Cooper
University Hospital

Bridges to Excellence

A publication for nurses and healthcare professionals

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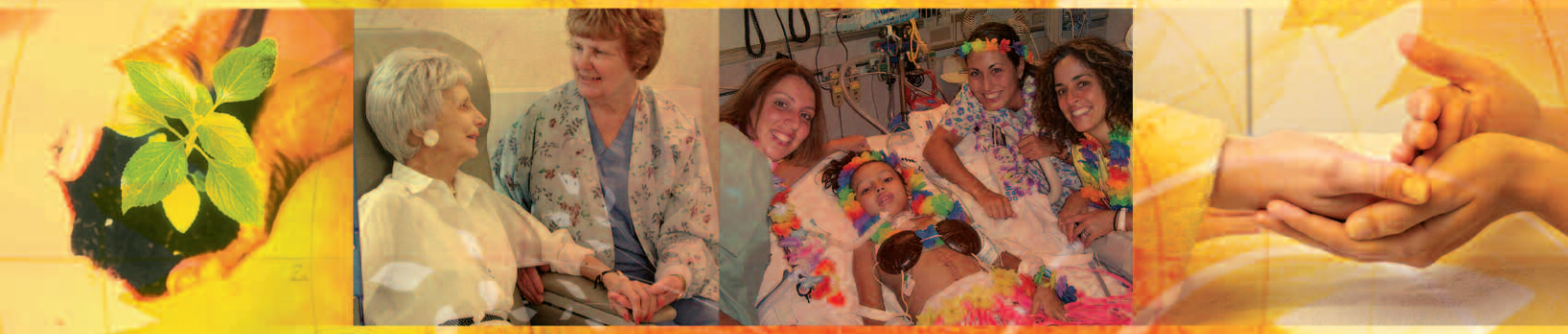

Patient-Family Centered Care

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From the Chief Nursing Officer

Elizabeth Bobulski, RN, BS, MPH • Senior Vice President of Patient Care Services and Chief Nursing Officer

Dear Colleagues,

As you open this edition of *Bridges to Excellence* you will discover a wide variety of topics on the continuum of patient care. Central to each is the importance of the interdisciplinary health care team and collaboration for optimal patient care. In addition, the importance of the core group that the patient defines as "family" are key to care and caring. Cooper is on a journey to create excellence in every dimension of patient and family centered care. To that end, employees from every department are contributing to the formulation of best practices to support patients, their families and each other. Key component teams are focused on areas such as healing environments, alternate therapies, and spirituality, to name just a few. It is an exciting time as we discover that every employee, in every department is a "care giver" to patients and to each other. Imagine the power in each of us to decrease anxiety and comfort others, it is awesome.

I invite you to learn more by reading this edition and as always, please let us know what you think.

Best regards,

Elizabeth Bobulski

Email comments to **Bobulski-liz@cooperhealth.edu**

***Bridges to Excellence* 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 *Bridges to Excellence* may obtain submission guidelines by contacting **Yhlen-kathleen@cooperhealth.edu**

The Magnet Model and Patient Outcomes: Is There a Connection?

Kathleen Yhlen, RN, MSN, NE-BC

The business of healthcare is increasingly competitive in nature and as a result there is widespread restructuring and redesign efforts to improve patient care and outcomes. Consequently, the healthcare environment is now characterized by the search for best practices, benchmarks, and quality targets. Some initiatives have served as exemplars for designing quality patient care and excellent nursing practice environments (Havens and Aiken, 1999). The organization of nursing in magnet hospitals has demonstrated both.

Magnet hospitals have been recognized for administering exceptional patient care and providing good nursing practice environments. The process to achieve magnet designation consists of a self-nomination, an initial application fee, written documentation of adherence to the 14 "forces of magnetism" and a site visit to verify that the 14 forces are in place in the organization (Table 1). In July 2008, the ANCC announced the next generation model for its esteemed Magnet Recognition Program®. The new magnet model is designed to provide a framework for nursing practice and research in the future, as well as serving as a road map for organizations seeking to achieve Magnet recognition. The magnet model configures the 14 Forces of Magnetism into 5 Model Components (Table 1). The objectives of the Magnet Recognition Program® include identifying excellence in the delivery of nursing services; promoting quality in a milieu that supports professional nursing practice, providing a mechanism for the dissemination of best practices in nursing, and to promote positive patient outcomes (Havens & Johnston, 2004).

Scott, Sochalski, and Aiken (1999) determined that the examination of patient outcomes is of particular importance to nursing because it allows nurses to target their concerns appropriately with respect to the patient and document the beneficial effects that professional nurses have on the patients for whom they care. The focus on patient care outcomes challenges healthcare professionals to be accountable and responsible for the results of their therapeutic actions. The evidence base in support of better patient outcomes for magnet hospitals is extensive. The magnet concept has been in place for almost three decades as the most successful organizational reform to attract and retain professional nurses in hospital practice, and has shown to achieve substantially more favorable patient outcomes compared to non-magnet organizations.

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Much of the research on magnet organizations as it relates to patient outcomes, centers on two findings, mortality rates as they relate to nurse staffing, and patient satisfaction as it relates to the professional practice attributes of nurses.

Nurses have long contended that work environments that are attractive to nurses also yield better outcomes for patients (Aiken, 2002). The objective for the first study of patient outcomes in magnet hospitals was to investigate whether magnet hospitals had lower Medicare mortality. Aiken, Smith, and Lake (1994) stated that magnet hospitals observed mortality rates that were 4.6% lower than the matched control hospitals. In a study that followed, AIDS mortality was compared to magnet and non-magnet hospitals. Magnet hospitals had mortality rates 60% lower that non-magnet hospitals (Aikens, Sloane, Lake, Sochalski, & Weber 1999).

Additional research conducted by Needleman, Buerhaus, Mattke, Stewart, & Zelvinsky, (2002) examined the relation between the amount of care provided by nurses in magnet hospitals and patient outcomes. They concluded that a higher number of hours of care by registered nurses per day are associated with better care for hospitalized patients. Sasichay, Scalzi, & Jawad (2003), studied the association between in-hospital mortality and nurse staffing variables. The findings revealed that the ratio of total nurse staffing to patients was significantly related to in-hospital mortality in both partial and marginal analyses, controlling for patient characteristics. The findings of these two studies support magnet research and add to our understanding of the importance of nurse staffing and its relationship to patient outcomes.

