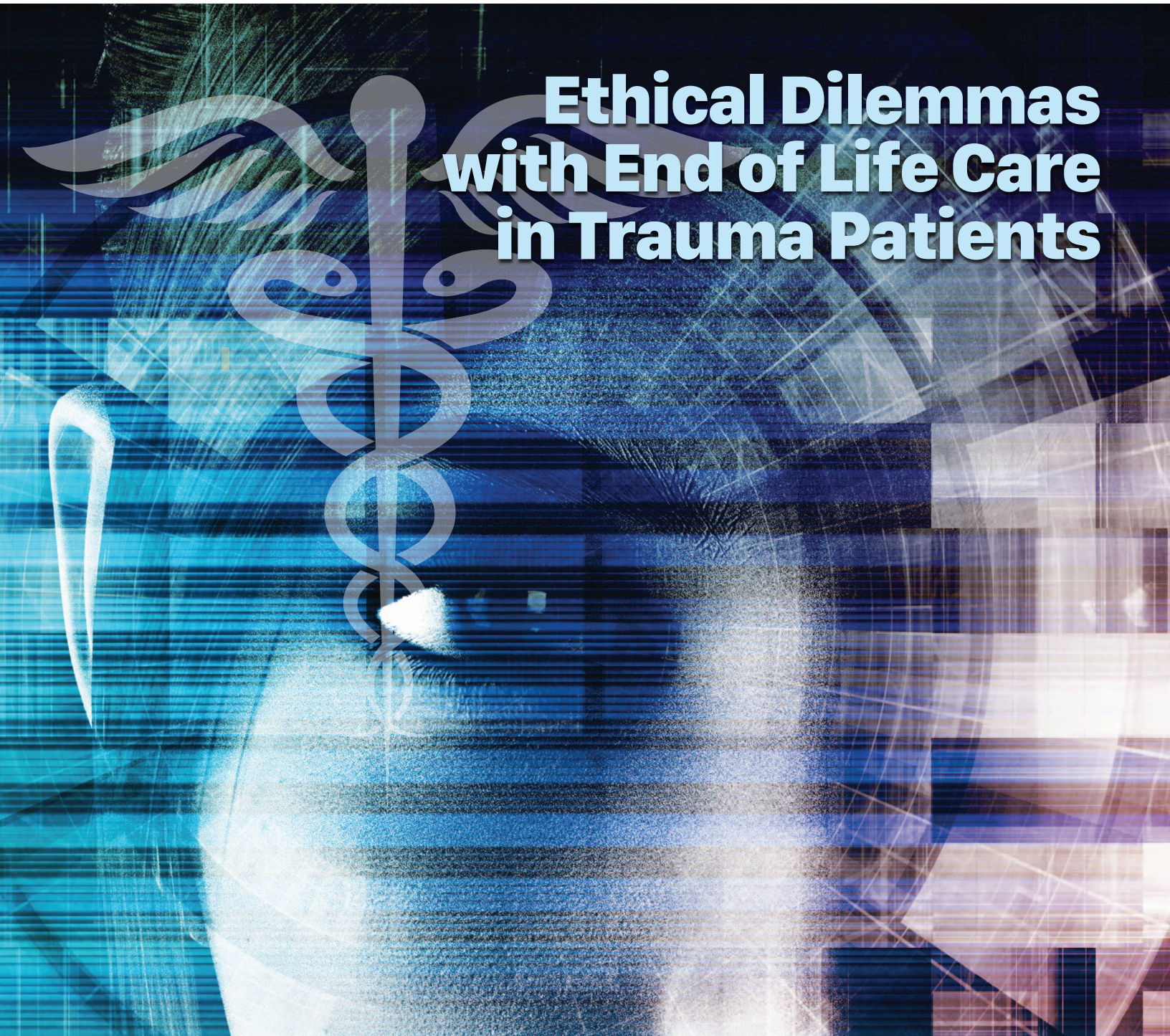
Cooper University Health Care

Cooper Bridges

A publication for nurses and healthcare professionals

SUMMER 2019 ▪ VOLUME 13, ISSUE 1



Ethical Dilemmas with End of Life Care in Trauma Patients

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Our Senior Nurse Leaders

In each new edition, we will be celebrating one of our Senior Nurse Leaders. In this edition, it is an honor to share an interview with Kathy Devine, Sr. Vice President and Chief Nursing Officer

Editor: Kathy, thank you for this opportunity. As our Chief Nursing Officer, could you share your vision for Cooper Nursing? What are your priorities for 2019?

