Cooper University Health Care

Cooper Bridges

A publication for nurses and healthcare professionals

SPRING/SUMMER 2014 ▪ VOLUME 8, ISSUE 1

Patient-Controlled Analgesia in the Post Anesthesia Care Unit

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Cooper
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From the Chief Nursing Officer

Stephanie Conners, MBA, RN, BSN, NEA-BC
Senior Vice President of Hospital Operations & Chief Nursing Office
Patient Care Services

Cooper Nurses and Collaborative Teams,

As we enter into 2014, we work in shared purpose to create an environment that truly reflects our mission To Serve, To Heal and To Educate. Together, we enhance teamwork and quality practice to make patient care at Cooper unmatched. As we struggle with significant fluctuations in volumes, you continue to work resiliently to ensure that the exceptional care that Cooper is known for continues seamlessly. With that said, we commit to recruiting and hiring top talent in an effort to meet optimal staffing levels. Your traditional warm welcome embraces the spirit of "One Team. One Purpose."

Looking ahead, our commitment to Safety, Service and Quality will be an enhanced focus in 2014. Our commitment to providing high quality patient care in conjunction with higher levels of role satisfaction is a top priority, but we need your help. Leading the advancement of clinical excellence starts with you and your voice. We encourage continued participation in shared governance and welcome ideas for positive change to enrich our care and satisfaction of our invaluable teams. I look forward to the exciting ideas coming from our front-line care providers and the customers we serve.

It is important to recognize that in a rapidly growing health care environment, our team is pivotal in the process of driving change. Your clinical judgment is valued and supported to help us progress into tangible practice. Your impact is significant. The Cooper team generates enthusiasm and establishes caring relationships within the hospital. As such, front line care providers at Cooper should be collaborative and creative in developing new ways to enhance care.

This will be an exciting year. In the coming weeks you will begin to hear about the activities planned for greater employee engagement. You will also learn more about an employee advisory committee. Please plan to participate – your voice matters! You can influence new and even greater enhancement for patient care at Cooper.

As your new leader, I look forward to continuing to support the nurses and collaborative teams. I encourage an environment of innovative learning and strong relationships that will provide opportunities to advance clinical practice. Your compassion, commitment and efforts are noticed, and I sincerely thank you for all that you do!

Remember, One Team, One Purpose.

Stephanie D. Conners

Email comments to **conners-stephanie@cooperhealth.edu**

The Voice of a Nurse

Nursing represents the largest workforce in the health care industry. We impact lives and have positive stories to share. Health care has never been simple, and neither has nursing. With the increasingly complex demands of today's healthcare, the collaborative voice of the Cooper nurses will give us the ability to significantly impact organizational change and the quality of care at the bedside. Cooper wants to hear your voice. Please join me in nurse driven discussions with Stephanie Conners CNO, Senior Vice President of Hospital Operations and other members of the Nurse Executive Council. Look for this exciting opportunity in the near future. Let's take our voices and help in the quest for exceptional safety, service and quality.

Sincerely,

Diana Hays, RN, CPN
Pediatrics

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: **Stauss-mary@cooperhealth.edu**

CARE DELIVERY

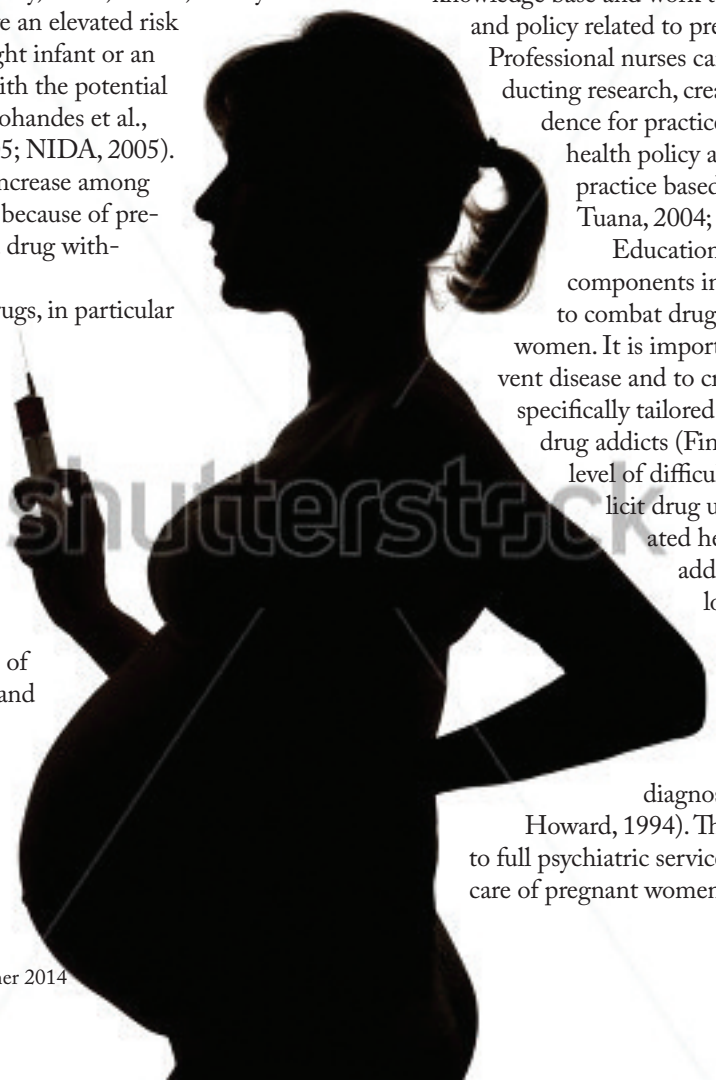
Nursing Care of Pregnant Women with Substance Abuse Issues

Nancy Murphy, RN, PhD(c), MSN

The available evidence on pregnant women using drugs demonstrates the existence of a significant health problem in the United States with deleterious effects for both the mother and her infant (Finnegan, 2010; Keegan, Parva, Finnegan, Gerson & Belden, 2010). Pregnant women using illicit drugs place themselves and their infants at greater risk for perinatal and postnatal complications (Keegan et al., 2010). In particular, pregnant women who abuse heroin face physical, medical and environmental dangers associated with their addiction that also impact the health of the fetus (National Institute of Drug Abuse [NIDA], 2005). Heroin users experience instability in housing and social support, possess poor eating habits, fail to meet the nutritional requirements recommended during pregnancy and fail to obtain regularly scheduled prenatal care more often than non-heroin users (NIDA, 2005). Similar dangers exist for pregnant women using other substances. Poly-substance abuse is commonplace for these pregnant women (Almario, Seligman, Dysart, Berghella & Baxter, 2009).