Table 1 Magnet Model and Forces

Model Components	Forces of Magnetism
Transformational Leadership	• Quality of nursing leadership • Management style
Structural Empowerment	• Organizational structure • Personnel policies and programs • Community and the hospital • Image of nursing • Professional development
Exemplary Professional Practice	• Professional models of care • Consultation and resources • Autonomy • Nurses as teachers • Interdisciplinary relationships
New Knowledge, Innovations, and Improvements	• Quality improvement
Empirical Quality Outcomes	• Quality of care

The Institute of Medicine (IOM) called for transforming the nursing environment to keep patients safe. Recommendations included, developing nursing work environments that enhance communication, collaboration and involvement in decision making about patient care, and nursing work (IOM 2003). For decades, these same features have been empirically associated with nurse recruitment, retention, and quality patient outcomes. Havens and Johnston (2004) concluded that magnet hospitals also known for these features have woven these features into the fabric of their organizations and are considered by some as "best practice" organizations for shaping quality patient care. Ironically, magnet hospital had these organizational features in place before the IOM made their recommendations. In the 2001 study "Staff Nurses Identify Essentials of Magnetism" Kramer and Schmalenberg (2002) stated that the eight essentials to giving quality patient care are working with other nurses who are clinically competent, good nurse-physician relationships and communication, nurse autonomy and accountability, supportive nurse manger-supervisor, control over nursing practice and practice environment, support for education, adequate nurse staffing, and concern for the patient is paramount.

Magnet hospitals have demonstrated organizational attributes that provide nurses with organizational support needed to fully use their knowledge and expertise to provide high-quality care (Havens and Aiken, 1999). Research on magnet organizations can provide hospitals and nursing leaders with information when designing the clinical workforce and developing or revising hospital policies. In January 2008, Cooper University Hospital's nursing team began a process to re-design its Nursing vision. The highlights include a focus on the importance of nursing team work within the core group and outside it to involve all disciplines for the best patient outcomes. Key to the vision is the ending statement, "…excellence in clinical care, research, and education will be evidenced by Magnet designation to validate continuous dedication to clinical excellence, research, and education." As nursing faces the challenges of this decade, every effort must be made to create work environments that attract and retain nurses to ensure that patients continue to receive the quality care they deserve.

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Application of the Bundle Theory to Improve Patient Care: Does it work?

Christa Schorr, RN, BSN

What is a bundle?

The Institute for Healthcare Improvement (IHI) developed the concept of "bundles" to help health care providers deliver the best possible care for patients undergoing particular treatments with inherent risks. A bundle is a structured way of improving the processes of care and patient outcomes: a small, straightforward set of practices — generally three to five — that, when performed collectively and reliably, have been proven to improve patient outcomes (http://www.ihi.org). The components of the bundle are based on scientific evidence which may or may not be performed consistently.

Healthcare providers have traditionally managed patients in a step-wise approach using diverse protocols, pathways, and care plans. This process of care is often based on evidence based guidelines to deliver precise patient care management. However, transitioning evidence into practice is challenging, making compliance with each element essential to measure and evaluate.

Purpose of a Bundle Model

The rationale for utilizing the bundle model is to consistently deliver the best care available to patients in a timely manner. Bundles should act as a cohesive unit to ensure all steps of care are reliably delivered and documented. This approach helps decrease clinical variation, prevents avoidable patient morbidity and results in reduced length of hospital stay and improved patient outcomes (Cooke & Holmes 2007).

Performance Improvement Bundle Initiatives

The bundle concept is not simply intensive care unit (ICU) specific but has expanded across departments with multidisciplinary involvement. Although challenges exist with implementation of such an extensive association, successful collaboration and achievement in process change can occur with enthusiastic involvement of front line care givers, identification of champions, and the support of quality team members to provide performance feedback. Several patient care bundles have been in the forefront as a result of the IHI's 5 Million Lives Campaign initially known as the 100,000 Lives Campaign. The goal of the campaign is to prevent undue harm to patients.

Several patient care bundles have been implemented at Cooper University Hospital including the prevention of ventilator associated pneumonia (VAP bundle) (Resar, 2007). This successful improvement effort was followed by the central line insertion bundle (http://www.ihi.org) and the severe sepsis bundles (Dellinger & Vincent, 2005). (Table 1)

The VAP bundle was initially designed to deliver specified care to patients receiving mechanical ventilation to help decrease untoward events and complications. The current VAP bundle includes preventative measures to decrease the risk to develop ventilator associated pneumonia. Each VAP event is estimated to add an additional $40,000 to the cost of a patient's care (Youngquist et al, 2007). VAP preventative measures may con-

Table 1 Bundles

Bundles	Performance Indicator Components
Ventilator Bundle	• Head-of-bed (HOB) elevation • Implementation of a daily "sedation vacation" along with a readiness-to-wean assessment • Peptic ulcer disease prophylaxis • Deep vein thrombosis prophylaxis
Central Line Bundle	• Hand Hygiene • Maximal Barrier Precautions Upon Insertion • Chlorhexidine Skin Antisepsis • Optimal Catheter Site Selection, with Subclavian Vein as the Preferred Site for Non-Tunneled Catheters • Daily Review of Line Necessity with Prompt Removal of unnecessary Lines
Severe Sepsis 6 hour Resuscitation Bundle	• Measure serum lactate • Obtain blood cultures prior to antibiotic administration • Administer broad-spectrum antibiotic, *within 3 hrs of ED admission and within 1 hour of non-ED admission* • In the event of hypotension and/or a serum lactate > 4mmol/L, deliver an initial minimum of 20 ml/kg of crystalloid or an equivalent • Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) > 65 mm Hg *In the event of persistent hypotension despite fluid resuscitation (septic shock) and/or lactate >4 mmol/L* • Achieve a central venous pressure (CVP) of ≥ 8 mm Hg • Achieve a central venous oxygen saturation (ScvO2) ≥ 70% or mixed venous oxygen saturation (SvO2) ≥ 65%
Severe Sepsis 24 hour Management Bundle	• Administer low-dose steroids for septic shock in accordance with a standardized hospital policy. *If not administered,* document why the patient did not qualify for low-dose steroids based upon the standardized protocol. • Administer drotrecogin alfa (activated) in accordance with a standardized hospital policy. *If not administered,* document why the patient did not qualify for drotrecogin alfa (activated). • Maintain glucose control ≥ 70, but < 150 mg/dl • Maintain a median inspiratory plateau pressure (IPP)* < 30 cm H20 for mechanically ventilated patients

tribute to decreased cost and mortality. The VAP bundle has been successfully reported to reduce the episodes of VAP (Resar, 2005; Youngquist et al, 2007).

Implementation of the VAP bundles requires education sessions, continuous assessment, data collection, and performance feedback. VAP bundle education for nurses has shown significant improvement in maintaining the head of the bed (HOB) >30° (Tolentino-DelosReyes & Ruppert, 2007). Daily patient care rounds can be utilized to assure bundle compliance and facilitate multidisciplinary education.

