



Bridges to Excellence

A publication for nurses and healthcare professionals

WINTER 2008-2009 ■ VOLUME 2, ISSUE 3



At the **Heart**
of the Matter

Professional Calendar

JANUARY 2009

- 5 • Dysrhythmia Interpretation Review Class
- 6 • The Power of Optimistic Thinking
- 12 & 13 • CCRN Review Course
- 13 • "First-Five Minutes" Course
- 19 • It's How To Say It
- 19 • Wound Care Updates
- 20 • Advanced LifePak 20 Training
- 21 • RN Preceptor Workshop
- 23 & 30 • ONS Chemotherapy and Biotherapy Course
- 27 • "First-Five Minutes" Course

FEBRUARY 2009

- 4 • Emotional Intelligence
- 4 • Mediation for Managers
- 6 • Advanced Preceptor Workshop
- 6 • Dysrhythmia Interpretation Review Class
- 6 • Code Review and Crisis Management for the Critical Care RN
- 6 • Wound Care Updates
- 10 • "First-Five Minutes" Course
- 12 • Spotlight: Effective Presentation & Posters

MARCH 2009

- 2, 4, & 6 • Basic Dysrhythmia Course
- 6 • Introduction to Performance Improvement
- 10 • "First-Five Minutes" Course
- 11 • Neonatal Developmental Series
- 12 & 19 • End of Life Nursing Education
- 13 • Code Review and Crisis Management for the Critical Care RN
- 17 • How to Deal with Challenging People
- 17 • Advanced LifePak 20 Training
- 24 • "First-Five Minutes" Course
- 30 • Wound Care Updates

For more information on continuing education courses please contact Cooper University Hospital, Patient Care Services-Education Department at **856-342-2459**; or log onto **www.cooperhealth.org**

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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



At the writing of this edition of Bridges to Excellence the country has a new President-elect and a deepening economic crisis. On the healthcare front we await a new Secretary of Health and Human Services and a promise of broader healthcare coverage for citizens. With the vast line up of issues to address, health care may move back on the priority list. We await what the future holds and continue to struggle with balancing increasing expense and shrinking revenues. Pay for performance is upon us and we play an integral role in providing safe, cost effective care.

As I read this edition I was reminded of our constant search to find the best answers to improve care despite the economic or social barriers. The power of the interdisciplinary team to create improved care plans and education is exciting and rewarding. Our focus must be to create a sense of teamwork among disciplines to continually ask the right questions and move to the right answers in our care.

Please begin to turn the pages within. I hope you will find this edition informative and a call to action for improved performance.

Best regards,

A handwritten signature in black ink that reads "Elizabeth Bobulski". The signature is fluid and cursive, with the first name and last name clearly legible.

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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



At the Heart of the Matter

Maryann Powell, RN, MS

Heart failure (HF) is just one of many significant Joint Commission core measures. The term core measure indicates a systemic, organized approach to treating specific diseases. This article will focus on the HF core measures developed by the Joint Commission in conjunction with the Center of Medicare and Medicaid Services (CMS) and the American Heart Association (AHA).

The current HF core measures include multiple elements which must be met in order to be in total compliance. Hospitals are scored according to how completely these measures are met. HF Core Measures (Table 1) and how well we document the stringent criteria specific to the elements of discharge instructions, evidenced-based HF medications at discharge, diet management through sodium monitoring, left ventricular assessment, and smoking cessation counseling are crucial to how we are viewed by the consumers and other providers. Patients and families can go to various web sites to view and compare hospital scores.

Meeting or not meeting the HF core measures can generate significant emotional responses from nurses, physicians and other members of the health care team. "We take good care of our patients," "just because we don't do the paperwork right doesn't mean we don't give good care," "this is just another ploy from the Joint Commission – it's not important to the patient," "of course we give great care, we are just not good documenters," "patients get confused with all of this information," "other hospitals that score perfectly, just do the paperwork, they don't really take care of the patient."

Unfortunately, we can provide the best possible care to all of our HF patients but if compliance of the evidenced-based core measures for HF is not documented, we are not meeting the needs

Consistent education and diligent preparation of the patient and caregiver for home management is mandatory for a safe transition to the home care setting.

of our patients. Care in the home setting is no longer simple. Elderly patients and their caretakers are expected to manage and administer complex and highly potent medications, increase and decrease dosages, stop and start drugs, know which drugs to take, read labels, understand portions, know sodium content of food, understand weight fluctuations, symptom control, and assume overall management of care. Thus, consistent education and diligent preparation of the patient and caregiver for home management is mandatory for a safe transition to the home care setting.

Cooper University Hospital (CUH) is striving to organize the safe discharge of our patients. This takes the whole team, all pulling together, all understanding and knowing the standards by which excellent care for HF is measured and executed.

In June 2007, CUH was the recipient of a two year grant sponsored by the Robert Wood Johnson Foundation. The purpose of this grant is to closely examine the heart failure population, determine exactly who they are, where they reside and how well healthcare providers are meeting their physical, educational and social needs in the hospital setting. Additionally, grant recipients are charged with careful identification and assessment of any barriers to patient care based on the race and ethnicity of HF patients. At this point, our perception was that we were fair and equitable in the delivery of care and that we consistently met all standards of care for the HF patient.

After 15 months of assessment and 2500 patient visits entered into the database, we have facts rather than perceptions to closely examine. We have a multidisciplinary team of dedicated and caring professionals. Physicians, nurses, dietitians, dietary aides, nursing assistants, physician assistants, data collectors, statisticians and the entire North and South 8 Nursing Team under the leadership of Lynda Giordano, RN, Clinical Director and Kathy Polimeni, RN, and Rowena Ripa, RN, Clinical Nurse Educators are committed to improving the outcomes of our HF patients. The data corrected the many misperceptions about who our patients were, where they came from, where they went after discharge and what their needs were. (Table 2)

The first objective of the grant is to monitor and improve the collection of race and ethnicity data at the time of admission to the hospital. When we initiated data collection, 25% of this vital information was missing from the patient's medical record. The data field was frequently left blank or identified as unknown.