Lack of adequate prenatal care and the use of illicit drugs are identifiable risk factors linked to perinatal morbidity and mortality (El-Mohandes, Herman, El-Khorazaty, Katta, White, & Grylack, 2003). Women abusing drugs have an elevated risk of delivering a pre-term, low birth weight infant or an intrauterine growth-restricted infant with the potential for future developmental delays (El-Mohandes et al., 2003; Finnegan, 2010; Henderson, 2005; NIDA, 2005). Incidence of morbidity and mortality increase among infants exposed to illicit drugs in utero because of prematurity, infection, fetal anomalies and drug withdrawal (Finnegan, 2010).

Infants exposed in utero to illicit drugs, in particular opiates, experience various degrees of withdrawal, known as Neonatal Abstinence Syndrome (Tichelkamp & Parish, 2008). Infants may experiences problems related to feeding, weight gain, gastrointestinal upset, sleep patterns, irritability and seizures (Tichelkamp & Parish, 2008). These symptoms complicate the transition into extra uterine life and cause increased lengths of hospital stay with substantial financial and social implications creating a public health concern (Sarkar & Donn, 2006).



Nursing: Central to the Solution

In general, health care providers have many responsibilities in caring for pregnant women with addictions (Zollinger, Saywell, Komal, Przybylski & Galloway, 2006). This care includes the following: treating patients with dignity and respect, screening patients, educating patients about addictions and treatments, making referrals for treatment as needed, understanding the intricacies of patients' lives, providing support, maintaining coordinated and collaborative care (Zollinger et al., 2006). Most importantly, it is essential that providers keep their knowledge current with evidence-based standards from organizations such as the American Congress of Obstetricians and Gynecologists (ACOG) and Centers for Disease Control (CDC) for expeditious screening, effective and timely interventions, continued evaluation and referral (Zollinger et al., 2006).

This issue is relevant to the nursing profession since nurses, in their roles as caregivers, educators, advocates and scholars in practice, education, politics and research, work with pregnant women with addictions (Fontenot & Fantasia, 2011). It is imperative that professional nurses join the discussions, contribute to the existing knowledge base and work to shape healthcare standards and policy related to pregnant women and addictions. Professional nurses can meet this challenge by conducting research, creating theory, generating evidence for practice based models, impacting health policy and advancing professional and practice based knowledge (Haslanger & Tuana, 2004; Rodgers, 2005).

Education and holistic care are key components in the development of solutions to combat drug addiction among pregnant women. It is important to promote health, to prevent disease and to create treatment programs specifically tailored to meet the needs of pregnant drug addicts (Finnegan, 2010). A significant level of difficulty exists in discontinuing illicit drug use despite the known associated health risks (NIDA, 2008). In addition, some common psychological characteristics of drug addicted pregnant women include: histories of physical and/or sexual abuse, family history of addiction, as well as presence of a psychiatric diagnosis (Beckwith, Espinosa & Howard, 1994). These problems demand access to full psychiatric services as part of the systematic care of pregnant women with substance abuse issues

(Beckwith et al., 1994). Women struggling with addictions can receive treatment to manage the disease through individualized interventions (NIDA, 2008). Individualizing care is something nurses do well and is central to the patient care philosophy. The American Nurses Association (ANA) outlines specific recommendations in their position statement "Non-punitive Alcohol and Drug Treatment for Pregnant and Breast-Feeding Women and their Exposed Children" (ANA, 2011).

Potential barriers to participation in treatment programs exist for women with addictions. Society has created a moral belief system that stigmatizes and dehumanizes people with substance abuse issues, especially those who are pregnant (Kandall, 2010; Zollinger et al., 2006). Therefore, the program design must evoke positive and supportive images with guaranteed privacy and confidentiality for all participants (Zollinger et al., 2006). Most importantly, obstacles to accessing treatment programs must be reduced or eliminated and programs must be affordable and able to accommodate the basic physical, social and economic needs of pregnant women, i.e., childcare, transportation (Zollinger et al., 2006).

While services may be directed to pregnant women with addictions, nursing advocacy for patients must also address the general public, policymakers/legislators and funding sources (Finnegan, 2010; Kandall, 2010; Zollinger et al., 2006). Nurses can increase the understanding of biological and physiological factors of addiction and specific health effects of certain drugs on pregnancy by educating the public (Henderson, 2005; Zollinger et al., 2006). Successful programs encompass an ability to publicize available referral, telephonic counseling and treatment services as well as standard measures of success and send motivating messages to encourage pregnant women to seek treatment (Zollinger et. al, 2006). Nurses can also advocate with government agencies and private sources for funding for adequate individualized services and research for pregnant women with addictions (Finnegan, 2010; Zollinger et al., 2006). The support of legislators is needed to enact laws that are less punitive and instead support pregnant women in their efforts to achieve sobriety and ensure that those with the greatest need get the services (Zollinger et al., 2006).

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CARE DELIVERY

Moderate Sedation

Anita M. Miller, MSN, CRNA and Kendra L. Simpson, MSN, CRNA

Moderate Sedation, also known as conscious sedation, is defined as a drug induced depression of consciousness. The patient maintains the ability to respond purposely either to verbal direction alone or by a light tactile stimulation. Ideally, patients will not require interventions to maintain a patent airway and will continue to spontaneously ventilate, all while cardiovascular function is also maintained (Department of Health & Human Services Centers for Medicare & Medicaid Services, 2011). The Joint Commission (TJC) has recognized both an increase in the number of procedures being performed under moderate sedation and an increasing number of patient complications due to moderate sedation. Together with the American Society of Anesthesiologists (ASA), TJC developed statements in regards to the granting of privileges for the administration of moderate sedation by non-anesthesia providers. Although the recommendations by TJC for moderate sedation training are extensive, it is ultimately left to each individual institution to develop their own set of criteria for credentialing moderate sedation privileges to non-anesthesia providers (ASA Task Force on Sedation and Analgesia by Non-Anesthesiologists, 2002).