Central Line Catheter Bundle

Central venous catheters (CVC) are used in the inpatient and outpatient setting. Presence of a CVC can put patients at increased risk for infection due to the break in the skin where the catheter is inserted. Infection may also place the patient at danger for severe sepsis and risk for death. Reports find that 90% of blood stream infections are associated with the presence of a CVC (Mermel, 2000). The estimated cost of a catheter related blood stream infection is $3,700-$29,000 (Soufir, 1999).

Compliance with the central line bundle should be assessed daily and with each new catheter insertion. Decreased line infections have been reported by multiple facilities when all elements of the bundle are completed 100% of the time (Berenholtz, 2004). Empowering nurses to actively assess compliance with the central line bundle may aid in assuring the best care practice with CVC.

Severe Sepsis Bundle

Severe sepsis is an expensive common diagnosis often requiring an ICU admission. The estimated cost for a patient with severe sepsis was reported to be $22,100 with an increased cost in non-survivors (Angus et al 2001). Mortality from sepsis ranges from 30-50% (Angus et al 2001). The Severe Sepsis Campaign (SSC) guidelines for the care of patients with severe sepsis and septic shock provided the format for a quality improvement program designed to decrease mortality from sepsis (Dellinger et al 2005). The SSC collaborated with the IHI to develop two care bundles, the 6-hour resuscitation and the 24-hour management bundles.

Application of the severe sepsis bundles has been reported by several investigators to have positive results. Two acute care hospitals in England collaborated in a study to evaluate sepsis bundle compliance on outcomes and found that non-compliance with the sepsis bundles had an increase in mortality (Gao, 2005). A national sepsis education campaign in Spain resulted in increased compliance with the sepsis guidelines and decreased hospital mortality (Ferrer et al 2008). Results from more than 120 institutions reporting their severe sepsis bundle data to the central site at the Society of Critical Care Medicine will be reported soon.

Measuring Compliance and Performance Feedback

Performance thrives when supportive, dedicated, knowledgeable healthcare providers have the proper tools and information available. Education, ongoing measurement of performance indicator compliance, and outcomes are necessary for ensuring best care practices. Performance feedback allows caregivers to view the results of their effort. Compliance with the bundle quality indicators in eligible patients may be the building blocks to provide the best care possible.

Discussion

The bundle care concept has been shown to improve process of care, decrease complications and mortality. Bundles are expanding to other areas of performance improvement. Reported new examples include the antibiotic bundle (Cooke & Holmes, 2007), pressure ulcer prevention bundle (Baldelli & Paciella, 2008), and ventilator weaning bundle (Crocker & Kinnear, 2008). Voluntary participation in national and statewide collaboratives using the bundles to improve patient care and outcomes is ongoing. Cooper staff members continue to serve as faculty and participate in these learning sessions. Evaluation of our patients' needs and safety risk remains the first step in improving patient care. Inclusion of a patient care bundle may assist in prevention of undue harm and or potential complications. Raising awareness and increasing our knowledge will ultimately benefit our patients and the institution as a whole.

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Patient-Family Centered Care: *Is it Good Medicine?*

Diane Flaherty, RN, MSN, MBA, NE- BC

Why Patient-Family Centered Care?

Whether it is called patient-centered care (PCC), patient-family centered care (PFCC), relationship-based care (RBC), or Planetree, creating an optimal healing environment for patients should be the number one concern for healthcare organizations and caregivers. The concept of patient-centered care is not new and in fact, it can be traced back well over a century. In her 1859 publication *Notes on Nursing*, Nightingale wrote:

> "The negative effects of foul odors, noise, obnoxious staff and visitors, tasteless food, dirt and hurried activity are deleterious to patient recovery. The healing nurse-patient relationship, hospital design for good hygiene, light and air in combination with beauty and symmetry are essential to healing."

Even with observations such as Nightingales', hospitals have historically been constructed as functional and efficient spaces with little emphasis placed on the mental and spiritual aspects of the healing environment (Geary, 2003). In fact, the hospital environment has often been compared to that of a prison since patients and prisoners alike are placed in dreary buildings with cold floors and drab surroundings (Geary, 2003). One may also argue that hospitals and prisons share the same philosophy when it comes to serving food given that patients and prisoners are often subjected to bland meals served at inflexible mealtimes. This type of atmosphere is certainly quite opposite of the healing environment that Nightingale described.

In order to expedite the healing process, patient-centered models of care suggest that the patient be the focal point when planning care. In addition, care should be personalized to meet the individual needs and preferences of every patient. The Institute of Medicine supports this notion and in 2001 they recommended that healthcare organizations become patient-centered rather than provider-focused, with plans of care designed to include patients' preferences and beliefs (Davidson et al., 2007).

Since it is suggested that a patient's plan of care be designed according to their wishes, it is essential for healthcare providers to know just exactly what it is that patients find important. After a decade of research and 350,000 patient survey interviews, the Picker Institute identified eight dimensions of care that patients value most. In the 1993 Picker Institute sponsored publication *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care,* the following Picker Dimensions of Quality was introduced:

- *Respecting a patient's values, preferences and expressed needs*
- *Access to care*
- *Emotional support*
- *Information and education*
- *Coordination of care*
- *Physical comfort*
- *Involvement of family and friends*
- *Continuity and transition*

According to the research, considering these eight dimensions when planning and implementing a plan of care will assist in improving a patient's overall satisfaction with their experience (Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993).

Although the Picker Institute may have conducted one of the most extensive patient surveys regarding perceptions of quality,

the Planetree Model began to shed light on the things that patients value most in years prior. The Planetree organization was founded in 1978 by Angelica Thieriot whose own experience both as a patient and family member of a hospitalized individual inspired her to address the way healthcare was being delivered. While Thieriot thought that the quality of the technical care received was good, she felt as though there was no humanistic aspect to the care (Frampton, Gilpin, & Charmel, 2003). Similar to the Picker Dimensions of Quality, the Planetree Model identifies ten elements of patient-centered care.

Planetree emphasizes that the human interaction element includes how the caregivers of the organization are treated. The model suggests that it is important to nurture relationships among coworkers and provide reward and recognition to employees. The idea is to keep employees energized about the work they do each and every day so they are able to assist in creating a healing environment for patients. Simply put, happy employees help make happy patients.

The idea is to keep employees energized about the work they do each and every day so they are able to assist in creating a healing environment for patients. Simply put, happy employees help make happy patients.