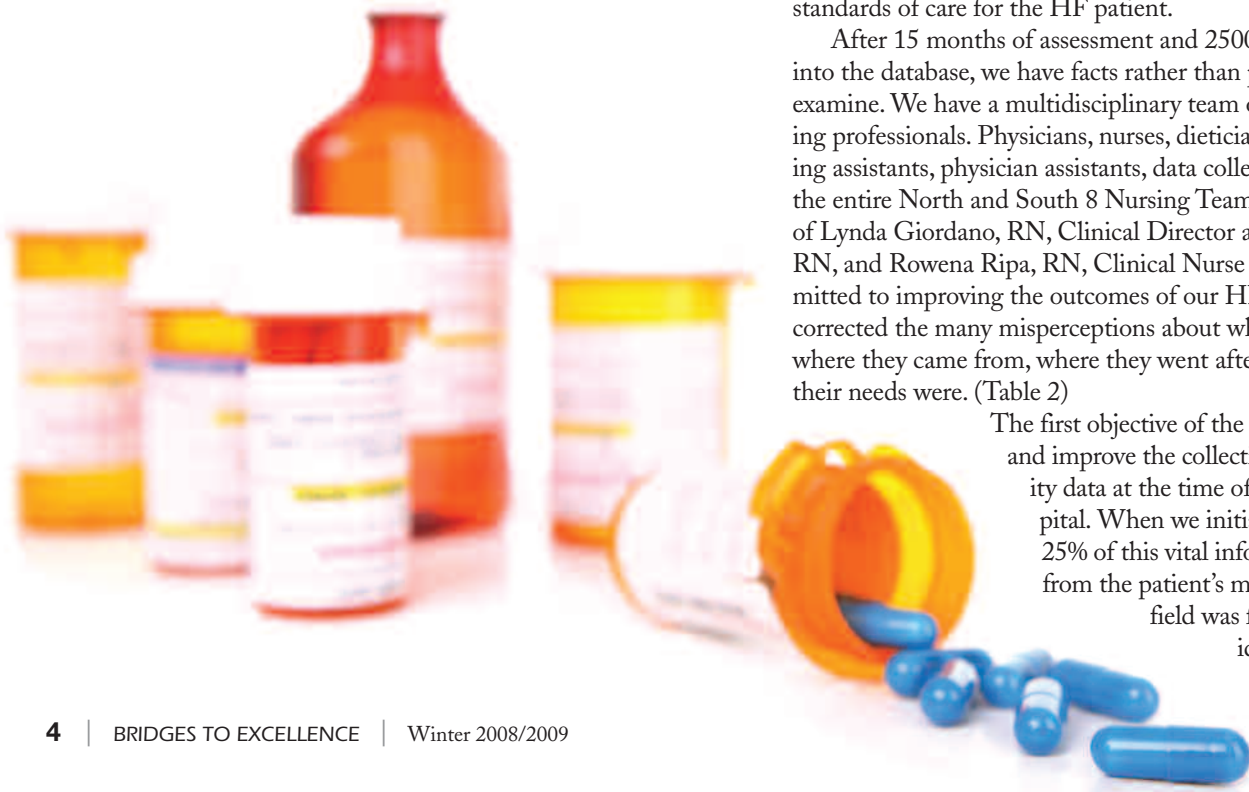


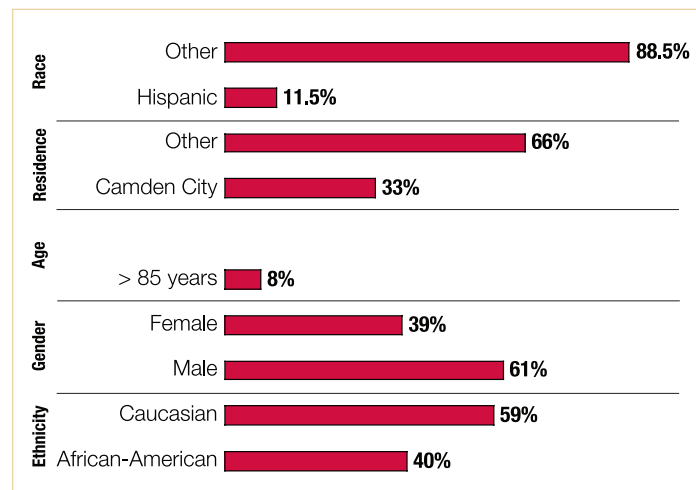
Table 1 HF Core Measures

Core Measure	Elements	Examples
Discharge instructions	Diet Activity Level Weight monitoring Signs & symptoms to report Medication instruction	Patients with underlying heart failure may code out heart failure as the principle diagnosis, therefore must be discharged with complete HF discharge instructions.
Left ventricular functional (LVF) assessment	Methods of evaluation include echocardiogram, stress testing or cardiac catheterization.	During, before or after hospitalization the HF patient must be assessed for LVF. If evaluation to be done post-discharge a note must be evident from MD
Angiotensin-converting enzyme inhibitors (ACE-I) or angiotensin II receptor blockers (ARBs)	Evidenced-based medications specific to improving the clinical outcomes of HF patients.	Examples include: lisinopril, enalapril, quinapril, valsartan, losartan, irbesartan. Reasons for not prescribing with an EF 45% must be specifically documented in order to meet the HF standard of care.
Smoking cessation counseling	Smoking tops the list of major alterable risk factors in heart and blood vessel disease	Discussing alternatives such as support programs, drug therapies, hypnosis and acupuncture are part of the education process

Through educational efforts and sheer tenacity, our compliance has increased to 100%. The Health Care Access Team is instrumental in acquiring this information and the data collectors are consistently assertive in ascertaining that this information is available for all patient visits. We are certain of our race and ethnicity mix and have adjusted our education and support efforts accordingly.

The second goal of the project is to provide and document the use of translators for discharge preparation and instructions for our non-English speaking patients and their families. Through the unconditional support of our Cardiology nursing teams, we are meeting this goal in at least 94% of the opportunities. Like most hospitals, we have many forms and educational materials available in multiple languages, as well as 24-hours/day, 7-days/week access to a translator service. Through a collaborative effort, we have volunteer translators from the nursing team available to assist with our bi-weekly nutrition class to provide an ongoing flow of dialogue with the patient/family unit to the dietician and nurse educators. This has proven to be a source of improved patient satisfaction and outcomes specific to discharge preparation.

Table 2 CUH Demographics



CUH is a fully committed health care provider that allows and encourages its teams' autonomy to make changes and explore solutions to the complex problems associated with chronic illnesses.

The third major goal of the project is to provide the date and time of the first follow-up visit to the cardiologist within two weeks following discharge, as part of the final discharge instruction. After one year of monitoring, our compliance with this goal is 75%. While not perfect, we consistently remain stable at 75% or greater. The objective of this goal is to underscore the importance of a physician visit following discharge for review and adjustment of their treatment plan. This initiative has improved compliance with follow-up care for the HF patient. Not all physician groups participate in making appointments prior to discharge. Thus, the data collected at follow-up phone calls shows that not all patients visit their Primary Care Provider or cardiologist within 2-4 weeks following discharge. Patients leaving the hospital with physician office appointments already made were more likely to meet this goal.

In December 2007, Cooper healthcare providers began to make follow-up phone calls to discharged patients not receiving home care services or enrolled in the HF-Telemetry study. This has given us a first hand opportunity to determine the many important aspects of care across the spectrum – from hospital to home. We are able to ascertain if the patients actually saw their physician within the first few weeks following hospital discharge. Additionally, it renders an opportunity to provide first-hand prompting or to answer questions concerning follow-up care that might be confusing for patients or families. This information proved astonishing.

Two-week and 30-day follow-up phone calls give us the

(continued on page 6)

(continued from page 5)

occasion to determine the success or failure of our most important efforts: medications and daily weights. We were pleased to discover that 92% of the patients contacted had their prescriptions filled and were able to list their discharge medications correctly. In addition, this one-on-one contact gave an opportunity to reinforce and provide supplementary information to the patient, regarding post-discharge needs and to resolve any confusion that remained specific to medications. Patients are asked and counseled about

This one-on-one contact gave an opportunity to reinforce and provide supplementary information to the patient, regarding post-discharge needs and to resolve any confusion that remained specific to medications.



Cooper
University Cardiology

My Ticket Out Of Here

Dear Patient/Caregiver:
This is Your Ticket Out of Here. Get all of these important items checked off before you go home. Do this by working with everyone involved in your care here at Cooper University Hospital.

- ☐ I have been given and understand the information packet related to my health condition.
- ☐ I have a scale to weigh myself at home.
- ☐ I understand and agree to record my weight at the same time each day and call my physician with a weight gain of 2 pounds in 24 hrs.
- ☐ I know what to do if my symptoms worsen.
- ☐ I know what my medications do and why I need to take them and why I shouldn't stop taking them.
- ☐ I have a way to get my prescriptions filled today.
- ☐ I know the resources available if I need to stop smoking.
- ☐ I understand that I need to follow-up with my doctor after discharge.
- ☐ I understand a low salt diet.

Patient Signature: _____

Date: _____

the need and importance of daily weights and the use of a weight diary. Prior to hospital discharge all patients/families who attend one of our diet/education classes are given a calendar diary. Patients are instructed to weigh themselves daily, first thing in the morning and to record their weight in the diary. They are instructed to bring this diary to their doctor's visit. Much to our satisfaction, 90% of patients are able to give us their previous days as well as current weight, indicating they are following the daily weight requirement. Patients out of compliance are re-educated about the importance of daily weights.