Since each organization is free to determine guidelines on these privileges, Cooper University Hospital (CUH)'s policy for moderate sedation was written by a team led by Dr. Michael E. Goldberg, MD, Chairman and Chief of the Department of Anesthesiology. This policy describes guidelines for initial and on-going credentialing for non-anesthesia providers in administering moderate sedation. The policy is specifically geared toward the nursing and medical staff who will be the primary administrators of moderate sedation. It outlines the definition of moderate sedation, the specific clinical areas approved for administration of moderate sedation and the types of procedures or diagnostics which fall into this category. As per CUH's policy, Registered Nurses (RN) must give moderate sedation during three different patient procedures; all while being supervised by a RN who is currently certified in moderate sedation. Individuals must also take a written exam obtaining a passing grade of at least 90%.

Traditionally, moderate sedation for certain procedures or diagnostics were limited to the in-patient hospital setting. As CUH has grown throughout the years and to keep current with a changing medical climate, it was necessary for moderate sedation privileges to extend to satellite sites. Due to an inconsistent number of clinical opportunities at these locations, some RNs have been unable to obtain the number of annual cases required to maintain their certification.

To rectify this barrier, a simulation-based, moderate sedation course was created. The initial task of developing and implementing this course, along with building simulation scenarios was implemented by Kendra L. Simpson, MSN, CRNA and Kate Comuso, MSN, CRNA with Amanda Burden, MD, Director of Simulation for CUH and Cooper Medical School of Rowan University, providing the physician's perspective. Development of this course, with an extensive power point presentation and various simulated clinical scenarios has become essential tools for teaching moderate sedation. The simulation scenarios provide an opportunity for the nurse to demonstrate not only their knowledge of sedative medications, but also their ability to rescue patients who have become clinically unstable during their moderate sedation procedure. Immediately following a successful scenario of resuscitation, a debriefing period occurs, allowing the nurse to directly reflect on their overall performance (Tobin, Clark, McEnvoy, Reves, Schaefer, Wolf & Reeves, 2013).

For the purpose of moderate sedation, clinical scenarios were developed to mimic real-life patient encounters and their possible physiological responses to multiple sedative-type medications administered by the RN (Tobin, Clark, McEnvoy, Reves, Schaefer, Wolf, & Reeves, 2013). The scenarios were designed to incorporate not just one specific skill set, but to combine a multitude of skills and knowledge the RN's already possess. The goal is to facilitate critical thinking, use of multi-modal assessment skills and ability to prioritize clinical responses serving to interrupt any potential complications resulting from the given moderate sedation (Park, 2011). The moderate sedation simulation course provides a safe learning environment for these goals to be achieved.

As our health care institution continues its growth to the surrounding communities and increases the number of satellite sites participating in procedures requiring moderate sedation, an increased need for education has erupted. The success of the initial moderate sedation course provided only to the satellite RNs prompted offering the course to the Critical Care Course participants. These nurses have the chance to participate in this moderate sedation course in the Simulation Lab with Kendra L. Simpson, Anita M. Miller MSN, CRNA and Edward McGrath, MSN, CRNA. At the conclusion of 2013, approximately 40 RNs have participated in the Moderate Sedation Course. This course will continue to be offered throughout 2014 with hopes of significantly increasing the number of RNs becoming educated in moderate sedation.

Special thanks to Greg Staman, RN, Operations Director of Simulation

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Cooper Against Domestic Abuse

Jennifer M. Bombaro RN, BSN, PCCN

PATIENTS / FAMILIES / COMMUNITIES

Introduction

According to the Center for Disease Control, one in four women and one in seven men has experienced severe violence by an intimate partner. Intimate Partner Violence is defined as "physical, sexual, or psychological harm by a current or former partner or spouse" (Saltzman, Fanslow, McMahon, & Shelley 2002). Many victims remain in abusive relationships due to fear or an obligation or stay for children and financial reasons. Furlow (2010) has noted that "health care encounters represent the most promising opportunities for identifying victims and intervening in patterns of abuse and all health care professionals have an ethical obligation to help identify cases of abuse." At Cooper University Hospital (CUH) treatment for victims of violence includes medical intervention in the Emergency Department (ED), social work consultation and support from the Domestic Violence Response Team (DVRT). There is also an interdisciplinary committee known as Cooper Against Domestic Abuse (CADA) to educate staff, create awareness in the community and support victims and their families.

Domestic Violence Response Team

The Cooper DVRT provides a variety of services to victims and witnesses of domestic violence and sexual assault. The volunteers participate in a 40 hour training program to prepare them as DVRT members. Goals of the DVRT include providing support in a safe and confidential environment, education on domestic violence awareness and promoting peace and harmony in all relationships.

The Nurses' Role

According to Furlow (2010) "domestic violence is often systematic-a prolonged pattern of violence rather than an isolated incident and frequently is perpetrated in an effort to exert control over the victim." Nurses at CUH screen patients for possible domestic violence by assessing for injuries in different stages of healing, often indicating a pattern of abuse. If suspected, it is essential for the nurse to speak privately to the patient and ask them if they feel safe at home. Patients who are identified as victims based on interview and physical assessment are given a social work consult. Nurses are part of a collaborative and empathetic approach to treating victims that includes nursing assessment, social work consultation, medical intervention and a link to law enforcement if the victim wishes.

Cooper Against Domestic Abuse (CADA)

CUH's interdisciplinary CADA committee was formed in 2005 and meets monthly. Committee members include nurses, social workers, employee assistance counselors, Camden County Women's Shelter representatives, pastoral care, the Jewish Center for Family Services and the Camden County Prosecutor's Office. The CADA committee provides educational quarterly seminars to CUH nurses and security personnel so they can respond effectively and provide resources to domestic violence victims when they present as patients. The nurses' role is to assess and identify victims when they present to the hospital.

The committee developed a small patient resource guide that can fit into a shoe. This guide lists phone numbers to assist victims with counseling for themselves and their children, local shelters and financial assistance. The guide is available in the Emergency and Labor and Delivery departments or by contacting the ED social worker. Other CADA outreach efforts include nurses and other members of the CADA committee who go into the community and make the information pamphlet available in places such as churches, physicians' offices, grocery stores and other shopping areas. In addition, Domestic Violence outreach tables have been set up outside the Keleman cafeteria, 3 Cooper Plaza and Voorhees to provide information to the public and Cooper employees. The pamphlets and information table provided by nurses and other members of the committee give victims the opportunity to come forward and speak safely with members of the committee or with the domestic abuse hotline.

