most common configuration for the air medical crew is a flight nurse and flight paramedic. However, an air medical crew could be composed of nurses, paramedics, physicians, or respiratory therapists. The typical requirements needed to be a flight nurse include: a minimum of 3-5 years of emergency, trauma, or critical care experience (typically most nurses have more than ten years of experience), EMS experience as an EMT, paramedic, or pre-hospital nurse, and certifications in Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support, Pre-hospital Trauma Life Support, and Advanced Trauma Life Support. The experience needed to be a flight medic includes 3-5 years of paramedic experience in a busy 911 system, and the certifications listed above. Most flight paramedics also have more than ten years of experience.

Traditionally, the flight paramedic was responsible for treating the patients from "scene" calls, while the flight nurse was responsible for the inter-facility critical care patients. Currently, the roles are interspersed and responsibilities are shared for all patients. The air medical crew exemplifies the word "team." The types of patients that are treated in the flight environment include all types of 911 patients (from acute strokes and MIs to all types of trauma), critically ill ICU patients (most commonly cardiac, neurological, burn, pulmonary), high risk OB, pediatric and neonatal patients. Continuing education and clinical training are necessary for the team to maintain clinical proficiency.

The helicopter can be thought of as trauma resuscitation bay and intensive care unit, all in one. Standard equipment includes a ventilator, critical care medications, infusion pumps, a cardiac monitor capable of transducing invasive lines, and advanced airway equipment. The environment that the air medical crew works in is usually stressful and chaotic.

The patient mentioned at the beginning of this article made a memorable impression on the flight team that day. When the patient was asked if he was ever in a helicopter, he simply answered "yes." During the flight, the patient elaborated that his life was saved twice by air medical teams. He was a Vietnam veteran who was injured twice, once during the Tet Offensive and once at the Battle of Hamburger Hill, hence, his two helicopter rides. The team found out from talking to the patient that he was the recipient of numerous Purple Hearts and a Bronze Star (for heroism). What made this patient so memorable was his humble gratitude towards the team for "saving his life, again." Ironically, the team felt that they should be thanking him.

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RESEARCH / EBP

A Comparative Study of Two Nebulizers in the Emergency Department: Breath Actuated Nebulizer (BAN) and Hand Held Nebulizer (HHN)

Dominic Parone, RN, BSN, CEN, CFRN; Mary Stauss, RN, MSN, APN, CEN; Beth Sherman, RN, BSN, CEN; Rebecca Johnson, RN, BSN, CEN; Linda Smith, RN; Carole-Rae Reed Ph.D., RN, APN, BC; Barry Milcarek, PhD; Krystal Hunter, MBA.

Background: The Breath Actuated Nebulizer (BAN) and the Hand Held Nebulizer (HHN) are two nebulizers used in the Emergency Department(ED) of Cooper University Hospital. The purpose of this study was to compare the nebulizers to identify which device resulted in a resolution of symptoms with fewer treatments. The primary hypothesis was that adult ED patients with a chief complaint of wheezing and dyspnea who were given nebulized treatments via the BAN would require less nebulizer treatments than those patients given nebulized treatments via HHN. In addition, the secondary purposes of the study was to determine if the BAN would have significantly higher peak expiratory flow measurements, lower Modified Borg Score, overall decreased respiratory rate and lower heart rates compared to subjects receiving nebulized treatments via HHN.

Methods: A single site, prospective, randomized, comparative design study was conducted in the ED between March 2010 and February 2011. Fifty four subjects presenting with dyspnea and wheezing and an Emergency Severity Index of 3 or 4 were enrolled and randomly assigned to one of two groups (BAN or HHN). Subjects were administered one to three nebulizer treatments (#1 Ipratropium bromide and Albuterol Sulfate, #2 Ipratropium Bromide and Albuterol Sulfate, #3 Albuterol Sulfate), which was consistent with the Emergency Department Advanced Nursing Guideline for wheezing. Nebulizer treatments were discontinued if patient's dyspnea or wheezing resolved. IRB approval was obtained prior to study commencement.

Results: There was no significant difference found between the HHN and BAN in respect to number of treatments, respiratory rate, peak flow measurements and Modified Borg scores in the 54 subjects. There was a difference of seven points in pulse rate between the pre and post second BAN treatment (n=51, p=0.01). Subjects in the BAN group who completed all three treatments (n=18) had a total treatment time that was on average of ten minutes longer than those in the HHN group.