Not only do patients deserve care tailored to include their preferences and beliefs, they are starting to demand it. Consumers of today expect a different kind of purchasing experience than they had previously sought (Frampton, Gilpin, & Charmel, 2003). With all the choices that are available in the marketplace, consumers expect options that coincide with their desires and needs. Successful businesses have done a good job of tuning in to the things that consumers want. It helps them to build brand loyalty and keep customers coming back. Healthcare organizations however, have been slow to change. Many organizations continue to define their product as a good technical or physical outcome (Frampton, Gilpin, & Charmel, 2003). Somewhere along the way healthcare organizations forgot why people come to them. Patients come not only for medical care; they also seek support, comfort, hope, and caring (Frampton, Gilpin, & Charmel, 2003).

Healthcare organizations that embrace the patient-centered care philosophy can reap the benefits of producing some significant positive patient outcomes. Kaplan, Greenfield, and Ware published a 1989 report that found patients with a chronic disease who were involved in decision making showed improvement in functional status and had a reduction in physiologic disease markers such as blood glucose levels (Sidani, 2008). Other studies indicate that lack of human interaction and social support can lead to poor cancer survival rates. In his 1993 book *Living Beyond Limits,* David Spiegel cites these studies and proposes that social support may serve as a buffer against stress, possibly decreasing the production of cortisol and prolactin—two known stress hormones (Frampton, Gilpin, & Charmel, 2003). The reduction of these hormones can help guard the immune system as stress is known to have ill effects on it.

In addition to improving patient functional status, decreasing physiologic disease markers and improving cancer survival rates, the practice of patient-centered care has been linked to a decreased patient length of stay (LOS). A 2007 study published in *Clinical Orthopaedics and Related Research* reported data collected on 618 patients that received elements of patient-family centered care after undergoing either a total hip arthroplasty or a total knee arthroplasty. The study revealed the LOS for these patients averaged 2.7 days while the national average LOS was 3.9 days (DiGioia, Greenhouse, & Levison, 2007).

Some of the most significant data existing on the positive outcomes of adopting a patient-centered care culture is with regard to

Until recently, satisfaction scores merely provided hospitals a means of self-assessment on how they perform and where improvements need to be made. Moving forward, patient satisfaction scores will be publicly reported. In addition, governmental payers could begin to reimburse hospitals based on their scores.

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patient satisfaction. More than ever before, patient satisfaction scores are weighing heavily on the minds of healthcare organizations across the country. Until recently, satisfaction scores merely provided hospitals a means of self-assessment on how they perform and where improvements need to be made. Moving forward, patient satisfaction scores will be publicly reported. In addition, governmental payers could begin to reimburse hospitals based on their scores.

For over two decades, the research has indicated that organizations who embrace the patient-centered care philosophy produce higher patient satisfaction scores. From 1986-1990, the University of Washington conducted a controlled trial of 618 patients hospitalized on the first Planetree unit and compared their outcomes with patients on other medical-surgical units. The Planetree patients were found to be significantly more satisfied with their overall hospital stay, nursing care, social support, environment and education they were given (Frampton, Gilpin, & Charmel, 2003). A 1996 randomized trial of 273 patients discharged from units that practiced patient-centered care also resulted in those patients reporting higher levels of satisfaction than the control group (Martin, Diehr, Conrad, Davis, Leickly, & Perrin, 1998). A Canadian study published this year further validated the above studies indicating that patients receiving patient-centered care have increased levels of patient satisfaction (Sidani, 2008).

Cooper's Commitment to Patient–Family Centered Care

In early 2007, Cooper University Hospital's Board of Trustees and senior leadership clarified our organization's vision:

> ***Cooper University Hospital will be the health care leader in the Delaware Valley, providing exceptional medical care and service for every patient, every day in a patient-centered, family focused environment.***

Cooper's leaders and staff spent more than a year benchmarking and exploring philosophies and approaches that would best support our organization in achieving our vision of providing higher levels of patient and family-centered care. Following numerous consultations with the Planetree organization and visits to several Planetree Affiliate sites, Cooper's Board and senior leadership decided that the Planetree philosophy of personalizing, humanizing and demystifying the patient and family healthcare experience and its ten organizing components would provide the best roadmap for our journey.

In April 2007, Cooper's leadership made a decision to become a Planetree Affiliate. Planetree Affiliates have the opportunity to network with other organizations committed to the creation of patient-centered care environments, differentiate ourselves in the marketplace as being a leader for change in healthcare and learn about new and innovative programs developed by Planetree that will assist our organization in providing patient-family centered care. Most importantly, Affiliate status gives us the support and guidance needed to transform our culture.

Our journey toward becoming a culture of patient-family centered care is well underway. To date, over 1,200 employees have attended a Planetree staff retreat and five component teams are in place working on various projects to assist in creating an optimal healing environment for both patients and employees. Some of the

programs currently being offered due to the hard work of the component teams include a hand massage program for patients, a multicultural music series in the lobby, the Art Aware program, a drop in De-Stress Program for employees, new physician recognition via all Cooper email, Compassionate Hands celebration for employees and a decibel reader pilot on North 7 to promote noise reduction. Projects currently in discussion include satellite music in the ER and Kelemen main stairwell, new web-based employee reward and recognition program, traveling activity/art cart for patients, white rose program and outdoor seating for employees at 3 Cooper.

The evidence suggests that not only is patient-centered care what today's discerning healthcare consumer wants, it is also needed to create an optimal healing environment. Data also exists suggesting that it can improve some key clinical outcomes and improve patient satisfaction. Although the extent to which patient-centered care is "good medicine" is still uncertain, ethically, it is indisputably the right thing to do. In the near future, healthcare organizations will most likely depend upon it to remain fiscally sound.

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Palliative Nursing Care

Christina Hunter RN, BSN, OCN; Mary Jane Durkin RN, BSN, OCN

Earn Contact Hour Credit (Contact Hour: 1.0)

Learning Objectives:

1. Discuss the nurses' role of providing quality palliative care
2. Describe the philosophy and principles of hospice and palliative care.
3. Identify the importance of collaboration within the interdisciplinary team
4. Describe the need for a thorough assessment of physiological, psychological, spiritual and social domains of quality of life for patients and families facing a life threatening illness or event

Nurses spend more time with patients who are facing the end-of-life than any other member of the healthcare team. Yet, many nurses feel inadequately prepared to provide comprehensive care due to the lack of resources and education offered for end-of-life nursing care. Research has helped to identify the need to improve palliative care and provide nurses with quality resources. The End of Life Nursing Education Consortium (ELNEC) was founded to provide a resource for nurses who assist patients and families with palliative and end-of-life care. Nurses should not work in isolation, but rather collaboratively with physicians and other members of the healthcare team to ensure the patient and family receive quality comprehensive care.