Abuse is a learned behavior and the pattern of abuse can be stopped with effective intervention. The

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CARE DELIVERY

Discharge Lounge: One Solution to Improving Patient Throughput

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

Hospital beds are important assets in a healthcare system and many barriers can affect patient flow. These issues include capacity crisis, diversions to other facilities, unwarranted wait times, inappropriate management of bed placement and a poor discharge process (Kloehn, 2004). The key to overcoming these barriers is to focus on patient flow; developing varying solutions aimed at specific points throughout the patient flow cycle (Zhu, 2011). Delays in discharge can be major contributors to the inpatient throughput traffic jam; signifying lack of bed availability to accommodate patient flow. This affects the care and satisfaction of both existing and new patients (Clark, 2005).

The development of a Discharge Lounge can facilitate patient flow. A discharge lounge is an area where patients already discharged can wait safely in a comfortable setting, thereby freeing up beds for acute care and new patients. The benefits of a Discharge Lounge include greater efficiency, improved patient care and increased patient satisfaction (Kloehn, 2004). The Patient and Family Center in the Roberts Pavilion at Cooper University Hospital (CUH) has a Discharge Lounge space for discharged patients who are waiting for their transportation. Patients who meet pre-determined criteria and have been discharged have access to the lounge area within the center (see Table 1).

TABLE 1 Patient Criteria

Able to ambulate without assistive device other than cane
Controlled pain without need for frequent oral analgesics (can go 6-8 hours without pain medications) or have access to own medications
Does not require frequent dressing changes or emptying of drains
Awake, Alert and Oriented, with no cognitive impairment
18 years of age and over
No isolation precautions
Continent of bowel and bladder; able to ambulate independently to restroom
Has a ride scheduled and can be picked up prior to 7:00 pm

The Discharge Lounge expedites the intake of new patients and provides discharged patients with superior customer service.

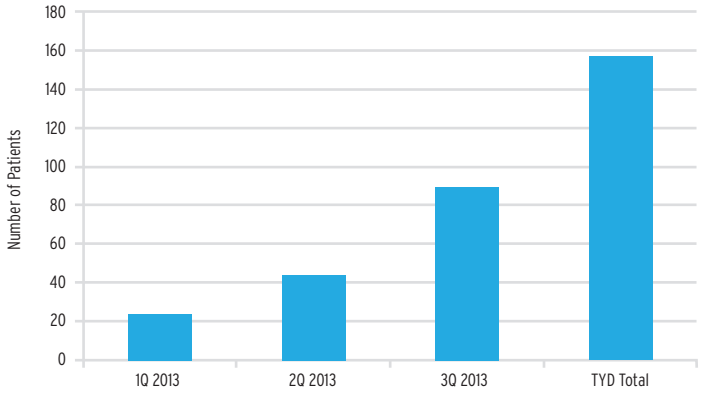
The Discharge Lounge at CUH has amenities that include computer access with wireless service, reading material, television, DVD players, movies, storage units for personal belongings and health resource information. Other amenities include complimentary light meals, beverages, healthy snacks, reclining lounge chairs, blankets and eye pillows.

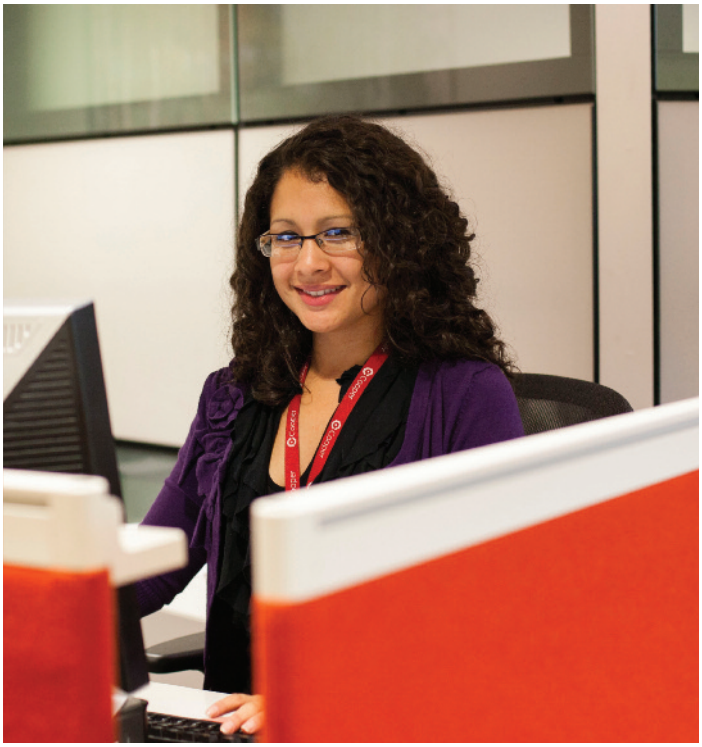
Patient Relations personnel staff the Patient and Family Center and Discharge Lounge providing assistance with communication amongst clinical staff, the patient and the patient's caregivers. In addition, the staff provides wheelchair service directly to the waiting car and can assist with scheduling follow-up appointments. The Discharge Lounge expedites the intake of new patients and provides discharged patients with superior customer service.

Patient throughput is complex and many factors must be considered when balancing quality of care and speed through the system. Effective management indicates efficiency within the healthcare system. A Discharge Lounge is used as a tool to improve efficiency while increasing patient satisfaction.

Email comments to **ripa-rowena@cooperhealth.edu**

FIGURE 1 **Patient Utilization of the D.C Lounge**





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CARE DELIVERY / EBP

A Descriptive Study of Pain in Abdominal Surgery Patients Using Patient Controlled Analgesia in the Post Anesthesia Care Unit

Christine Albano, RN, CCRN, CPAN and Jennifer Stanger, RN, BSN

Contributions by Claire Forys, RN, MSN, CPAN; Linda Webb, RN, MSN, CPAN; Nancy Ballistreri, RN, BSN, MS; Susan Remster, RN, CPAN; Barry Milcarek, PhD; Krystal Hunter, MA

BACKGROUND

The American Pain Society defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." When this definition is applied in the clinical setting, it is important to emphasize that pain is an experience that is both personal and subjective. The patient's report of pain is the gold standard for pain assessment (Odom-Forren, 2012). One of the most common methods of managing the post-operative patient's pain is the use of IV patient-controlled analgesia (PCA). Through the use of PCA, patients self-administer pain medication by pressing a button that is attached to an infusion pump in order to deliver a preset amount of pain medication through their IV. The PCA therefore incorporates this concept that the patient's perception of pain is the most reliable indicator of pain, and thus, only the patient knows how much medication is required to relieve it (Odom-Forren 2012).