The ultimate goal is to engage the patient and family in understanding and complying with their long-term treatment plan. Successful patients understand and fully participate in developing and maintaining the treatment plan, consisting of daily medications, daily weight, low sodium intake, fluid restrictions (in some instances), and reporting of any variations to the physician. In an effort to fully engage the patient in a contract with the

health care team, CUH has instituted "My Ticket Out of Here." This is a carefully worded, yet simply spelled out general treatment plan that helps the patient through his/her continuum of care – from hospital to home. (See Illustration) Cooper's HF and Nursing Team developed this contract in September 2008. The physicians refer to the contract, while the follow-up phone calls remind the patient about their agreement and participation in their overall plan of care.

CUH is a fully committed health care provider that allows and encourages its teams' autonomy to make changes and explore solutions to the complex problems associated with chronic illnesses. HF is just one of those complexities. Changes are continuously being made to improve the healthcare outcomes of those we are dedicated to serve. Data will prove our successes and opportunities. Changes in care delivery will be based on careful analysis of the data. Core Measure compliance with the HF Indicators will serve as a barometer to the public. Cooper is committed to excellence and the delivery of the best possible evidenced-based care.

Email comments to Powell-Maryann@cooperhealth.edu

Comparison of Different Methods to Minimize Hemolysis Rates of Coagulation Specimens in the Emergency Department



Beth Sherman, RN, BSN, CEN; Lorene Pugh, RN, BSN, CEN; Annette Bell, MS, MT(ASCP)SH; Karen Looby-Rodriguez, LPN; Dominic Parone, RN, BSN, CEN; and Mary Stauss, RN, MSN, APN, CEN

Abstract

Introduction: Significant delays occur in the treatment and disposition of patients in the emergency department due to the necessity to repeat certain laboratory blood tests when samples are hemolyzed. A major contributing factor to hemolysis is thought to be related to blood withdrawal techniques; however, limited experimental studies have been done to determine the best technique for avoiding hemolysis.

Objectives: To compare the hemolysis rates of coagulation blood samples obtained with two different methods for obtaining blood commonly used in emergency departments: directly through an intravenous (IV) catheter hub with or without extension tubing in place.

Methods: Subjects for the study were a convenience sample of emergency department patients with a newly inserted, 20 Gauge IV catheter. Using a prospective, randomized, experimental study design, blood was obtained for coagulation testing through the IV catheter with or without extension tubing. Hemolysis was determined by the clinical laboratory using a standardized, color visualization scale, with results reported as the level of hemolysis (0 to 1100 mg/dL) and whether the sample was considered hemolyzed and requiring a repeat blood sample. Data was analyzed with analysis for variance (ANOVA), with $p < 0.05$ considered significant.

Results: A total of 100 emergency department patients were studied. The level of hemolysis ranged from 0 to 1100 mg/dL, with an average (\pm SD) of 150.5 (305.1) mg/dL and 221.4 (398.3) mg/dL for samples obtained with and without extension tubing, respectively. ANOVA found no statistical difference between the two groups ($p > 0.05$). The rate of hemolysis requiring a repeat blood sample for the two blood withdrawal techniques was the same (32%).

Conclusions: This study found a high rate of hemolysis of specimens obtained for coagulation studies in ED patients. Obtaining the blood samples directly from the hub of a newly inserted IV device or from the end of an extension tubing connected to the IV hub had no effect on the level or rate of sample hemolysis. Additional studies are needed to determine what factors or techniques can reduce hemolysis rates in coagulation samples obtained in emergency department patients.

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References:

- Grant MS. The effect of blood drawing techniques and equipment on the hemolysis of ED laboratory blood samples. *Journal of Emergency Nursing* 2003; 29: 116-121.
- Tanabe P, Kyriacou, D, & Garland, F. Factors affecting the risk of blood bank specimen hemolysis. *Academic Emergency Medicine* 2003; 10:897-900.
- Dugan L., Leech L., Speroni K., & Corriher J. Factors affecting hemolysis rates in blood samples drawn from newly placed IV sites in the emergency department. *Journal of Emergency Nursing* 2005; 31:338-345.
- Cox S, Dages J, Jarjoura D, Hazelett S. Blood samples drawn from IV catheters have less hemolysis when 5-mL (vs. 10-mL) collection tubes are used. *Journal of Emergency Nursing* 2004; 30:529-533.
- Kennedy C, Angermuller S., King R., Novello S, Walker J, Warden J, et al. A comparison of hemolysis rates using intravenous catheters versus venipuncture tubes for obtaining blood samples. *Journal of Emergency Nursing* 1996; 22:566-569.
- Seeman S, Reinhardt, A. Blood sample collection from a peripheral catheter system compared with phlebotomy. *Journal of IV Nursing* 2000; 23:290-7.
- Lippi G, Salvagno G, Brocco G, Guidi G. Preanalytical variability in laboratory testing: influence of the blood drawing technique. *Clinical Chemistry Laboratory Medicine* 2005;43:319-325.
- Gilboy N, Tanabe P, Travers DA, Rosenau AM, Eitel DR. Emergency severity index, version 4: implementation handbook. AHRQ Publication No. 05-0046-2. Agency for Healthcare Research and Quality: Rockville, MD. 2005. Available at: www.ahrq.gov.
- Cohen J. Statistical power analysis for the behavioral sciences, revised edition. New York: Academic Press; 1977.
- Faul F, Erdfelder E. GPOWER: A priori, post-hoc, and compromise power analysis for MS-DOS. Available at: <http://www.psych.uni-duesseldorf.de/aap/projects/gpower/>. Accessed May 1, 2008.
- BD Global Technical Services. Relative hemolysis scale. (2005). Retrieved 3/19, 2007, from www.bd.com/vacutainer.
- Bush V, Mangan L. The hemolyzed specimen: causes, effects, and reduction. *BD Lab Notes* 2003;13(1):1-end.
- Becton, Dickinson and Company. (2008). BD vacutainer CPT cell preparation tube with sodium citrate (2008). Retrieved 8/9, 2008, from <http://www.bd.com/vacutainer/products/molecular/citrate/procedure.asp>.

A major contributing factor to hemolysis is thought to be related to blood withdrawal techniques; however, limited experimental studies have been done to determine the best technique for avoiding hemolysis.





Performance Improvement and the Evaluation of Nursing Care Quality

Jennifer L. Innes, RN, BSN

Introduction

Nursing today is perhaps more complex than ever before, and each shift presents new challenges for the bedside nurse. In the midst of the daily quest to prioritize time and other scarce resources, performance improvement principles can seem like abstract ideals. The objective of this article is fourfold:

1. To enhance nurses' understanding of the discipline of performance improvement and health care quality.
2. To reinforce the interdependent nature of the relationship between clinical practice and performance improvement methodologies.
3. To inform nurses of current trends in health care quality that will greatly impact the way future nursing care is delivered in the United States.
4. To empower nurses at all levels to take an active role in the process of shaping the future of the nursing profession.

What is Performance Improvement?

Performance improvement is the continuous process through which we measure and pursue quality in health care. In a landmark 2001 study, health care quality was characterized by the Institute of Medicine as care that is safe, effective, efficient, patient-centered, timely, and equitable.

The Relationship between Clinical Practice and Performance Improvement

Nurses, consciously or unconsciously, act as champions of health care quality every day, through actions targeted to obtain the best patient outcomes. These targeted actions can be documented and subsequently translated into data points for collection and analysis. When this data set is considered in conjunction with data related to patient outcomes, such as length of stay, infection rates, and mortality rates, a cause-and-effect relationship may be established. This measurement process is the foundation of performance improvement. It is important to emphasize that alone, measuring data will not cause performance to improve; just as monitoring vital signs will not improve a patient's condition. It is practitioner intervention that is the catalyst for improvement. Nurses can measure the effects their interventions have on patient outcomes, using performance improvement methodologies.