Conclusions: This study demonstrated no clinical difference between the BAN and HHN in terms of respiratory rate, peak flow, perception of dyspnea and number of treatments. It is possible that the longer treatment times account for the elevated pulse rate. The data suggests that the higher cost and the longer treatment time associated with the BAN do not justify the continued use of the BAN in this setting. The discontinuation of the BAN in our emergency department generated an average cost savings of $4,400.00 annually. We recommend that these devices be tested with a larger sample size to further test the differences between these two devices.

PATIENTS / FAMILIES

REFLECTIONS

Striving For '5'

At Cooper Digestive Health Institute

Karen Mitchell, RN and Christine Wadehn, RN

Cooper Digestive Health Institute has been open for four years, during which time the staff have focused on improving patient satisfaction. Our goal is to be a Press Ganey Summit award winner for patient satisfaction. Reward recipients are distinguished by their dedication to excellence in both quality of care and patient satisfaction. Summit Award winners must first achieve and then maintain patient satisfaction at the 95th percentile or greater. Reaching this pinnacle is impressive. Staying there, even more so.

When we began this journey, our patient satisfaction scores were in the 87th percentile. We conducted a literature search, evaluated the available evidence and created our "Summit Symposium." This committee is composed of representatives from every area of our facility: Patient Care Representatives, direct care RNs, nursing leadership, GI Technicians, physicians and CRNAs. Sub-committees were developed to work on particular issues identified through patient feedback.

The first subcommittee focused on keeping family and patients informed throughout their visit at Cooper Digestive Health Institute. A "Rounding" plan was developed to address this need. A patient liaison makes rounds in pre-op and post-op every half hour and is responsible for informing patients and families of delays, providing updates on the patient's progress and answering any patient and family questions. This innovation has led to very positive feedback from patients and families.

Our second subcommittee focused on our goal to improve our Press Ganey scores from 87% to 95% or greater Press Ganey scores are rated on a one to five scale with five being the highest score obtainable for patient satisfaction. We developed a logo "Strive for 5" to advertise our goal. In addition, we created a thank you letter from our nurse manager that includes a statement about the possibility of a follow up phone call or letter from Press Ganey asking the patient to evaluate their experience at Cooper Digestive Health Institute. The letter includes our "Strive for 5" logo as well as our nurse manager's phone number providing an avenue for the patient to voice any concerns regarding their experience during their visit at Cooper Digestive Health Institute. The patient receives the thank you letter upon discharge. This endeavor has also been well received.

A third subcommittee was created to address the need for nourishment for waiting family members as we do not have any vendors on the premises. A coffee cart was developed after reviewing NJ state regulations. The Patient Service Representatives monitors and restocks the cart as needed throughout the day. This has been a big hit!

Cooper Digestive Health Institute Staff

Our latest subcommittee focused on ways to make our patients and families feel more confident in our care and a more personal bond with the Cooper Digestive Health Institute staff. A "Brag Board" was born. The Brag Board focuses on our staff accomplishments, achievements and certifications. This board is located in the waiting room and is changed on a monthly basis. This has proven to be a great morale booster for both patients and staff.

The subcommittees of the Summit Symposium meet monthly to re-evaluate, reinforce and gather new ideas and information for further improvements in patient satisfaction. At last look our Press Ganey scores have reached the 95th percentile. The changes we have instituted have proven to be effective and we are working hard as we "Strive for 5".

Email comments to **mitchell-karen@cooperhealth.edu**
or **wadehn-christine@cooperhealth.edu**

"The most splendid achievement of all is the constant striving to surpass yourself and to be worthy of your own approval."

Cooper
University Hospital

c/o The Cooper Health System
3 Executive Campus, Suite 240-B
Cherry Hill, New Jersey 08002

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Health System

Professional News

CERTIFICATIONS:

Congratulations to our Air Two Flight Nurses (**Rick Rohrbach, RN, CFRN, Ray Bennett, RN, CFRN, Joseph Bone, RN, CFRN, Tracy Iglesias, RN CFRN, Dominic Parone, RN, CFRN, Bill Rice, RN, CFRN, David Salati, RN, CFRN, Joseph Saloma, RN, CFRN, Steven Teitelman, RN, CFRN!**) All 9 have obtained Flight Nurse Certification.

Donna Conrey, RN, CEN, certified in Emergency Nursing

DEGREES:

Merlin Mammen, RN, MSN
Western Governor's University

APPOINTMENTS:

Mary Stauss, RN, MSN, APN, CEN, has been appointed to the ENA Clinical Practice Committee

Gretchen Lawhon, RN, PhD, was inducted as a Fellow into the America Academy of Nursing.