PURPOSE

The purpose of this study was to evaluate the levels of pain associated with patients using PCA with demand dose only (PCADD) versus the levels of pain reported by those patients using PCA with basal rate (PCABR). Despite the common use of PCA in post-operative management, our review of the literature showed very limited research conducted on whether or not PCABR is superior to PCADD use alone.

Our hypothesis was that patients using PCABR would exhibit better pain control than those patients with only PCADD.

This study sought to answer the following questions:

1. Is there a difference in the level of pain in the first two hours of PCA use with or without a basal rate?
2. Is there a difference in the total amount of pain medicine administered in the first two hours of PCA use with or without a basal rate?
3. Is there a difference in the trend of pain scores reported over time between those patients having only PCADD versus PCABR?

DESCRIPTION OF STUDY

Total sample size was 93 post-operative patients recovered in the Post-Anesthesia Care Unit (PACU). The PCABR group had 33 patients. The PCADD group had 58 patients. The narcotic used (ie: Morphine vs. Hydromorphone vs. Fentanyl), the presence or absence of a basal rate and the presence of an On-Q pump were completely pre-determined by the individual physician's orders.

In order to evaluate the severity of the patients' pain, the patients were asked to rate their pain on a 0-10 point scale, using the Numeric Rating Pain scale (Odom-Forren 2012) "0" being no pain and "10" being the worst pain they have ever experienced. The pain scale data was collected over six pre-determined time periods

The nurse plays a vital role in both educating the patient on the use of PCA as well as monitoring the effects of PCA in order to assure effective pain management of each individual patient.

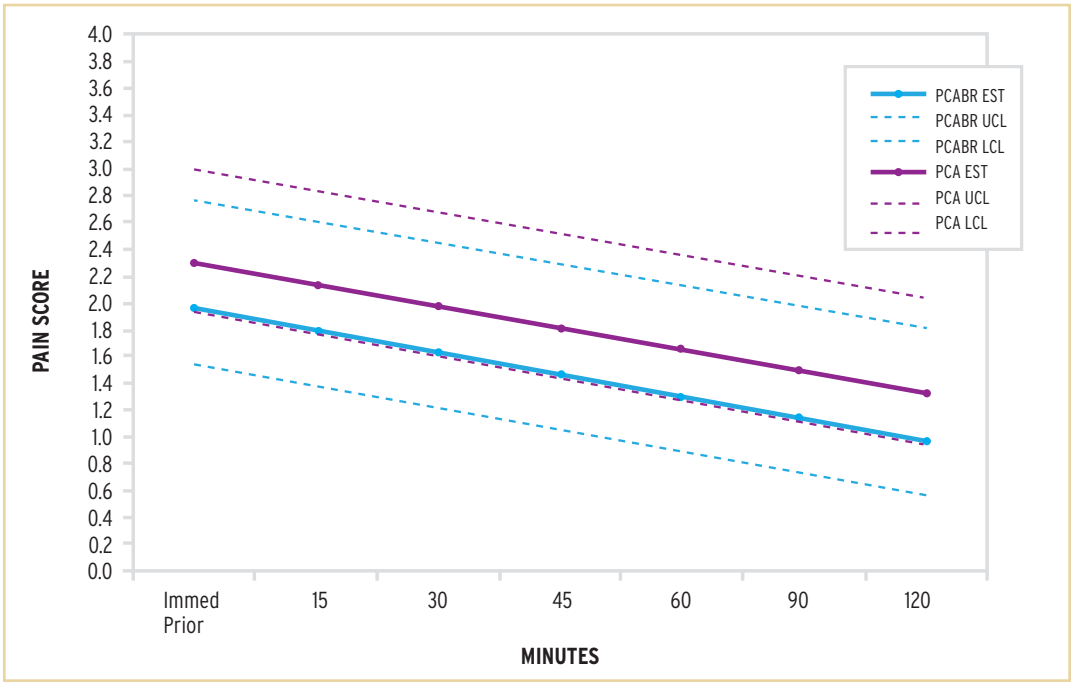
TABLE 1 Inclusion and Exclusion Criteria for Study

Inclusion Criteria	Exclusion Criteria
Patients having acute or scheduled open incision abdominal surgical procedure who received general anesthesia	Patients undergoing post-trauma surgery
Patients over the age of 18 and less than 75 years of age	History of IV drug abuse and/or chronic pain
Ability to follow directions on the use of the PCA pump	Surgical procedures > 4 hours in length
Anticipated length of stay in the PACU of at least 2 hours duration	Perforated bowel or other major surgical complications

TABLE 2 Patient demographics in both groups

	Total (n=93)			PCADD (n=59)			PCABR (n=34)		
	Mean	Min	Max	Mean	Min	Max	Mean	Min	Max
Age (years)	52.78	25	74	52.88	25	74	52.78	25	74
Weight (lbs)	185.26	112	330	185.75	112	330	185.24	120	330
Height (inches)	64.75	48	74	64.68	58	74	64.75	58	74
Gender		Male 12	Female 81		Male 11	Female 48		Male 1	Female 33

FIGURE 1 **Difference in pain scores between PCADD and PCABR in the first two hours**



PCABR = PCA with Basal rate
PCA = PCA without basal rate
EST = Regression estimate
UCL = Upper confidence limit
LCL = Lower confidence limit

of the PACU patient's stay:

1. On arrival
2. Immediately prior to PCA pump being initiated (usually within 15-20 minutes of arrival time)
3. 15 minutes after PCA start time
4. 45 minutes after initiating PCA
5. 75 minutes after initiating PCA
6. 120 minutes after arrival in PACU or prior to transfer to surgical floor

A data collection tool included each patient's age, gender, ethnicity, weight and height. Information on the type of open abdominal surgical procedure was obtained directly from the operative record. Data collected also included length of operative time and PACU stay. PCA narcotic used and PCA settings were also noted. The amount of opioids as well as any antiemetics administered was also collected.

Nurses are constantly reminded of the concept that pain is the FIFTH vital sign and the management of pain is extremely important to the patients' experience.

Patient education regarding the use of PCA equipment is necessary to ensure optimal clinical outcomes and efficacy.

FINDINGS

In order to equilibrate the data for opioid analgesia amongst patients using different narcotic agents, the Total Morphine Equivalent (TME) was calculated for all three opioids; Morphine, Hydromorphone and Fentanyl. The TME was calculated upon the following assumption:

Morphine 1mg IV is equal to Hydromorphone 0.15mg,
AND
Morphine 1mg IV is equal to Fentanyl 0.01mg.