Kathy Devine: 2019 has been and continues to be a year for resetting. Our health system experienced significant growth over the past few years; therefore, there is an organizational focus on supporting infrastructure needs. For Nursing, we will continue to prioritize efforts which will stabilize our Nursing teams and work environments.

Editor: Can you elaborate on what you mean by infrastructure?

KD: We have been strengthening Nursing's infrastructure or foundation by evaluating care models and implementing innovative approaches to staffing, optimizing EPIC to enhance nursing workflows, partnering with Supply Chain leaders to ensure units are adequately stocked with patient care supplies. We are also collaborating with various support departments such as Environmental and Transport to ensure such services are adequate allowing nurses to focus on the provision of clinical care.

In addition, we are reevaluating orientation processes for nurses as well as ensuring we provide continuing education and professional development opportunities. We have joined a New Jersey Hospital Association state initiative called Nursing Workplace Environment and Staffing Council or NWESC. The purpose of this pilot program is to provide a framework for staff nurses and nursing leaders to build and sustain healthy work environments for all nurses to provide exceptional care, as well as to develop and thrive professionally. This project is based on the American Association of Critical Care Nurses' (AACN) standards for healthy work environments which focus on; skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership. For 2019, the NWESC at Cooper has focused on nurse recruitment/retention, meaningful recognition, and orientation/preceptorship.

Editor: What are your goals for 2020?

KD: Efforts related to stabilizing Nursing's foundation will continue into 2020. In addition, nurses will be engaged in the development of a strategic plan for professional nursing at Cooper. This plan will include the advancement of a vision statement that will inform our professional practice and governance structure.

Next year, we also want to build upon the work we have done to engage staff nurses to be unit-based champions to improve our clinical and quality results for such measures as CAUTI, pressure injury, and service standards. Collectively, the work of our unit-based champions, unit-based councils, and nursing practice councils will further advance nursing practice, patient outcomes, and best practices.

Editor: Where do you see Cooper Nursing in 3 to 5 years?

KD: I believe Cooper Nursing will be well down the pathway to professional excellence. Through teamwork and inter-professional collaboration, we can make Cooper the academic health system of choice for nurses across our region, creating and sustaining an exceptional work environment where nurses can learn and grow professionally while providing advanced, evidenced-based patient care.

Cooper Bridges Mission:

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

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

Nurse Navigation

Norma Colwell-Rowello, RN, MSN, APN-C, OCN, Kristine Mykulowycz, BSN, RN, CTTS, Mary Rooney, MSN, RN, OCN, CBCN, Charu Vora, BSN, RN, OCN, MSW, Susan Maltman, MSN, RN, Jacqueline Bockarie MSN, RN

An oncology nurse navigator (ONN) is a professional registered nurse with oncology-specific clinical knowledge who offers individualized assistance to patients, families and caregivers to help overcome healthcare system barriers. An ONN provides education and resources to facilitate informed decision making and timely access to quality health and psychosocial care throughout all phases of the cancer continuum. This encourages an interdisciplinary approach to treatments and wellness (FACS, 2016). ONNs are leaders who support patients and their families through some of the most challenging obstacles in their lives.

The American College of Surgeons (ACS) Commission on Cancer (COC) establishes standards in cancer care to ensure that quality, multidisciplinary, comprehensive cancer care is offered to patients in their accredited communities (FACS, 2016). For cancer programs to achieve and maintain this accreditation, specific patient-centered standards must be upheld including a requirement established in 2016 for centers to employ a patient navigation process (FACS, 2016). As an accredited cancer program, MD Anderson Cancer Center at Cooper utilizes a variety of teams and networks to improve the care their patients receive—including the implementation of oncology nurse navigators.

The first patient navigation program was implemented in 1990 for patients with breast cancer in New York City (Oncology Nursing Society, 2013). A major goal of this program was to increase access to cancer screening and clinical follow-up among medically underserved women through community outreach and the elimination of health access barriers (Oncology Nursing Society, 2013). This empowers patients by promoting autonomy (Oncology Nursing Society, 2013). Over the following twenty years leading into today's programs for patient navigation, the roles have expanded to include cancer care throughout all stages—prevention through survivorship (Oncology Nursing Society, 2013). Establishing expanded responsibilities ensures that navigators provide more comprehensive care that patients both need and desire.