Table 1 **Deficiencies and Barriers in Providing Adequate Palliative Care** (NIH, 2004; Jennings et al., 2005)

Inadequate care for seriously ill hospitalized adults
Lack of training, knowledge and skill of health care providers
Communication barriers regarding goals of care
Aggressive curative treatments in advanced disease
Inadequate and inappropriate use of hospice services
Patients are dying in institutions when they would rather have died in their own home
Aggressive curative treatments that prolong the dying process and contribute to physical and emotional suffering
Lack of training in the area of pain management and other end-of-life symptoms
Restrictive visiting hours for families

Table 2 **Leading Causes of Death** (Minino, 2007)

10 leading causes of death in the U.S. in the year 2000 in order of prevalence
Heart Disease
Malignant Neoplasms
Cerebrovascular Diseases
COPD
Accidents
Diabetes
Alzheimer's Disease
Influenza and Pneumonia
Kidney Disease
Septicemia

History and Research

Nursing has a long history of caring for patients experiencing end-of-life and palliative care issues. Research studies reveal major deficiencies in providing adequate end-of-life and palliative care (Table 1). For this reason, a substantial need exists to improve palliative care. In America, a disparity exists between the way people die and the way they want to die. Most adults would prefer to be cared for at home if terminally ill and would prefer to be involved in a comprehensive program of end-of-life care, such as hospice. Americans have many fears and concerns about the death and dying process, such as; fear of being in pain, fear of being a physical and financial burden to their families or their elderly spouses, fear of the prospect of a prolonged death, and the fear of abandonment by healthcare providers.

Many changes have occurred over the last century regarding death and dying in America. In the late 1800's health care providers had little to offer the sick beyond the easing of symptoms associated with disease. Most deaths occurred at home with the extended family members caring for the dying person and most people died within days of the onset of their illness. In the early to middle 1900's immigration in the United States was at a peak and was followed by the first "baby boom." Vast improvements in living and working conditions, sanitation, an emphasis on disease prevention, and decreased infant mortality have improved patient outcomes. The focus of healthcare during this era shifted from easing suffering to curing disease. Society's expectations changed regarding treatments and interventions for curable as well as incurable illnesses. Patients whose disease failed to respond to treatments were given less priority. Death itself became equated with medical failure.

Over the past 100 years, we have witnessed many changes in cause of death, demographic, and social trends. Degenerative diseases replaced communicable diseases as the leading causes of death in the U.S. and in most economically advanced countries. In 2000, the ten leading causes of death accounted for 80% of all deaths in the United States (Table 2). Life expectancy has risen sharply and death rates have declined, which has been linked to the reduction in infant and child mortality. In the early 1900's people died at home surrounded by loved-ones, however today, people are dying in institutions with strangers caring for them, as they suffer from prolonged, chronic illnesses with an increased financial burden being placed on their families because of expensive treatments being offered and provided.

Defining Hospice and Palliative Care

Hospice began in the late 1960s when modern programs to care for dying patients were organized. The word "hospice" borrowed from the Middle Ages, was used to designate way-stations for pilgrims on their way to the Holy Land. Today, hospice care is a delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical,

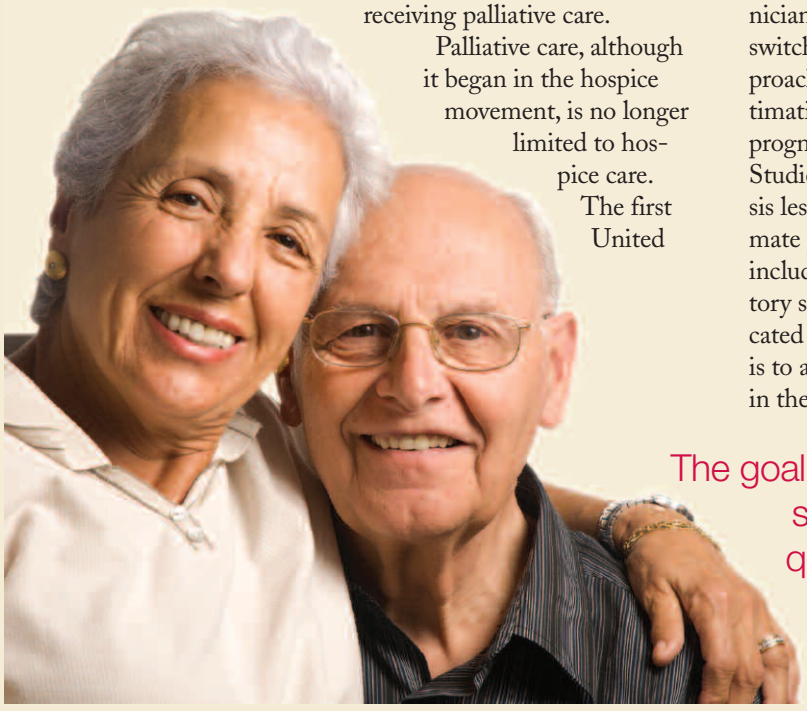
(continued on page 12)

(continued from page 11)

psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. Hospice supports the patient and the surviving family through the dying and bereavement process. In addition, comprehensive medical and supportive services are provided across a variety of settings and are based on the premise that dying is a part of the normal life cycle. Care is provided in homes, residential facilities, hospitals, nursing facilities and other settings such as prisons.

Terminally ill patients and their families often resist hospice care because it is associated with death. This resistance has forced healthcare providers to begin advocating for the use of an alternative concept, which is palliative care. Palliative care is defined as both a philosophy of care and an organized structural system for delivering care (Sepulveda et al., 2002; World Health Organization, 2002). This approach can improve the quality of life for patients and families facing life-threatening illness, through the prevention and relief of suffering accomplished by early identification, impeccable assessment, and treatment of pain.

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of stage of the disease or the need for other therapies. It expands traditional disease-model medical treatments to include goals of enhancing quality of life for patients and family members, assistance with decision-making, and providing opportunities for personal growth. An interdisciplinary team can provide care along with life-prolonging treatment or as the main focus of care. Integral to all health care delivery settings palliative care identifies physical, psychological, spiritual, and practical burdens of illness. The word palliative comes from the Latin word pallium meaning cloak or cover-up. The goal is to "cover-up" the pain and other debilitating symptoms so that they are reduced and no longer visible. Aggressive symptom management is prescribed in order to improve quality of life. The patient may be actively receiving treatment for symptoms such as surgery or radiation and at the same time receiving palliative care.