There was a mean change in the pain scores from 15 minutes to 120 minutes after either PCABR or PCADD initiation. There was a downward trend in the mean pain scores for both groups during the patients' two-hour stay in PACU. Interestingly, data showed that the patients who received PCABR did achieve initial pain relief more quickly that the PCADD group. When the TME was compared between the two groups, no statistically significant difference was noted. However, the PCABR group did have a higher mean TME, which may have contributed to this group's lower pain score over time. Moreover, it should be emphasized that there were NO cases of oversedation, reintubation or adverse reactions in either group. This is of particular importance, considering the PCABR group had a higher TME.

CONCLUSION

Nurses are constantly reminded of the concept that pain is the fifth vital sign and the management of pain is extremely important to the patients' experience. The resulting data demonstrated that PCA, both with and without basal rates, can be an efficient method in controlling pain in the post-operative surgical patient. Use of the On-Q pump, in conjunction with PCA for pain control, can be very effective, even when used with PCADD alone.

This data validated that the patients who received PCABR received higher amounts of opioids while achieving initial pain relief more quickly and exhibited lower pain scores over time than the PCADD group. Moreover, no subjects in either group experienced complications due to oversedation. Thus PCA, both with or without a basal rate, can be used safely and effectively.

Patient education regarding the use of PCA equipment is necessary to ensure optimal clinical outcomes and efficacy. The addition of end tidal CO2 monitoring in patients using PCA may increase the comfort level of physicians to order basal rates for patients with suboptimal pain relief with PCADD. The Joint Commission mandates that all individuals have the right to effective pain management. The Agency for Healthcare Research and Quality asserts that institutions have the responsibility for pain management and that patients should have access to the best level of pain relief available (ASPAN 2012 Pain and Comfort Clinical Guideline). Thus, the nurse plays a vital role in both educating the patient on the use of PCA as well as monitoring the effects of PCA in order to assure effective pain management of each individual patient.

Email comments to **albano-christine@cooperhealth.edu**
or **stanger-jennifer@cooperhealth.edu**

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Professional News

(continued from page 16)

Jane Greene Ryan, RN, PhD, Cooper Nurse Research Coordinator travelled to India and Spain during the fall of 2013 to teach and present research which she is conducting at Drexel University. In October, she accompanied two other faculty members and one MSN (nursing education) student to Baru Sahib India where Drexel has an on-going partnership with a Sikh university and college of nursing. During the ten days in India they presented at a national Indian conference hosted by their sister university, taught undergraduate nursing students and conducted nursing faculty development. Jane was thrilled to be asked to teach a 2-day seminar on qualitative research to the Indian nursing faculty. Because of her interest in global health and vulnerable populations the conference topic chosen for her was Global Perspectives on Socioeconomic Disparities. She was invited to return in October 2014. A poster describing this on-going work has been accepted for the 26th Annual Eastern Nursing Research Society meeting being held in Philadelphia April 9-11. The poster is titled Global Partnerships: Nursing Faculty and Students in India and the United States.

Jane Greene Ryan, RN, PhD, presented in Madrid at the International Conference of Education, Research and Innovation on qualitative research she is conducting on the use of gaming strategies to engage nursing students. This aspect of the research compared the use specific gaming techniques between traditional undergraduate students learning in a face-to-face classroom to RN-BSN students who are learning in an on-line environment. Her presentation was titled, Evaluation of the use of an Online Asynchronous Interactive Learning Exercise.

Deborah Schoch, RNC, PhD, (candidate), IBCLC, CCE, CPST, presented a 4 hr preconference session Neonatal Developmental Conference in New Orleans about Nurturing the Family During Feedings in the NICU. She also presented two breakout sessions titled "Can We Define Breastfeeding Readiness in Premature Infants?" and "Applying Baby Friendly Concepts to the NICU Setting."

Cooper Against Domestic Violence

(continued from page 7)

Camden County Prosecutor's Office is a part of the CADA committee and enforces legal accountability to abusers. They also work with Volunteers of America to provide a counseling program for male abusers. Information on legal assistance from the Camden County Prosecutors' office is provided if the victim wishes. Also, a representative from the Camden County Prosecutors' office will accompany the victim to court to testify against the abuser.

Conclusion

The CADA committee, in collaboration with other support systems in place at CUH, has supported patients and employees who are victims of domestic violence to feel safe. The goal of the committee is to raise community awareness and provide resources to victims and their families. Nurses are essential in identifying and assisting victims through thorough assessment and awareness to the resources that exist. If you or someone you know is a victim of domestic violence please contact the CADA committee or call the National Domestic Abuse hotline 1-800- 572-7233.

Email comments to **bombaro-jennifer@cooperhealth.edu**

References

Furlow, B. (2010) Domestic violence. Radiologic Technology, 82(2), pgs 133-53.

Saltzman, L., E., Fanslow, J., L., McMahon, P., M., Shelley, G., A. (2002) Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Reflections

(continued from page 15)

and younger brother were migrant and homeless for the most part. We met the family on the eve of a special event, with Ivan preparing for his first day of kindergarten. In her report, she noted that the average parent spends $500 dollars to prepare their child for the first day of kindergarten. Ivan didn't even have breakfast his first day of school. Ivan was nervous but quickly was intrigued by his new school. Having practiced his numbers, he was able to tell his teacher that there were three wheels on a tricycle, but sadly was stumped when asked how many meals people eat in a day. With over half of Camden's youth living below the poverty level, Ivan is not alone in his struggle. In a community whose murder rate has been seven times the national average, the simple act of walking to the bus stop often poses a great challenge. The show would go on to follow other Camden children and detail the impact that family conflict, lack of nutrition and community stressors have on the lives of these children. Sawyer discussed these issues at great length with many community leaders, including Bruce Main. I was shocked it took a national show to draw attention to a humanitarian issue that was occurring mere minutes from my own home in comfortable suburbia.

Each year, Urban Promise hosts numerous fundraising events, including their annual banquet at the Scottish Rite Auditorium in Collingswood. In 2012, the keynote speaker was Diane Sawyer, still involved and still inspired by the organization's accomplishments. I wondered who was hosting ABC's national news that Thursday evening! As she was being introduced, the founder, Bruce Main, reminisced about the shocking phone call that he received from ABC expressing Diane's interest in Urban Promise. He knew this national coverage would be a "game changer." Thinking about the time I had watched her report, I smiled because I knew he was right.