Nurses are crucial components to patient navigation because of their clinical expertise as professionals with direct experience assessing patients, offering support and education, managing various aspects of treatment in addition to a proven willingness to collaborate with interdisciplinary teams and clinicians (Oncology Nursing Society, 2013). Because of this experience in the field, nurse navigators can effectively anticipate patient's needs, initiate referrals and provide valuable tools and education throughout the many stages of their treatment. This offers patients a sense of control over a difficult situation and reduces overall stress. (Oncology Nursing Society, 2013). ONNs have specific characteristics which include keen oncology knowledge, strong interpersonal skills, ability to develop collaborative relationships, organizational skills including prioritizing patient needs, critical thinking, decision making and leadership skills. These proficiencies and experiences cannot be mimicked by other professionals, making them essential to the navigation process.

Nurse navigators at MD Anderson at Cooper practice care that underlines current standards and emphasizes patient empowerment and support.

Cancer site-specific navigation is modeled after an evolving standard of care that is constantly shifting as more research and best-practices

develop. Oncology nurses were originally chosen to be navigators who focused on specific systems and aspects of care that addressed access and coordination (Blaseg, Daugherty, & Gamblin, 2014). The efficient and effective coordination of care remains an objective of all nurse navigation, specialty focuses have enhanced care and empowered patients through the use of oncology nurses who have direct experience working with patients throughout their entire journey as cancer patients (Blaseg et al., 2014). This kind of care now utilizes disease site-specific services which include specialized education, symptom management, psychosocial support and other necessary but often otherwise overlooked aspects of treatment and care (Blaseg et al., 2014). Blaseg and colleagues (2014) explain that the most recent models are based on disease, treatments pursued and completed, risk for recurrence, and other personalized aspects rather than efforts to promote disease-free survivorship (as was the focus on the original model in 1990). These navigation models are key to patient success as they emphasize the unique needs of each individual patient and their treatment plans. As patients have similarly unique needs and challenges that only expert oncology nurses and teams can navigate for patient success.

Nurse navigators at MD Anderson at Cooper practice care that underlines current standards and emphasizes patient empowerment and support. The navigators handle aspects of care that enhance the experience of each patient and attempts to remove barriers of care (See table 1). Gordils-Perez, Schneider, Gabel, and Trotter (2017) explain that nurse navigators must build relationships with patients and their families, offer support after diagnosis, coordinate care between other clinicians and health care teams, provide initial education about what to expect during the treatment process, answer questions about care options and available clinical trials, and direct patients to support services that are relevant to their situations (for example: social services, nutritionists, language translators and community resources).

When nurse navigators are not utilized, patients experience poor outcomes, disjointed care and communication about treatment, less educated decision-making and at-home care, less psychosocial and community support, and challenges obtaining financial and transportation resources (Gordils-Perez, Schneider, Gabel, & Trotter, 2017). The use of nurse navigators improves both the quality and efficiency of care received by patients which improves patient prognoses and overall outcomes (Gordils-Perez et al., 2017).

As more evidence-based research becomes available and technology advances, both patient needs and the role of the nurse navigator will continue to change. Implementing more nurse navigators who are committed to learning and growing as the industry and role evolves is crucial to patient success.

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References:

Blaseg, K., Daugherty, P., & Gamblin, K. (2014) Oncology Nurse Navigation Delivering Patient-Centered Care Across the Continuum. Pittsburgh, PA: Oncology Nursing Society.

Commission on Cancer (2016). Cancer Program Standards: Ensuring patient-centered care. Retrieved from https://www.facs.org/quality-programs/cancer/coc/standards

Gordils-Perez, J., Schneider, S., Gabel, M., & Trotter, K. (2017). Oncology Nurse Navigation. Development and implementation of a program at a comprehensive cancer center. *Clinical Journal of Oncology Nursing,* 21(5), 581-588. doi:10.1188/17.CJON.581-588

Oncology Nursing Society (2013). Oncology Nursing Society Oncology Nurse Navigator Core Competencies. Retrieved from https://www.ons.org/sites/default/files/ONNCompetencies_rev.pdf

Oncology Nursing Society (2017). Oncology Nursing Society Oncology Nurse Navigator Core Competencies. Retrieved from https://www.ons.org/sites/default/files/2017ONNcompetencies.pdf

Table 1.