Palliative care, although it began in the hospice movement, is no longer limited to hospice care. The first United States hospital-based palliative care programs began in the late 1980s at only a handful of institutions. Hospice includes: interdisciplinary care, medical appliances and supplies, drugs for symptom and pain relief, short-term inpatient and respite care, homemaker/home health aide assistant, counseling, spiritual care, volunteer services, and bereavement services. Some agencies provide home palliative services, as well as home hospice, so that patients can more easily transition between the two services. Both provide interdisciplinary care of the whole person and family including education and support, as well as providing bereavement services. The goal is to improve the quality of life for the patient and their family.

Nurses are the health care providers who spend more time with patients and their families than any other member of the health care team. Nurses can impact quality of life by identifying persons with any life-threatening illness or condition. This identification can occur in a variety of settings including acute care, emergency departments, rehabilitation centers, long-term care, skilled nursing facilities, infusion clinics, and at home. Early identification means that palliative care can be started sooner, allowing patients and families to set and achieve goals (Coyle, 2006).

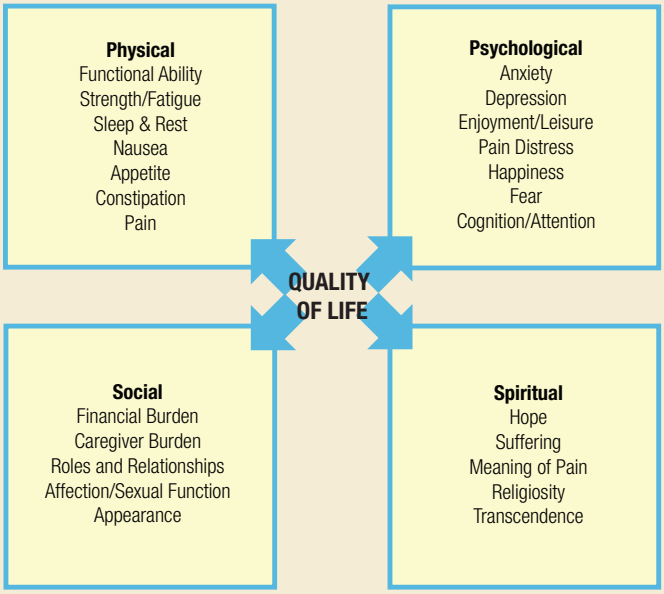
Quality of Life Model

The meaning of quality of life differs from person to person and is defined by one's own life experience. It is important to examine each dimension of the patient and families life, which encompasses the physical, psychological, social and spiritual, by examining each dimension nurses are able to assist in providing the most holistic care possible. The dying process impacts all dimensions (Ferrell, et al., 1991). Healthcare providers should not assume what "quality" means to the patient and family. Quality of life is determined by the unique needs of the patient and family.

Guidelines and Tools

In the early stages of illness, prognoses help clinicians and patients weigh the benefits of therapies. In advanced stages, the clinician and patient may need to re-examine goals of care and switch to aggressive palliative care over aggressive curative approaches (Lamont & Christakis, 2002). Prognostication is the estimation of the future course of a disease and survival. Reliable prognostication in advanced disease is difficult, if not impossible. Studies indicate that physicians tend to accurately predict prognosis less than one-third of the time, and generally tend to overestimate prognosis (Lamont & Christakis, 2002). Survival predictors include performance status, clinical signs and symptoms, laboratory studies, and clinician predictions. While studies have indicated that clinicians tend to overestimate survival, a useful method is to ask yourself "Would I be surprised if this patient were to die in the next six months or so?" This helps the clinician determine

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of stage of the disease or the need for other therapies.



ENECL SuperCore Curriculum

Adapted from Ferrell et al., 1991

when further discussions are needed, revisiting goals of care, and for whom appropriate palliative and end-of-life services including advance care planning, comfort care, and increasing psychological, social and spiritual support might be beneficial (Lynn et al., 2000).

Healthcare providers need to assess the patient and identify interventions that can improve palliative care. A number of valid and reliable tools are available to assess the physical and emotional symptoms, spirituality, functional status, quality of life, and caregiver outcomes. Information regarding these assessment tools can be found at the following websites: The Toolkit of Instruments to Measure End-of-Life Care (TIME) (www.chcr.brown.edu/pcoc/toolkit.htm), City of Hope Pain and Palliative Care Resource Center (http://prc.coh.org).

The Nurse's Role

Nurses have a unique opportunity to maintain patients' and families' hope by providing excellent physical, psychosocial, and spiritual palliative care (Esrek, 2006). This can be done by not only preventing and managing end-of-life symptoms, but by encouraging patients and families to transcend their current situation by giving them a sense of control when possible. Encouraging reminiscing and maintaining open relationships, while trying to prevent patient and family isolation. Nurses can help to facilitate participation in religious rituals or spiritual practices. These are not the only defining features for the nursing role, but also support the philosophy and principles of palliative care as well as reflect the dimensions within the Quality-of-Life model.

Everyday, nurses are invited to be present at the last moments of a patient's life and to care for the bereaving family. Nurses can use therapeutic presence as a means to communicating care for the patient struggling with emotional and spiritual elements of suffering associated with multiple losses. One of the greatest gifts nurses can offer to patients and their families is the gift of their presence (Borneman & Brown-Saltzman, 2006).

Conclusion

Patient deaths may be a cause for distress for the nurse therefore, increased knowledge and professional development is essential to improve patient care. There is no right way to die and no cookbook approach, so nurses need to be flexible when meeting the changing needs of the patient and family. Not all deaths are peaceful or "good" and it may be difficult to control symptoms or to resolve issues that the patient and/or family want addressed. Palliative care is best provided when nurses are functioning as part of an interdisciplinary team. Nurses individually, and collectively as a profession, play a vital role in improving care at the end-of-life. In order to continue this difficult work of "not being able to fix things," nurses must grieve the loss of their patients and be grateful for the privilege to make this journey with them. Hopefully, others will accompany us when our time comes – and indeed it will (Vachon, 2006).

We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed…When we are no longer able to change a situation,… we are challenged to change ourselves"

Victor Frankl, 1959
psychotherapist and concentration camp survivor

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Nursing Certification: Raising the Bar

Terri Merola RN, MSN, CPN; Lynn Ruoss, RN, MSN, CCRN- CSC, APN; Linda Wicker RN, MSN, CCRN

Certification is the validation of an individual nurse's qualifications for practice in a defined area, based on predetermined standards, recognized knowledge, skills and abilities beyond the scope of RN licensure and is administered by a nongovernmental agency.

Certification benefits patients, families, employers and nurses. Americans prefer hospitals that employ nurses with a specialty certification. According to a Harris Poll conducted in 2002, three out of four or 75% of those surveyed said that given a choice, they would most likely select a hospital who employs a higher percentage of nurses with a specialty certification.