I have spent my entire career at Cooper University Hospital. In an interview, I was asked why I wanted to continue to work at Cooper as a nurse anesthetist. I said that I was committed to the South Jersey community and now that I reflect, eleven years later, I feel the same. Except for a brief 36 month "sabbatical" at Pennsylvania Hospital while pursuing an MSN in nurse anesthesia, I have been continually drawn to this community since 1996. Time and time again, I am graced to know patients that are unique and blessed, however struggling in the reality of living in abject poverty. The local children I care for always take me aback the most. Their innocent eyes are so full of wonder, but often are dulled by the socioeconomic disparities that are so much a part of their lives. It seems that the dreams and aspirations of young people are all quite similar. For the children of Camden and others living in poverty in the South Jersey community, the realization of the dream is frequently marred by a lack of opportunity. Urban Promise and its community partners are empowering children with the realization of a brighter future. For more information on Urban Promise, go to urbanpromisecamden.org.

Email comments to **DiDonna-Marlo@cooperhealth.edu**

PATIENTS / FAMILIES / COMMUNITIES

REFLECTIONS

An Urban Oasis

Marlo DiDonna RN, CRNA, MSN

Marlo DiDonna and Nailah

Excitement. Motivation. Opportunity. These are the words that come to mind whenever I visit the Camden Forward School, the elementary school that was formed in 1997 through the dedication and the dream of Urban Promise supporters. I liken it to a sanctuary. It is a place that when I leave it, I am sad to go but a lot better off for visiting. With each visit, I am privileged to witness the young lives that are developing and thriving from this positive educational environment.

These bi-annual events are special days that begin with a student performance from the elementary school and sometimes even the high school, Urban Promise Academy. Bruce Main, the founder, shares the current events and progress reports on the schools and then the real fun begins. The sponsors are escorted to their partners' classrooms and get to have lunch, share in a special snack, participate in a project and generally "catch up." My partner is Nailah. We have been partners since her kindergarten year and today she is a thriving second grader. She likes to sing, play with her cousin and do word search puzzles!

A partnership is a school year commitment. A partnership donation allows a child to attend one of the Urban Promise schools on "scholarship," free of the monetary burden that it would take to attend. Each year that I recommit to a sponsorship, I am hopeful but never know if Nailah will be returning. I understand that life is ever changing and at times, unstable in these children's lives. I have been pleased to see that Nailah continues to be a student making great progress in her education at the Camden Forward School.

The history of Urban Promise shows that a group's commitment can elicit potent change. In1988, Urban Promise volunteers began a summer camp in East Camden for the neighborhood children. The mission was simple: the camp would be a safe place where children could spend their summer days protected from the harsh streets of Camden. The community was delighted and since then, Urban Promise has grown immensely in the programs that are available for the children of Camden. Continuing with their summer camps, Urban Promise has grown to include a private elementary school, a private high school, several afterschool programs and various fine arts and recreational programs. On average, 100% of Urban Promise high school students graduate, 93% go on to college and 83% of college attendees graduate. Compared to averages elsewhere in Camden City schools, these statistics are staggering.

Their "Street Leaders" program is a very unique one, in that it involves Camden teens giving back and nurturing younger Camden children. Each party is empowered with a vision of hope for the future through tutoring, mentoring and coaching. According to the Urban Promise website, "the heart of the Street Leader Program is challenging teens to use their influence to make positive changes in the lives of the younger children, in their own lives and throughout their communities."

Beginning with a budget of approximately $12,000 in 1988, Urban Promise now works from a budget of $3.6 million and employs more than 55 full-time employees. They also privately employ many Camden teens providing them with income, work skills and unique opportunities. In addition to local corporate sponsorships, such as Holman Automotive and Campbell Soup Company, Urban Promise has over 30,000 private donors, all helping to reach the 640 children that Urban Promise serves in the city of Camden.

UrbanPromise
believe. become. belong. be promise.

My interest in Urban Promise began in 2007 on a Friday evening after a typical evening shift. I began to watch an episode of "20/20." Diane Sawyer's report was entitled, "Waiting on the World to Change," a series of reports that would explore the plight of American children living in poverty. The program would go on to be honored with many awards, including an Emmy award for excellence in journalism. That evening she chose to highlight Camden, NJ, at that time the most dangerous city in America. As I watched, I continued to see footage of familiar scenes and areas that I had come to know as a result of my daily commute to Cooper Hospital over the years. I also viewed footage of a side of Camden I had only heard about; dangerous streets whose inhabitants were young families sharing their blocks with crack houses, prostitution rings and gang violence. We met Ivan that night, a bright and energetic little boy living in the midst of a dangerous community and an uncertain future. He, his mother

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Professional News

DEGREES:

Elizabeth Alonso, RN, MSN, completed the Adult Gerontology Acute Care Nurse Practitioner program with an MSN from Rutgers University School of Nursing.

Kellyann Carter, RN, BSN, received her BSN from Grand Canyon University

Susan Delfino, RN, BSN, received her BSN from Wilmington University

Matthew R. Dering, MSN, RN, CCRN, CEN, completed the Adult Gerontology Acute Care Nurse Practitioner program with an MSN from Rutgers University School of Nursing.

Lisa Durso, RN, BSN, received her BSN from Drexel University

Marika DuTot, RN, BSN, received her BSN from Drexel University.

Diane Floyd, RN, BSN, MSN, CCRN, NE-BC, earned an MSN degree with a focus in nursing education from Walden University

Michele Hailey, RN, MSN, MBA, received her MBA - Health Administration and MSN - Executive Leadership from Wilmington University.

Michael Iovacchini, RN, BSN, received his BSN from Chamberlain College of Nursing

Tara McHugh received her BSN from Grand Canyon University

Crystal Turner, RN, BSN, received her BSN from Thomas Edison University.

Linda Williams, RN, MSN, APN, completed a post Master's Family Nurse Practitioner program from Widener University. She is now certified as a Family Nurse Practitioner by the American Academy of Nurse Practitioners and by ANCC in Nursing Administration.

MaryJo Cimino, RN, MSN, CCRN, received her MSN- Nursing Leadership from Walden University.

Cheryl Kazmierski, RN, MSN, graduated from Rutgers University with a MSN with a certificate in Adult Health Gerontology Primary Care.

CERTIFICATIONS:

Judy Weller-Ball, RN, CAPA, passed the Certified Ambulatory Perianesthesia Nurse certification exam.

Maria Eastlack, RN, BSN, CAPA, passed the Certified Ambulatory Perianesthesia Nurse certification exam.