PUBLISHED:

"Anticoagulation Management in the Ambulatory Surgical Setting" AORN Journal, April 2012.
Diana Hill Eisenstein, MSN, RN, FNP-BC, CNOR

AWARDS:

Don Everly, RN-BC, MSN, MBA, NEA-BC, CNML, CEN, CPEN, CPN, CCRN-CMC, CCNS, CNS-BC, ONC
2011 NJ Emergency Nurses Association Trauma Award

CUH Annual Nursing Awards

The UC/CADV Award for Excellence in Cardiovascular Nursing Practice: **Anthony Curcio, RN, BSN**

The Selma & Martin Hirsch Clinical Excellence Award (Staff): **Susan Breslin, RN**

Cooper Nursing Alumni Clinical Nurse Excellence Award: **Rebecca Johnson, RN, BSN, CEN**

Carol Tracy Compassion Award: **Norma Rowello, RN-BC**

The Ruth Parry Memorial Award for Excellence in Geriatric Nursing Practice: **Ann Audio, RN, CCRN**

John Henry Kronenberger Memorial Award for Neonatal Nursing Practice: **Diane Wachter, RNC, BSN**

The Philip & Carole Norcross Award for Excellence in Nurse Leadership: **Jeanne Greer, RN, CGRN**

The Barbara & Jack Tarditi Family Award for Nurse Mentorship: **Cynthia Garretson, RN, BSN**

The Barbara & Jack Tarditi Family Excellence Award for Nurse Research: **Deborah Schoch, RN, MSN**

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

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

Ronald Bernardin Memorial Award for Pediatric Nursing Practice: **Michelle Doyle, RN, BSN, CPN**

The Philip and Carole Norcross Award for Excellence in Perioperative Nursing Practice: **Jenifer Stanger, RN, BSN**

The Lynn Nelson Memorial Award of Excellence: **Linda Smith, RN**

Excellence in Trauma Nursing Practice: **Donna Hartzell, RN-BC, BSN**

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

Excellence in Critical Care Nursing: **Adisa Kljuco, RN, BSN**

Nurse of the Year: **Rebecca Johnson, RN, BSN, CEN**

PRESENTATIONS:

Dominic Parone, RN, BSN, CEN, CFRN; Carole-Rae Reed, PhD, RN; Beth Sherman, RN, BSN; Linda Smith, RN; Rebecca Johnson RN, BSN, CEN; Mary Stauss, RN, MSN, APN, CEN; Barry Milcarek, PhD; Krystal Hunter, MBA, (2012). A Comparative Study of Two Nebulizers in the Emergency Department: Breath Actuated Nebulizer (BAN) and Hand Held Nebulizer (HHN). [POSTER]. NJENA Emergency Care Conference, Atlantic City, NJ, March 2012.

Jonelle O'Shea, RN-BC, MSN; Phyllis DiCristo, RN-BC, OCN, BSN; Norma Rowello, RN-BC; Christina Hunter, RN-BC, OCN, BSN; Ana Denton, RN-BC, OCN, BSN; Carole-Rae Reed, RN, PhD, APRN Comparison of different thermometers for temperature measurement in oncology patients [POSTER]. 2012 CUH Research Week

Janette McFetridge, MSN, RN; Colleen Agostini, RN, CCRN; Lisa Brooks, BSN, RN-BC; Lynda Brooks, RN; Kimberly Browne, LSW; Mary-Jo Cimino, BSN, RN, CCRN; Christie Clarke, RN; Shara Cox, BSN, RN; Kathy Coyle, RN; Desiree Easterwood, BSN, RN; Karen Fluehr-Heinkel, BSN, RN; Robin Gardner, RN; Suzanne Gould, RN, MHA,CCRN; Lisa MacAdams, RN; Adisa Kljuco, BSN, RN; Donna Louis, RN; Rosemarie Maitland, BSN, RN, CCRN; Ebony Marinnie, RN; Jean Minder, BSN, RN; Carole-Rae Reed, PhD, RN, APN, BC; Meggan Zarrella, BSN, RN The effect of a multi-disciplinary education program on documentation compliance of an ICU Patient/Family Communication "bundle" related to end-of-life care. [POSTER]. 2012 CUH Research Week

Linda Webb, RN, BSN, MSN, CPAN; Claire B. Forys, RN, MSN, CPAN; Christine Albano, RN, CCRN; Nancy Ballistreri, RN; Jennifer Stanger, RN, BSN; Carole-Rae Reed, PhD, RN, APRN; Barry Milcarek, PhD; Krystal Hunter. MBA Controlling PACU patients' pain: PCA pump with basal rate vs. no basal rate [POSTER]. 2012 CUH Research Week