"One of the primary purposes of nursing certification is to promote the development of specialty areas of nursing by establishing minimum competency standards and recognizing those who have met the standards" (Oncology Nursing Certification Corporation, 2003). The rise in consumerism in the face of a nursing shortage and the profession's movement to elevate nursing as a career option has given prominence to the value of certification in nursing. Nursing certification holds merit not only for nursing practice, it is also essential to meet multiple standards within the American Nurses Credentialing Center's Magnet Recognition Program for excellence in nursing services. (Shirley, M., 2005).

Certification in nursing represents an example of professional credentialing and is a voluntary process undertaken by practicing nurses. Specialty nursing certification is considered THE standard by which the public recognizes quality nursing care. Successful completion of a specific certification examination validates excellence in understanding of the core curriculum content within a nursing specialty , and adherence to practice standards defined in that clinical area. Certification through a national credentialing body involves an understanding of evidence-based nursing practice and application of these practices in a designated clinical specialty. (Shirley, M. 2005).

The American Board of Nursing Specialties (ABNS) performed a survey in June 2005, using the "Perceived Value of Certification Tool," in order to determine the professional nurses' personal value of certification. Using a four point Likert scale for each response ranging from strongly agree to strongly disagree, 18 statements related to certification were measured. Twenty ABNS member organizations representing 36 different certification credentials participated in the survey. Over 94,000 nurses responded. On average most certified nurses had worked in their specialty area for 8 1/2 years prior to becoming certified. Over 95% of the respondents strongly agreed with the following statements:

Nursing Certification:

1. enhances feelings of personal accomplishment
2. provides personal satisfaction
3. indicates professional growth
4. validates professional credibility
5. provides a professional challenge
6. promotes recognition from employers
7. increases overall consumer confidence (Prowant, 2006)

In addition to identifying reasons why nurses seek certification, the survey also analyzed barriers that may deter some nurses from becoming certified. This data was obtained by those nurses who did not hold certifications in their given specialty. The two most common barriers identified were:

1. cost of exam
2. lack of institutional support and rewards for obtaining certification

Another question explored by this survey was why would a certified nurse allow their certification to expire? The following reasons were described:

1. no longer in the given specialty
2. inadequate or no compensation for certification
3. inadequate or no recognition from employer (Prowant, 2006).

At the present time many nurses in the Maternal-Child Division of Cooper University Hospital (CUH) will be seeking their certification through the National Certification Corporation (NCC). Cooper will be hosting the examination in September of this year. Currently, over 60% of the inpatient Pediatric and PICU nursing staff collectively hold a certification in Pediatric Nursing, some of whom have only been nurses for the two year minimum required (to meet the hours worked) to sit for the exam. Additionally, critical care, trauma and progressive care is sending registered nurses to attend a certification course (also in September) taught by a nationally renowned speaker and sponsoring that same speaker in January of 2009. The goal is to send the nurses to a review course and then assist them in registering for, and taking the Critical Care Registered Nurse (CCRN) exam a month later.

Were you aware that CUH will reimburse you, upon successful completion of the certification exam, the full amount of the exam? Being certified at Cooper provides one to three also offers points on the professional clinical ladder. Certification in nursing "raises the bar" in quality patient care, develops and retains nurses within the organization, and support for this endeavor, provides the hospital with a competitive advantage (Shirley, 2005).

If you are certified, congratulations and kudos for your dedication to our patients and our profession. If you are not certified, what is it that is stopping you? You owe it to yourself and to the patients under your care every day to seek this very important professional milestone.

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Wicker-Linda@cooperhealth.edu

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REFLECTIONS:

A Nursing Journey

Diana Mason-Rhock, RN ▪ North/South 10

I got my start in 1987 as a nursing assistant in the Intensive Care Unit, Neuro Science Unit/Ortho and later Trauma Unit/North Seven. I always wanted to be a nurse since childhood, but I just procrastinated about getting started. While working in the ICU, I had started classes but took them inconsistently. As staff on the old North 7 unit, I worked with great nurses like Karen, Dottie, Freya, MJ and Gwen. While providing patient care, Dottie encouraged me to consider going to nursing school. She said that I would make a great nurse because of my compassion and caring ways with patients. So, on my lunch break that day I took a walk down to Camden County College and obtained information on how to get back on the road to becoming that nurse that others saw in me.

I graduated from Camden County College/Our Lady of Lourdes School of Nursing with an Associates Degree in Nursing and am currently a registered nurse on the Medical/Surgical Unit. It is a very rewarding feeling to help others in need of care. I feel nursing is a special gift. I have been fortunate throughout my nursing journey to be able to help others and make a difference in their lives, in and out of the hospital. One patient comes to mind where I made a difference in his life.

It was 06:45 and I was approaching the unit to find the night shift nurses running around in a frenzy. I immediately thought, "Oh my God," it is going to be one of those days, which is the start of my work week. After report was given, I took a deep breath, looked over my assignment to see which patient I would see first. When I re viewed all of my patients, it really didn't matter who to see first since none of them had life threatening issues. However, one patient did catch my eye; a male in his 30s admitted with bowel obstruction. He refused on admission and the shift prior to take any meds to help him prep for further studies (x-rays, CT scan). I said to myself, he didn't have me yet let me try. I believe communication is one of my strongest attributes with my patients and family.

So I went in to the patient room, introduced myself to him and his family. I asked him and his family what they understood so far about their son's plan of care and the reason he was admitted. The patient stated that the doctors informed him that he needed surgery on his bowels and he might not make it through. The parents started to initially blame themselves saying they shouldn't have fed him those unhealthy foods which contributed to his clogged bowels. I asked the patient and his parents if I can explain what is happening and the treatment that can be started to prevent surgery. So I reassured the patient and his family as I began to explain any and all treatments we can administer before surgery is considered. The patient and his family agreed as long as I was a part of the plan of care. I had the patient for the next three days and one including overtime. So every morning I would come into his room and he was ready for his treatment plan with a smile as well as his family. The fear of surgery was a sigh of relief and trust was built between the patient, family and myself. By the end of the week, the patient was able to avoid surgery and go home and continue living his normal life.

A nurse is never alone in caring for her patients. In these particular case health care members such a dietary and social worker were notified. The parents of the patient were in their 70s and taking care of him all by them selves. One week later after discharge I ran into the patient's family and they thanked me with sincere gratitude. They shared that they were able to get a nursing assistance for a couple hours a day. Not only could the parents enjoy sometime together but the patient was able to get one on one care. As I departed from the family, they asked me again how they can repay me for what I have done spared their son surgery and possible his life. I answered with a smile, "I am a nurse, that's my job!"