Lisa Geoghegan, RN, BSN CAPA, passed the Certified Ambulatory Perianesthesia Nurse certification exam.

Rebecca Hack, MSN-MBA, RN, CPAN, CMSRN, passed the certification in Perianesthesia Nursing exam.

Brianna Marshall, RN, BSN, CDE, was certified to be a Certified Diabetes Educator by the National Certification Board for Diabetes Educators.

Maria Meneses, RN, BSN, CCRN, passed the certification the Critical Care Registered Nurse exam.

Kim Potorti, RN, BSN, CAPA, passed the Certified Ambulatory Perianesthesia Nurse certification exam.

Carol Pulley, RN, MSN, NVRN, CPHQ, received the Acute Neurovascular RN Certification from the Association of Neurovascular Clinicians.

Linda Smith, RN, CEN, passed the Certification in Emergency Nursing exam.

Sandra Torney, RN, BSN, CAPA, passed the Certified Ambulatory Perianesthesia Nurse certification exam.

Glory Veluz, RN, BSN, CCRN, RCIS, is now a Registered Cardiovascular Intervention Specialist as certified by Cardiovascular Credentialing International.

PUBLICATIONS:

Goldschmidt, K., & **Greene-Ryan, J.** (2014). MOOCS in Nursing Education. *Journal of Pediatric Nursing* (in press).

Schoch, Deborah E. RNC, IBCLC, CCE, CPST; Lawhon, Gretchen PhD, RN, CBC, FAAN; Wicker, Linda A. RN, MSN, CCRN; Yecco, Giselle RN, APN. (2014). An interdisciplinary multidepartmental educational program toward baby friendly hospital designation. *Advances in Neonatal Care*, 14(1), p. 38-43.

PROFESSIONAL GROWTH AND DEVELOPMENT

Christa Schorr, RN, MSN, FCCM, co-authored:

1. Wang Z, Xiong, Y, Schorr C, Dellinger RP. Impact of sepsis bundle strategy on outcomes in patients suffering from severe sepsis and septic shock in China. *J Emerg Med* Apr 2013 44(4) 735-741.
2. Han B, Bhatia R, Traisak P, Hunter K, Milcarek B, Schorr C, Eid H, Feinstein D, Cronin P, Kolasinski S. Clinical presentations and outcomes of systemic lupus erythematosus patients with infection admitted to the intensive care unit. *Lupus*. 2013;22(7):690-6.
3. Kleinpell R, Aitken Leanne, Schorr C. Implications of the new international sepsis guidelines for nursing care. *Am J Crit Care*. 2013 May:22(3) 212-222.
4. Abouzgheib W, Meena N, Jagtap P, Schorr C, Boujaoude Z, Bartter T. Percutaneous dilational tracheostomy in patients receiving antiplatelet therapy: is it safe? *J Bronchology Interv Pulmonol*. 2013 Oct;20(4):322-5.
5. Rincon F, Patel U, Schorr C, Lee E, Ross S, Dellinger RP, Zanotti-Cavazzoni S. Brain Injury as a Risk Factor for Fever Upon Admission to the Intensive Care Unit and Association With In-Hospital Case Fatality: A Matched Cohort Study. *J Intensive Care Med*. 2013 Oct 16.
6. Schorr CA, Zanotti S, Dellinger RP. Severe sepsis and septic shock: Management and performance improvement. *Virulence*. 2013 Dec 11;5(1).

Christa Schorr, RN, MSN, FCCM, co-authored a chapter on Intensive Care Unit Administration and Performance Improvement in the book: *Critical Care Medicine: Principles of Diagnosis and Management in the Adult. 4th ed.* Editors: Joseph E. Parrillo and R. Phillip Dellinger. Elsevier Saunders Philadelphia. Mosby: Print 2013. 1239-1250.

Christa Schorr, RN, MSN, FCCM, co-authored an editoral for Damuth E, Schorr C. Goldilocks in the ICU: Too few beds, too many or just right? *Crit Care Med*. 2013 Dec; 41(12):2820-1.

Stephen A. Teitelman, BS, RN, CEN, CCRN, CFRN, CTRN, PHRN, MICP, NREMT-P, FP-C, CCP-C, authored, "A 20-Year-Old Man with Respiratory Distress" in the November/December 2013 (Vol. 32, Number 6) issue of *Air Medical Journal*.

APPOINTMENTS:

Julie Mesiano, RN, BSN, is now adjunct faculty member at Widener University co-teaching health assessment labs with Mary Francis RN, MSN, APN (Trauma).

AWARDS:

Diane Hyman, RN, BSN, OCN, received the 2014 Martin Luther King Community Service Award for her efforts with the "Sister Will You Help Me" cancer support group.

David Salati, RN, BSN, CFRN, CCRN, MICP, Flight Nurse and **Larry Fornicola, MICP, FP-C, Air Two Flight Paramedics,** took first place in the Meti simulation games held during the New Jersey OEMS conference in Atlantic City on November 13-16, 2013.

Christa Schorr, RN, MSN, FCCM, was awarded the 2013 Presidential Citation for outstanding contributions to the Society of Critical Care Medicine and the 2013 ESICM and SCCM in Conjunction with the 42nd Annual Congress - Recognition for Dedication and Work to Improve Patient Care through the Surviving Sepsis Campaign.

PRESENTATIONS:

Sharon K. Byrne, DrNP, APN, NP-C, AOCNP, CNE, Oncology Outreach Programs, presented "Academic and Non Profit Clinic Partnership: Improving Global Health Outcomes and Education in Haiti" Nursing Leadership in Global Health Symposium, hosted by Vanderbilt University.

Janice Delgiorno, RN, MSN, APN, presented "Chest Tube Management" at Temple's Trauma Symposium.

Janice Delgiorno, RN, MSN, APN, presented "When Fun Turns Tragic: Situations leading to Pediatric Injury" at the Eastern Association for the Surgery of Trauma/ Society of Trauma Nurses Collaborative next week in Naples, FL.

Diane Hyman, RN, BSN, OCN, was a panelist on February 12, 2014 for a webinar hosted by Living Beyond Breast Cancer. The topic was "Addressing Health Disparities to Improve the Care of African American Women Affected by Breast Cancer".

Elizabeth Lee, RN, and **Janice Delgiorno, RN, MSN, CCRN, ACNP,** presented "Time is Brain: Case Studies in Traumatic Brain Injury" at TRENDS in Critical Care Nursing: King of Prussia PA and at the NJ State EMS Conference in Atlantic City.

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