Current Trends in Health Care Quality

Recently, there has been increased scrutiny from the public and private sectors regarding the evaluation of health care quality, including the quality of nursing care. In the 2004 white paper *Transforming Care at the Bedside*, the Institute for Healthcare Improvement emphasized, "as the most highly trained professionals regularly at patients' bedsides, registered nurses (RNs) play a central role in ensuring the quality of hospital care."

Most nurses are familiar with the concept of measuring quality

through clearly defined, evidence based metrics- think of working to achieve compliance with the Joint Commission/ Centers for Medicare & Medicaid Services (CMS) sponsored Core Measures.

Core Measure indicators are largely physician-driven, although they are certainly influenced by nursing practice. In contrast, nursing-sensitive quality indicators primarily "represent processes and outcomes that are affected, provided, and/or influenced by nursing personnel" (National Quality Forum, 2007). Organizations such as the National Quality Forum (NQF) and the American Nurses Association (ANA) have endorsed specific consensus indicators designed to measure and evaluate the quality of nursing care. The ANA began development of the National Database of Nursing Quality Indicators (NDNQI) in the early 1990s, as part of its National Center for Nursing Quality (NDNQI, undated). See Table I for examples of nursing-sensitive quality indicators.

These indicators represent a tremendous opportunity for the nursing profession to showcase the clinical and economic value of quality nursing care, especially given recent policy developments related to health insurance and reimbursement. Using nursing sensitive outcome indicators is crucial to effectively demonstrate that nurses make the critical, cost-effective difference in providing safe, high-quality patient care (International Council of Nurses, 2008).

Historically, and perhaps illogically, hospitals have been equally reimbursed regardless of the quality of the patient care provided.

Table 1 Comparison of NDNQI and NQF Measures of Nursing Care Quality

Measures of Nursing Care Quality	
NDNQI Indicators	NQF Nursing-Sensitive Measure Set
RN survey: Job satisfaction	Death among surgical inpatients with treatable serious complications (also referred to as "failure to rescue")
RN education and certification	
Pediatric pain assessment scales	Smoking cessation counseling for patients with acute myocardial infarction, heart failure, and pneumonia (these are also Core Measure indicators)
Pediatric IV infiltration rate	
Psychiatric patient assault rate	
NDNQI and NQF	
Voluntary nurse turnover rate	
Nosocomial infections:	
• Ventilator-associated pneumonia (VAP)	
• Central line-associated blood stream infection (CLABSI)	
• Catheter-associated urinary tract infections (CAUTI)	
Restraint prevalence	
RN survey: Practice environment scale	
Nursing hours per patient day	
Staff mix	
Pressure ulcer prevalence	
Patient falls	
Patient falls with injury	

Recently, there has been a movement toward a model of paying for performance that began with federally-funded health insurance plans and is spreading rapidly to private insurers. This system involves setting performance expectations, measuring performance, and, based on the results, rewarding providers through financial and other incentive programs (Mason, Leavitt, and Chaffee, 2007). An example of an incentive that does not provide direct financial compensation, yet could still ultimately impact the hospital's bottom line, is the reporting of rates of performance on quality indicators to the public.

In October, 2008, the CMS began withholding reimbursement for the care associated with the following hospital-acquired conditions: Pressure ulcers, catheter-associated urinary tract infections, vascular catheter-associated infections, and hospital falls associated with injury. In addition, by 2010, scheduled increases in Medicare reimbursement, normally calculated to compensate for market inflation, will be withheld from hospitals that do not publicly report performance on certain quality measures, including the nursing-sensitive indicator commonly referred to as "failure to rescue" (CMS, 2008).

Key nursing leaders and organizations, including the ANA, welcome this increase in transparency and are demanding even greater scrutiny of the impact of nursing care on patient outcomes. In March, 2008, a statement was given on behalf of the ANA to the United States Senate Finance Committee that included the following proclamation:

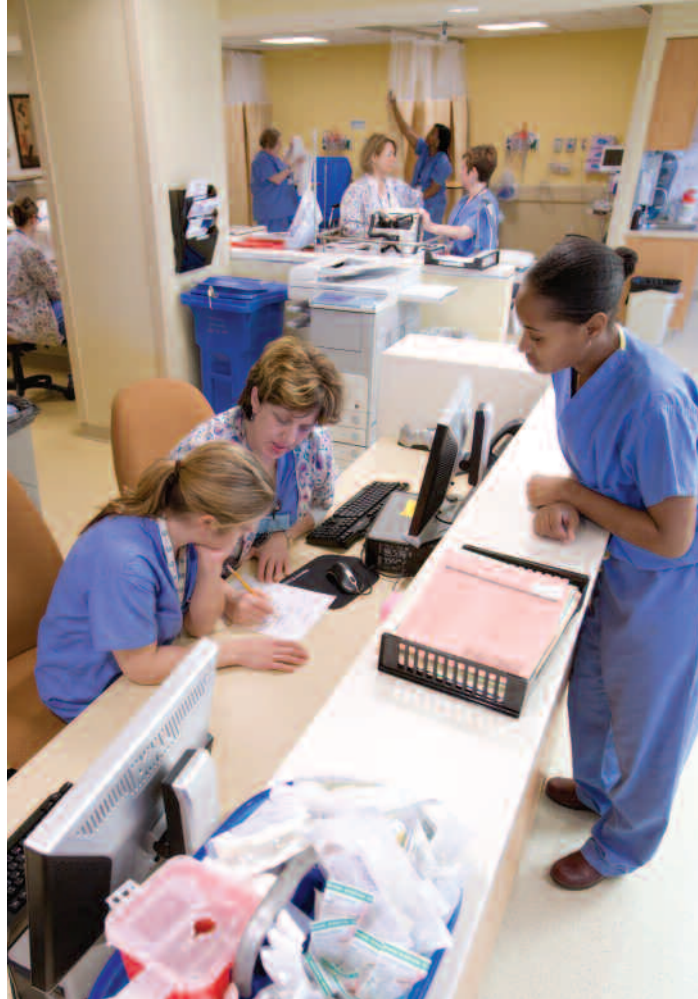
"CMS is urged to re-examine its payment structure and recognize the value of nursing. Whatever changes are made in the [CMS] payment structure, there needs to be some recognition of the value that nursing brings to patient outcomes and quality improvement" (Senate Finance Committee Roundtable transcript, 2008). Nurse leaders are being urged to accelerate the adoption of nursing-sensitive quality measures (Kurtzman and Jennings, 2008).

The model of linking quality and reimbursement represents a paradigm shift in the health care industry that will take time to mature, and it will pose the challenge of organizational culture change in many institutions. More research and experience are needed to inform the development of valid quality measures and to assess the prevalence and effectiveness of the current strategies; however, it is clear that the pendulum will not swing back toward reimbursement for avoidable hospital-acquired conditions (Mason, et al., 2007).

Impact on the Nursing Profession

The potential implications of these changes for the nursing profession cannot be underestimated. Nurses are no longer the silent majority among patient care providers. The new emphasis on health care quality reinforces what nurses have always known: we are an integral part of the patient care team.

The pay-for-performance model provides added incentive for organizations to address common nursing concerns related to staffing, working environment, and availability of resources. The onus is on hospitals to do a much better job preventing adverse events by optimizing nursing care (Welton, 2008). The new model also encourages opportunities for increased collaboration between the disciplines, as evidence continues to mount proving that, in general, high performing hospitals share the characteristic of a deeply ingrained sense of teamwork.



While a strong commitment to performance improvement must be emphasized from the highest levels of hospital administration, it is equally important that direct care staff recognize their own authority and responsibility to contribute to overall patient care quality. Every day, strategies are being formulated to improve the quality of care provided to our patients. The power and skills necessary to do so lie within the hands of the bedside nurse; please consider becoming involved in the decision making.