"It is a constant challenge to see patients at their worst sickness and a blessing to help them get better. I know that sometimes taking care of the patients involves taking care and giving support to their families."

It is a constant challenge to see patients at their worst sickness and a blessing to help them get better. I know that sometimes taking care of the patients involves taking care and giving support to their families. You must teach and educate not only he patient, but the primary care giver as well. My family will frequently ask me why I go to work happy and never complain. I tell them that I love what I do; it comes natural! Each day a difference is made in someone's life and I can honestly say that I was a part of making that difference. How many professionals can say that and truly mean it. With nursing, I honestly can say it is my bag and I offer 110% to my patients being there for them clinically, emotionally and spiritually.

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Professional News

PRESENTATIONS:

Trends in Trauma & Cardiovascular Nursing, Valley Forge Convention Center; King of Prussia, PA, April 7-10, 2008
Presentation: Mastery Session: Trauma-getting beyond the basics
Kathy Devine, RN, BSN, CCRN; Stacey Staman, RN, MSN, CCRN, Diane Floyd, RN, BSN, CCRN, CNA, and Debra Williams, RN, MSN

Trends in Trauma & Cardiovascular Nursing, Valley Forge Convention Center; King of Prussia, PA, April 7-10, 2008
Presentation: The High Profile Patient: Managing behind the scenes
Diane Floyd, RN, BSN, CCRN, CAN

Trends in Trauma & Cardiovascular Nursing, Valley Forge Convention Center; King of Prussia, PA, April 7-10, 2008
Presentation: Blast Injuries
Kathy Devine, RN, BSN, CCRN

NJ Hospital Association Pressure Ulcer Collaborative March 25, 2008
Poster Presentation
Elizabeth Adomanis, RN, CCRN

2008 Oncology Nursing Society Congress May 15, 2008 Philadelphia, PA
Podium Presentation: Educational Parties as a Strategy to Promote Breast Health Awareness in the Underserved Population
Sharon Byrne RN, MSN, APN, NP-C, AOCNP

2008 Cancer Institute of New Jersey/ Robert Wood Johnson Medical School Annual Cancer Retreat May 28, 2008
Poster Presentation: Educational Parties as a Strategy to Promote Breast Health Awareness in the Underserved Population
Sharon Byrne RN, MSN, APN, NP-C, AOCNP
Evelyn Robes-Rodriguez RN, MSN, APN,C, AOCN

PUBLISHED:

Lynn Ruoss, RN, MSN, CCRN-CSC, APN
Insulin pumps: Improving quality of life, *Advance for Nurses,* August 18, 2008

Mary Stauss RN MSN APN CEN
Therapeutic hypothermia for cardiac arrest survivors, *Journal of Emergency Nursing,* August 2008.

AWARDS:

Cooper University Hospital 2008 Nursing Excellence Award Recipients:

Christina Puglia, RN
Clinical Nurse Excellence Award

Priscilla Van Sant, RN
Charlotte Tobiason Memorial Award

Susan Hoffman, RN
Excellence in Trauma Nursing Award

Kelly Jakubowski, RN
Jean Patterson Award

Amy Stevens, RN
John Kronenberger Memorial Award

Joan D'Antonio, RN
Ruby Gross Leadership Award in Nurse Excellence

Andrea Spagnola, RN
Carol G. Tracey Compassion Award

Tenille Stubbs
Excellence in Perioperative Surgical Technology Award

Barbara Riley, RN
Excellence in Perioperative Nursing Award

Mary Jane Durkin, RN
Moorestown Auxiliary Memorial Award for Excellence in Outpatient Nursing

Brooke Walsh, RN
Moorestown Auxiliary Memorial Award for Geriatric Nursing

Phyliss DiCristo, RN
Sara Hirsch Memorial Award for Excellence in Oncology Nursing Practice

Veronica Kaiser, RN
Theodore Hirsch Memorial Award for Excellence in Cardiovascular Nursing Practice

Iris Medina
Theodore and Sara Hirsch Memorial Award

Brooke Walsh, RN
2008 Nursing of the Year Award

2008 Nominees for Clinical Excellence Awards:

Kate Wood,
Tracy Reynolds,
Deihann Cooper
Clinical Nurse Excellence

Donna Louis,
Maryanne Figueroa
Jean Patterson Memorial Award

Susan Sherman
Ruby Gross Leadership

Pearl Lawrence
Perioperative Surgical Technology

Kimberly Vaughan
Perioperative Nursing

Elizabeth Koch,
Beth Sherman,
Bernadette Malinowski
Moorestown Auxiliary Memorial for Outpatient Nursing

Debra Rever
Theodore and Sara Hirsch Memorial Award

Kathleen Bryson
Moorestown Auxillary Memorial for Geriatric Nursing

Other Awards:

Datascope and AACN Multidisciplinary/ Collaboration Award for 2008. Given to the ICU/CCU and ED staff at the AACN National Teaching Institute, May, 2008 in Chicago. Nominated by Christa Schoor, RN, BSN and Mary Stauss, RN, MSN, CEN, APN

DEGREES:

Kathleen Yhlen, RN, MSN, NE- BC
University of Delaware

Linda Wicker, RN, MSN, CCRN
Faileigh Dickinson University

CERTIFICATIONS:

Sharon Byrne RN, MSN, APN, NP-C, AOCNP
Nurse Practitioner, Cancer Screening Project
Advanced Oncology Certified Nurse Practitioner

APPOINTMENTS:

Carole-Rae Reed, PhD, RN, CS, APN BC
Research Coordinator
Department of Patient Care Services

Linda Rowan, RN
Interim Heparin Protocol RN

LADDER APPOINTMENTS:

Level 3

Jamie Eisle, RN . . . . . TICU
Glenn Zeigler, RN . . . . . TICU
Susan Lieberman, RN . . . . . M/I
Christina Richards, RN N7
Diane Yerkes, RN . . . . . VSC
Elaine Helmer, RN . . . . . Cath Lab
Dale Beloff, RN . . . . . NICU

Level 4

Donna Wood, RN . . . . . NICU
Dina Pleis, RN . . . . . NICU
Christine Ward, RN . . . . . M/I
William Sheffield, RN . . . . . Special Tests
Jane Hassan, RN . . . . . NICU
Lucy Suckhrie, RN S5

Level 5

Lorraine Pugh, RN . . . . . ED
Barbara Wenning, RN . . . . . Cath Lab
Dominic Parone, RN . . . . . ED
Cynthia Baggot, RN . . . . . Cath Lab
Katie Hilferty, RN . . . . . PICU

Level 6

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