Email comments to Innes-Jennifer@cooperhealth.edu

References:

- American Nurses Association. (undated). NDNQI: *Transforming data into quality care*. Retrieved October 1, 2008, from www.nursingquality.org.
- Centers for Medicare and Medicaid Services (2008). *Fiscal year 2009 quality measure reporting for the 2010 payment update*. Retrieved October 10, 2008 from www.cms.hhs.gov/apps/media/fact_sheets.asp.
- Committee on Quality of Health Care in America, Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academies Press.
- International Council of Nurses. (undated). Nursing matters fact sheet: *Nursing sensitive outcome indicators*. Retrieved October 2, 2008 from www.ich.ch/matters_indicators.htm.
- Kurtzman, E. and Jennings, B. (2008). Trends in transparency: Nursing performance measurement and reporting. *The Journal of Nursing Administration*, 38, #7/8, pp. 349-354.
- Mason, D., Leavitt, J., and Chaffee, M. (2007). *Policy & politics in nursing and health care*, (5th ed.). St. Louis, MO: Saunders Elsevier.
- National Quality Forum. (2007). *Nursing performance measurement and reporting: A status report*. Issue Brief No. 5. Retrieved October 10, 2008 from www.qualityforum.org.
- Welton, J. (2008). Implications of Medicare reimbursement changes related to inpatient nursing care quality. *The Journal of Nursing Administration*, 38, #7/8, pp. 325-330.



Healthcare Avoidance: A Critical Review

Sharon K. Byrne, DrNP(c), APN, C, AOCNP

Introduction

Healthcare avoidance is a common problem that has a negative impact on the well-being of the adult population residing within the United States. It is a relevant phenomenon for professional nursing study since it can represent a significant barrier to healthcare. It can impede an individual's health behaviors or cause them to delay obtaining healthcare. The current knowledge gap, specific to healthcare avoidance, may directly and indirectly inhibit the use of conventional health care. This will ultimately interfere with the overarching goals of Healthy People 2010 related to increasing quality and years of healthy life and eliminating health disparities (Healthy People 2010).

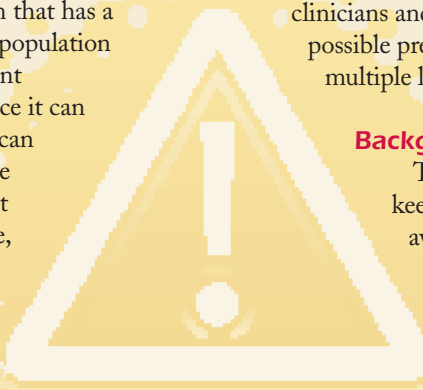
In spite of recognition of avoidance and delay behaviors as interfering factors related to healthcare, knowledge about this concept based on research is limited. There is a need to interconnect information from existing studies to build a more comprehensive account of the phenomenon and identify important issues that research has left unresolved. This in turn should better direct future research related to healthcare

avoidance. The results of the review are directed toward clinicians and educators who are endeavoring to address possible predisposing factors to healthcare avoidance at multiple levels.

Background

The term avoidance is described as the act of keeping away from something; mentally or physically avoiding something that causes distress (Changing Minds Organization, 2007). The term delay is often used in combination with avoidance. The notion of avoidance as a concept of interest first appeared in communication literature related to information seeking or coping.

The information-seeking models of Johnson (1997) and Wilson (1999) discussed factors that prompt an individual to either avoid or seek information. These physiological, cognitive and effective factors, influenced by an individual's cultural background, demographics, environment, and /or psychological status, are important for nursing to acknowledge in their respective patient population. Patients will seek out health related information when it is consistent with their belief system, existing knowledge



base, or has personal relevance. Self efficacy also influences information seeking behaviors. Alternatively, health information that is contradictory to a patient’s prior knowledge, personal opinion, beliefs, or values is avoided. In these instances seeking information may lead to mental discomfort or dissonance. Therefore, information or recognition of symptoms that are incongruent with an individual’s value system may lead to healthcare avoidance behaviors.

The Theory of Reasoned Action (Ajzen & Fishbein, 1980), the Theory of Planned Behavior (Ajzen, 1991), the Theory of Care-Seeking Behavior (Lauver, 1992), the Transtheoretical Model (Prochaska, DiClemente, & Norcross, 1992) and Behavioral Model of Health Services Use (Aday & Anderson, 1974; Phillips, Morrison, Anderson, et al, 1998), although not specifically focused on health care avoidance, can be used to assist in understanding the response of an individual regarding health-related action.

The first two theories assume that a response to the prospect of becoming ill or illness itself are influenced by concerns related to disease, and one’s assessment of the relative effectiveness and acceptability of available preventive action and/or treatment options. The theories also elaborate on the social and environmental context within which decision making occurs. These contexts are influenced by facilitating conditions, clinical factors, demographic factors, and expectations about outcomes and result in either positive or negative care seeking behaviors.

Lauver’s (1992) Theory of Care-Seeking Behavior appears to be a useful theoretical framework for understanding the psychosocial variables and facilitating conditions that influence care-seeking behaviors. These influencing factors include, but are not limited to, an individual’s health expectations, values, social norms, social support, fear, denial, problem solving, accessibility, and insurance coverage (Reifenstein, 2007).

The Transtheoretical Model (1992) evaluates an individual’s motivation or readiness to move through stages of behavioral change. Prochaska, DiClemente, and Norcross (1992) describe pre-contemplation as an important stage applicable to healthcare avoidance as it implies that an individual has no intention of changing behavior e.g. seeking care for a health problem anytime soon, or recognizing or modifying a problem. The timeframe for this stage is defined as no change in behavior within the next six months in the foreseeable future.

Finally, the Behavioral Model of Health Services Use or Behavioral Model of Utilization (Aday & Andersen, 1974; Phillips et al, 1998) has been proposed by the field of health service research as a integrated theoretical framework for the study of “the characteristics of the health care system and populations at risk (inputs) to the outcomes or outputs: actual utilization of health care services and consumer satisfaction with these services” (Aday & Andersen, 1974). Variables related to healthcare avoidance utilizing this framework include the characteristics of the healthcare delivery system, equitable access, personal, family and community resources, social and organizational structures, customer satisfaction, and provider characteristics such as physician gender.

Literature Review

A synthesis of the both quantitative and qualitative literature highlights three areas that will increase the knowledge of the profession on the topic of healthcare avoidance; attributes of the

concept of healthcare avoidance, identification of factors that influence avoidance or delay in healthcare seeking behaviors, and a review of multidisciplinary studies that have explored the concept to date.

Attributes of Healthcare Avoidance

The critical attributes of healthcare avoidance that differentiate this concept from related phenomenon are protective distancing, multidimensionality, and variability (Ottenbreit & Dodson, 2004). Protective distancing occurs when an individual or cohort of the population distances itself from utilization of preventive health services, treatment seeking, and treatment adherence. Multidimensionality includes observing spatial distance (physical dimension), failure to acknowledge a situation (cognitive dimension), passively accepting an unfavorable situation (emotional dimension), self-imposed isolation (social dimension), and finding an alterative escape activity (behavioral dimension).

(continued on page 12)

Figure 1 Predisposing Factors related to Healthcare Avoidance.

Socio-demographic factors:	<ul style="list-style-type: none"> • age • ethnicity/racial factors • education • socioeconomic/income level
Personal barriers:	<ul style="list-style-type: none"> • anxiety, fear, denial, stress or worry • attitude • confidentiality concerns • coping strategies • cost i.e. co-payment or self payment • cultural and/or religious beliefs • financial/resource limitations • health beliefs • lack of knowledge • lack of support or family or friends • language barriers • perception of vulnerability/risk • service access issues such as transportation • stigma or embarrassment of problem/illness • time constraints
Provider issues:	<ul style="list-style-type: none"> • attitude and knowledge of the provider as perceived by the individual • distrust of providers and/or the science community • lack of access to a provider/regular source of healthcare/treatment facilities in the local community • lack of consistency of the provider to make referrals for care • lack of user friendly service hours i.e. interfere with employment or childcare commitments
Administrative issues:	<ul style="list-style-type: none"> • insurance or underinsured/uninsured status • scheduling problems

The variability of these dimensions are manifested in a variety of ways ranging from not seeking care and canceling appointments; to anxiety, fear, or denial of symptoms and/or diagnosis and non-adherence to prescribed treatment regimens (Ottenbreit & Dodson, 2004; Reifenstein, 2007).

Antecedents of Healthcare Avoidance.

The variables identified that are associated with avoidant behaviors could be characterized as demographic, personal, provider, and administrative based (see figure 1). Demographic factors included age, socioeconomic status, ethnicity, and education. Personal barriers are related to attitude, knowledge, time constraints, financial and other resource limitations, lack of support of family or friends, and stigma or embarrassment of health related problems/illnesses. Service access barriers can potentiate avoidance behaviors. Individuals may delay or avoid healthcare due to transportation issues, lack of user friendly service hours, or lack of treatment facilities in the local community. Many healthcare providers offer hours that interfere with employment or childcare commitments. Provider variables have been characterized in the literature as the lack of access to a provider, consistency of the provider to make referrals for care, the attitude and knowledge of the provider as perceived by the individual consumer, and distrust of providers and/or the science community. Administrative difficulties such as insurance or scheduling problems may also affect healthcare avoidance and delay (Brems, Johnson, Warner & Roberts, 2006; Corrigan, 2004; Reistvedt & Trinkaus, 2005).

Summary of Multidisciplinary Research.

There are several factors that emerge from a review of literature from the disciplines of health education, psychology, medicine, nursing, and physiotherapy. Healthcare avoidance is a concept that can impede positive health seeking behaviors and lead to delay of care services, non-adherence with treatment regimens, or total lack of access to the healthcare system (Asch et al., 1998; Corrigan, 2004; Ottenbriet & Dodson, 2004; Moore, 2004; Riefenstein, 2007; Tromp et al., 2005). Second, this delay or avoidance in care is related to multiple individual and/or healthcare system related factors as previously discussed. A third variable that emerged from the literature review is the impact of avoidance behaviors on healthcare consumers with multiple health alterations. For example, one of areas explored in nursing research is the association between body weight, stigma, and healthcare avoidance (Drury & Louis, 2002). Stigma, both societal and medical, has been identified as a significant factor in avoidance of healthcare of obese women, particularly in utilization of preventive health services. Reasons for delaying or avoiding health care in the obese population includes both weight related and non-weight related factors. These factors include, but are not limited to, low self esteem, gained weight, and the need to undress for evaluation. More recently, Reifenstein (2007) addressed care seeking behaviors of 48 African American women with breast cancer symptoms. Pearson correlation and regression analysis showed that denial was associated with increased delay behaviors. Participants in the study delayed or avoided healthcare for an

average of 63 days.

Healthcare avoidance behaviors have been documented in other multidisciplinary health related research among varied racial/ethnic groups, members of both genders, and within a continuum of care services ranging from prevention to rehabilitation. Healthcare avoidance encompasses both acute and chronic disease, physical and psychosocial conditions, and genetic disorders (Abraham, 1993; Adams et al., 1993; Ballantyne, Gignac & Hawker, 2007; Dury & Louis, 2002; Elfving et al., 2007; Facione et al., 2002; Fontaine et al., 1998; Fuller, Dudley & Blacktop, 2004; Larkey et al., 2001; Mella-Gordan & Carleton, 2003; Olson et al., 1994; Ramirez et al., 1999; Swinkels-Meewis et al., 2006).

Discussion

The potential costs of healthcare avoidance are significant. Expenditure related to healthcare is most likely increased in relation to increased healthcare avoidant or delay behaviors on the part of consumers. These costs are not only monetary. Avoidance behaviors can lead to emotional numbness toward a pending diagnosis, unwanted intrusions of threatening health information and material, loss of working days and productivity on the workforce, and increased morbidity and mortality.

Recommendations for Clinical Practice and Future Research

There are a number of recommendations that emerge from this review of the literature. They include, but are not limited to:

1. Identification of a standard definition for healthcare avoidance to allow for recognition of the concept as area of concern for nursing and other healthcare professionals and more accurate classification of literature addressing the topic.
2. A call for multidisciplinary descriptive and qualitative research efforts to identify healthcare avoidance experiences in a variety of health related conditions and ethnic/racial populations.
3. Integration of a theoretical framework into nursing research exploring the context within which individual intention to engage in healthcare behavior occurs.
4. Development of intervention based research to decrease healthcare avoidance behaviors in at risk populations such as ethnic minorities, elders, financially or functionally disadvantaged, female, and obese populations.
5. Determination of educational and supportive interventions to assist potential healthcare consumers to cope with avoidance behaviors.
6. Investigation into the potential and actual costs of healthcare avoidance on individuals, the healthcare system, and society as a whole.

Conclusion

Healthcare avoidance is a distinct and dynamic concept that has a negative impact on the well-being of the adult population and their health-illness continuum. It is a multidimensional coping mechanism utilized by individuals in response to perceived healthcare threats and can be influenced by a variety of behavioral,

cognitive, environmental, physical, and social factors. As the concept of healthcare avoidance can represent a significant barrier to health promotion, treatment seeking and treatment adherence, it requires further integrated study by various health related disciplines, including the nursing profession. This systematic research should focus on the correlates of healthcare avoidance, identification of patients at risk for avoidant behaviors, methods of measuring the impact of avoidance of health, and implementation of effective interventions to decrease healthcare avoidance and

promote health-seeking behaviors. Ultimately, clinicians and researchers will work together to decrease the impact of avoidance on healthcare decision-making, thereby reaching the overarching goal of Healthy People 2010 (Healthy People 2000).

Email comments to Byrne-Sharon@cooperhealth.edu



References:

- Adams, C.H., Smith, N. J., Wilbur, D. C., & Grady, K. E. (1993). The relationship of obesity to the frequency of pelvic examinations: do physician and patient attitudes make a difference? *Women & Health*, 20(2), 45-57.
- Aday, L. & Andersen, R. (1974). A framework for the study of access to medical care. *Health Services Research*, 9, 208-220.
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50, 179-211.
- Ajzen, I & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, NJ: Prentice-Hall
- Asch, S., Leake, B., Anderson, R., & Gelberg, L. (1998). Why do symptomatic patients delay obtaining care for tuberculosis? *American Journal of Respiratory and Critical Care Medicine*. 157, 1244-1248.
- Ballantyne, P.J., Gignac, M.A., & Hawker, G.A. (2007). A patient-centered perspective on surgery avoidance for hip or knee arthritis: lessons for the future. *Arthritis Rheumatologist*, 57(1), 27-34.
- Blomberg, K., Ternestedt, B. M., & Tishelman, C. (2007). How do women who choose not to participate in population-based cervical cancer screening reason about their decision? *Psycho-Oncology*, 10, 1270-1279.
- Brems, C., Johnson, M., Warner, T. & Weiss Roberts, L. (2006). Barriers to healthcare as reported by rural and urban interprofessional providers. *Journal of Interprofessional Care*, 20(2), 105-118.
- Changing Minds Organization (2007). Retrieved July 18, 2007 from www.changingminds.org/explanation/behaviors/coping/avoidance.htm
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.
- Drury, C. A. A., & Louis, N. (2002). Exploring the association between body weight, stigma of obesity, and health care avoidance. *Journal of the American Academy of Nurse Practitioners* 14(12), 554-561.
- Elfving, B., Andersson, T., & Grooten, W. J. (2007). Low levels of physical activity in back pain patients are associated with high levels of fear-avoidance beliefs and pain catastrophizing. *Physiotherapy Research International*, 12(1), 14-24.
- Facione N. C, Miaskowski, C, Dodd, M. J., & Paul S. M. (2002). The self-reported likelihood of patient delay in breast cancer: new thoughts for early detection. *Preventive Medicine*, 34, 397-407.
- Fuller, R., Dudley, N., & Blactop, J. (2004). Avoidance hierarchies and preferences for anticoagulation: semi-qualitative analysis of older patients' views about stroke prevention and the use of warfarin. *Age and Aging*, 33, 608-611.
- Fontaine, K. R., Faith, M. S., Allison, D. B., & Cheskin, L. J. (1998). Body weight and health care among women in the general population. *Archives in Family Medicine*, 7(4), 381- 384.
- Healthy People 2010. Retrieved October 2, 2006, from <http://www.healthypeople.gov/about/hpfact.htm>
- Hsu, J., Reed, M., Brand, R., Fireman, B., Newhouse, J.P., & Shelby, J.V. (2004). Cost- sharing: patient knowledge and effects on seeking emergency department care. *Medical Care*, 42(3), 290-296.
- Johnson, J. D. (1997) *Cancer-related Information Seeking*. Cresskill, New Jersey: Hampton Press.
- Larkey, L. K., Hecht, M. L., Miller, K., & Alatorre, C. (2001) Hispanic cultural norms for health-seeking behaviors in the face of symptoms. *Health Education & Behavior*, 28(1), 65-80.
- Lauver, D. (1992). A theory of care-seeking behavior. *Image: Journal of Nursing Scholarship*, 24, 281- 287.
- Mella-Gordon, M.L., & Carleton, U. (2003). Women's abuse experiences and health: mediators of the abuse-health relation and factors influencing healthcare avoidance. *Dissertation Abstracts International: Section B; the Sciences and Engineering*, 64(5-B), 2432.
- Moore, P.J. (2004). Psychosocial factors in medical and psychological treatment avoidance: the role of the doctor-patient relationship. *Journal of Health Psychology*, 9(3), 421-433.
- Olson, G. I., Schumaker, H. D., & Yawn, B. P. (1994). Overweight women delay medical care. *Archives of Family Medicine*. 3, 888-892.
- Ottensbreit, N. D., & Dodson, K. (2004). Avoidance and depression: the construction of the cognitive-behavioral avoidance scale. *Behaviour Research and Therapy*, 42(3), 293-313.
- Phillips, K. A., Morrison, K. R., Andersen, R. & Aday, L. (1998). Understanding the context of healthcare utilization: assessing environmental and provider-related variables in the behavioral model of utilization. *Health Services Research*, 33(3), 571-596.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist*, 47(9), 1102-1114.
- Ramirez, A. J., Westcombe, A. M., Burgess, C. C., Sutton, S., & Littlejohns, P. (1999). Factors predicting delayed presentation of symptomatic breast cancer. *Lancet*, 1127-1131.
- Reifenstein, K. (2007). Care-seeking behaviors of African American women with breast cancer symptoms. *Research in Nursing & Health*, 39, 542-557.
- Reistvedt, S. L., & Trinkaus, K. M. (2003). Psychological factors related to delay in consultation for cancer symptoms. *Psycho-Oncology*, 14, 339-350.
- Schwartz, M. D., Lerman, C., Miller, S.M., Daly, M., & Masny, A. (1995). Coping disposition, perceived risk, and psychological distress among women at increased risk for ovarian cancer. *Health Psychology*, 14(3), 232-235.
- Thompson, H. S., Valdimarsdottir, H. B., Winkel, G., Jandorf, L., & Redd, W. (2004) The group-based medical mistrust scale: psychometric properties and association with breast cancer screening. *Preventive Medicine*, 38, 209-218.
- Tromp, D. M., Brouha, G. J., Hordijk, J. A., Winnubst, J.A. M., Gebhardt, W. A., van der Doef, M. P., & De Leeuw, J. R. J. (2005). Medical care seeking and health-risk behavior in patients with head and neck cancer: the role of health value, control beliefs and psychological distress. *Health Education Research*, 20(6), 665-675.
- Vahabi, M., & Gastaldo, D. (2003). Rationale choice(s)? Rethinking decision-making on breast cancer risk and screening mammography. *Nursing Inquiry*, 10(4), 245-256.
- Wilson, T. D. (1999). Models in information behaviour research. *Journal of Documentation*, 55(30), 249-270.



VISION: Cornerstone to Building the Future

Kathleen Yhlen, MSN, RN, NE-BC

Nursing is a highly complex and challenging profession that exists within a rapidly changing health care environment. It is essential for nurses to be focused in order to provide quality patient care. Concern for the patient is paramount and nurses need to agree on an agenda that meets this goal. Developing a vision statement is one way to stay focused and facilitate achieving desired goals.

A clear vision is a powerful tool that can transform the future. According to Soule (2002), a vision is a picture of a desired future and implies why a business or program should work toward that future. It is about stretching, taking risks, and working on long-term goals and dreams. For a vision statement to be powerful and to empower, every nurse in the organization must know and believe that he or she can make the vision a reality (Zager & Walker, 2005).

Vision statements are challenging to develop due to the constant shifting of driving forces that create rapid change and uncertainty. A vision can align people to a common cause and

Cooper's Nursing Vision

By the year 2012, Cooper Nursing in partnership with Patient Care Services will be the leader in the Delaware Valley providing exceptional patient and family-centered care. We will be the Employer of Choice as evidenced by an interdisciplinary team approach that is collaborative and cohesive. Our Magnet designation will validate our continuous dedication to clinical excellence, research and education

serve as a catalyst for transformation to help establish the incentives to make necessary short-term changes in the interest of long-term success (Soule, 2002). Zager & Walker (2005) concluded that a vision statement: (a) attracts commitment and energizes people, (b) creates meaning in workers lives, (c) establishes a standard of excellence, and (d) bridges the present to the future.

Effective use of facilitation and leadership skills are needed to develop a vision statement. Time is also required in order to create, reflect on, and consider the implications the vision brings. In addition, gaining trust among the stakeholders is essential. The first step in developing a vision statement is to start with an idea-generating session. Next the first copy is drafted and the stakeholders begin to react, discuss, and modify the proposal. Subsequently, a second, third, and perhaps several drafts may be necessary and developed over time until the team reaches consensus. When the final proposal is reached, the vision statement must be clearly communicated so all can share in the commitment to make the vision a reality.

Cooper University Hospital (CUH) is currently on a journey to create excellence in every aspect of patient and family centered care. To that end, the Nursing Team has recently developed a vision statement to achieve this goal. The process took approximately six months to develop and finalize (see Table 1).

Email comments to Yhlen-kathleen@cooperhealth.edu

Table 1 CUH Vision Statement Development Process

1. Senior Vice President Patient Care Services/Chief Nursing Officer and Associate Chief Nursing Officer drafted initial ideas
2. Initial ideas compared and merged into first draft
3. First draft presented for discussion and feedback to Senior Directors
4. Second draft developed and shared with Clinical Directors for comments
5. Third draft developed and presented to Associate Clinical Directors for feedback
6. Fourth draft developed and presented to Clinical Educators for suggestions
7. Fifth draft developed and posted on all patient care units for input from RNs and Unit-Based Councils (interdisciplinary team members, including medical residents, fellows and attending physicians). Input was also sought from the RN Retention Task Force
8. Sixth and final draft developed after consensus reached by all stakeholders
9. In addition to all stakeholders involved, Nursing's vision was reviewed and clarified by the Senior VP/CNO at the Medical Executive Committee, and Administrative Council

References:

Soule, B. (2002). From vision to reality: Strategic agility in complex times. *American Journal of Infection Control*. 30(2), 107-119.

Zager, L.R., & Walker, E.C. (2005). One vision, one voice: Transforming caregiving in Nursing. *Orthopaedic Nursing*. 24(2), 130-133.

“A vision can align persons to a common cause and serve as a catalyst for transformation to help establish the incentives to make necessary short-term changes in the interest of long-term success.”

Change is Good

By Dee Stanton, RN, CCRN



“...the things that make me most proud are the things I did to improve my practice and pass on my knowledge to others.”

Many changes have occurred in nursing since I became a nurse 42 years ago. After graduating from Grady Memorial School of Nursing, I worked on a medical-surgical floor for approximately 4 years. It was only the beginning of a long career.

My husband accepted a new job, so we moved to New Jersey and where I had my first experience with critical care. I was one of the first nurses to work in what was defined as an Intensive Care Unit (ICU). This was a very exciting time for me and nursing in general because critical care was an all new concept of multidisciplinary, collaborative practice. Professional skills and nursing practice were changing in leaps and bounds

In 1980 I came to Cooper as a staff nurse in the Coronary Care Unit (CCU). Certainly there were many memorable experiences that will always be in my heart and mind, but one stands out vividly in my memory.

It was a usual July day in the CCU; fast paced and busy. I was on day shift waiting for my shift to end, when the voice of the monitor tech resounded “Check bed 4, Check bed 4.” With adrenalin now flowing, the nursing team ran to room 4 to find a male patient in a tachycardic rhythm. He was awake but symptomatic with a wide complex rhythm. If you have ever worked in July, you know that the former Interns were now the new Residents and very new to critical care. The Resident at the bedside was perplexed as to how to treat this patient. The decision had to be made quickly as the patient had started to deteriorate. I suggested a new drug called Amiodarone, but because of the patient’s unstable hemodynamics and low blood

pressure the Resident and his team opted to support the patient with intravenous fluids. Needless to say, this treatment did not work and a call was placed to the Attending Cardiologist. The Cardiologist confirmed the need for a more aggressive treatment. Amiodarone was given and it obliterated the rhythm and stabilized the patient. It was the fast action and the persistence of the nursing staff that affected the positive outcome of this patient.

In over 42 years, I have had the opportunity to experience a wide spectrum of nursing roles ranging from staff nurse, cath lab technician, assistant nurse manager, nurse manager, and preceptor. However, the things that make me most proud are the things I did to improve my practice and pass on my knowledge to others. For example: passing the Critical Care Registered Nurse certification exam, receiving the Theodore Hirsch Award for Excellence in Cardiovascular Nursing Practice, being honored as clinical nurse of the year by the Black Nurses Association, and being a preceptor and BCLS/ACLS Instructor are all key pieces of my nursing life. I have worked at Cooper over 25 years (I am a member of the 25 year club) and work hard while I am here. Although I love my job, my days off are spent at community health fairs, teaching community CPR and being Chairperson of the Women’s Missionary Society of my church. It is a good balance.

Professional nursing practice demands that nurses be patient advocates, administer physical care, oversee the action and reactions to the care we provide, and also to collaborate. Thus we improve outcomes for the patients in our care, and ultimately reduce morbidity and mortality. It is the enthusiasm and the zeal of the critical care nurse that makes this happen every day.

Email comments to
Stanton-Columbia@cooperhealth.edu



Professional News

AWARDS:

Cooper University Hospital ICU/CT-ICU and CCU is proud to announce that it has received the Beacon Award for Critical Care Excellence, an award given by the American Association of Critical-Care Nurses (AACN).

DEGREES:

Beth Sherman, RN, BSN, CEN, Emergency Department staff nurse, Drexel University

CERTIFICATIONS:

Stacey Staman, RN, MSN, CCRN and **Betsy Maier, RN, BSN** received their EPIC Inpatient Certification, September 2008.

Beth Sherman, RN BSN CEN received certification in Emergency Nursing

Margaret Stager, RNC-OB received certification in Inpatient Obstetrics

Delia Walck BSN, RNC-OB received certification in Inpatient Obstetrics

Margaret Nece RNC-OB received certification in Inpatient Obstetrics

Linda Riley RNC-OB received certification in Inpatient Obstetrics

Erin Green BSN, RNC-OB received certification in Inpatient Obstetrics

Ruthann Callaghan RNC-OB received certification in Inpatient Obstetrics

Cheaw Li BSN, RNC-OB received certification in Inpatient Obstetrics

Anna Maria Sheehan BSN, RNC-OB received certification in Inpatient Obstetrics

Peggy O'Connor RNC-OB received certification in Inpatient Obstetrics

Eileen Cabalo BSN, RNC-OB received certification in Inpatient Obstetrics

Evelyn Padilla RNC-MNN received certification in Maternal Newborn Nursing.

Allison Richter RNC-MNN received certification in Maternal Newborn Nursing.

Diane Byars BSN, RNC-MNN received certification in Maternal Newborn Nursing.

Kelly Campbell RNC-MNN received certification in Maternal Newborn Nursing.

Christine Ward BSN, RNC-MNN received certification in Maternal Newborn Nursing.

Sue Lieberum RNC-MNN received certification in Maternal Newborn Nursing.

Christie Pipolo, RN-BC received certification in Medical Surgical Nursing

Stephanie Urbanski, RN-BC received certification in Medical Surgical Nursing

Joanne Ludwick, RN-BC received certification in Medical Surgical Nursing

Nancy Schmidt, BSN, RN-BC received certification in Medical Surgical Nursing

Ellen Buckalew, RN-BC received certification in Medical Surgical Nursing

Joan Talbot RN-BC, MSN, APN, CNS received certification in Medical Surgical Nursing

Sherry Wright, RN-BC received certification in Medical Surgical Nursing

Donna Hartzel, RN-BC received certification in Medical Surgical Nursing

Michelle Hackett, RN-BC received certification in Medical Surgical Nursing

Genalyn Vargas, RN-BC received certification in Medical Surgical Nursing

Micheline Eakins, RN-BC received certification in Medical Surgical Nursing

Haemin Lee, RN-BC received certification in Medical Surgical Nursing

Doris Bell, RN-BC received certification in Medical Surgical Nursing

Joan Pino-Talbot, RN-BC, BSN received certification in Medical Surgical Nursing

Maria Mendez, RN-BC received certification in Medical Surgical Nursing

Esther Word, RN-BC received certification in Medical Surgical Nursing

Lisa Moriarty, RN-BC, MSN, ONC, CNS received certification in Medical Surgical Nursing

PRESENTATIONS:

Trends in Critical Care Nursing, Valley Forge Convention Center; King of Prussia, PA, October 28, 2008
Presentation: Acid-Base Balance and ABG Analysis

Stacey Staman, RN, MSN, CCRN

APPOINTMENTS:

Cheryl Koehl, RN, MSN, appointed to the National Education Committee of the Emergency Nurses Association.

Thomas M. Salerno, RN, BA, MA, appointed Clinical Director of the Cardiac Cath/EP Lab

Stacey Staman, RN, MSN, CCRN, appointed as a reviewer for AACN's *Critical Care Nurse* journal.

LADDER APPOINTMENTS:

Level 3

Crystal Turner, RN PCU

Nancy Gibson, RN, BSN M/I

Suja Joseph, RN, MSN PCU

Christine Kelly, RN TSDU

Adrienne Bell, RN TICU

Victoria Johnson, RN, BSN TSDU

Stacey Carr, RN N/S9

Brooke Walsh, RN PCU

Leanne A. Mader, RN, BSN, CCRN ICU

Level 4

Ed Norton, RN, BSN TICU

Phyllis DeCristo, RN, OCN N/S9

Tracy Reynolds, RN, OCN N9

Marybeth Chambers, RN, BSN ICU

Andrea Lore, RN BSN ICU

Carolyn Scratchard, RN, MSN VSC

Bernadette Malinowski, RN BSN VSC

Kim Vaughn, RN, BSN VSC

Angela Jones, RN, CAPN VSC

Jacqueline Brooks, RN, BSN NICU

Level 5

Debbie Cutrona, RN, BSN, CCRN PACU

Deihann Cooper, RN, BSN, CAPA VSC

Level 6

Rosemarie White, RN, MS, PNC Psych

Kristen Coyle, RN, MS, ANCC, RNC MICU



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