Responsibilities of ONN	Definition and examples
Assess patient needs	This occurs pre-appointment via phone referrals, during initial patient visit, & at follow up after initial visit. Includes need for additional services: social work, dietary, rehab, finance.
Identify potential and realized barriers to care	Barriers include language, transportation, and culture.
Knowledge base of community support	Includes finding resources: American Cancer Society, Lung force, support groups, etc.
Facilitates scheduling to promote continuum of care	Appointments, diagnostic testing, procedures
Participates in multidisciplinary approach of care	Works with all modalities of care for a patient such as surgery, medical oncology and radiation oncology.
Facilitates individualized care of the patient	Helps each patient with understanding of their unique culture, knowledge, and needs
Supports smooth transition from diagnosis to care	Work with patient from point of diagnosis and staging to active treatment plan.
Assists patients with issues of patient goals of treatment	Works with palliative care and end of life issues without being discriminatory or judgmental
Builds trusting relationships with patients	Through communication and listening skills
Liaison between patient, caregivers and providers	First point of contact with assisting in guiding the patient
Advocates for the patient	Empowers the patient to make known their needs and wishes
Assess educational needs	Provides resources: handouts, websites, and structured educational classes for chemotherapy, radiation therapy, and more.
Reinforces the significance of adherence	Assists the patient in time lines, goals and scheduling of care.
Contributes to the development of the Cancer program	Works with administration and other intricate team members to assist in the cancer centers vision of patient care.

Oncology Nursing Society (2017)

A Transformational Journey in Fall Reduction… Why You Should Trust The Process

Pamela Young, BSN, RN

Our mission statement at Cooper University Hospital (CUH), "to serve, to heal and to educate," guides the delivery of care to our patients each and every day. While living this mission, we get a sense of pride and job satisfaction from impacting safe patient outcomes. Of all the healthcare workers in the hospital setting, nurses tend to feel the ultimate responsibility for the safety of their patients.

One of the more serious threats to patient safety in the hospital setting is falls. Accidental falls are among the most common incidents reported in hospitals complicating approximately 2% of hospital stays. Rates of falls in the US hospitals range from 3.3 to 11.5 falls per 1000 patient days (Boudin et al., 2013). There is nothing more tragic to a nurse than to have a patient fall and get injured.

As a Nurse Leader, I have experienced the loss of a caring, compassionate and competent bedside nurse shortly after her patient had a fall with injury. The significant injury caused by the fall led to the deciding factor for this nurse to leave the bedside. Protecting our patients from falls and protecting our nurses from experiencing the guilt associated with falls, should be a number one priority in a high reliability organization. The purpose of this article is to outline our journey in fall reduction and identify the value of data collection, data analysis and a tailored approach to fall prevention.

Pavilion 7 (P7) is a 30 bed Orthopedic/Neurology unit located in the Pavilion building of CUH. Our highly engaged staff led by our dynamic leadership team, have developed strategies based on our own analytics to successfully impact fall reduction. Fall data showed P7 had a total of 35 falls in 2015 and 33 falls in 2016. After the custom strategies were implemented, we successfully reduced our falls to 13 total falls for 2017. This was a 66% reduction of falls. We are excited to share our journey toward success!

First, implementing a strategy, the leadership team and staff used all the standard methods we could find for fall reduction. We solicited unit champions and made poster presentations to increase awareness on our unit. We utilized our fall assessment tool in the electronic health record. We increased our par levels of the standard yellow socks, yellow gowns and yellow bracelets to ensure compliance of use. Additional bed and chairs alarms were purchased. We raised awareness of our falls in unit based council and staff huddles. As an Orthopedic unit, we purchased a walker for every patient room to ensure an assistive device was readily available if needed. Actually, we did not see much of a difference in fall reduction in spite of all of these measures until we took additional steps.

Next, systematically fall data was collected and analyzed focused solely on P7. The data collected was specific such as patient age, gender, diagnosis, service, status and time of day. Analysis of

One of the more serious threats to patient safety in the hospital setting is falls. Accidental falls are among the most common incidents reported in hospitals complicating approximately 2% of hospital stays.

the data collected revealed surprising trends that drastically changed our course of action. The data revealed captivating and thought-provoking details on each fall in our unit. To our surprise, the service of the patient revealed the biggest opportunity that yielded the greatest impact in fall reduction. Our unit has a ratio of approximately 75% Orthopedic and 25% Neurology patients. Logically, we assumed the Orthopedic patients with surgical work on a limb would be our highest n=falls (number of total falls). The data revealed the complete opposite. Our Neurological population of patients contributed to our highest percentage of falls with orthopedic patients very low. Armed with this revelation, we completely changed our course of action and took a hard look at our Neurological patient population. Our research concluded, most of our Neuro patients were in our stroke unit and many of our stroke patients were active members of the community prior to their stroke. These patients have the greatest potential to fall. Think about it… yesterday they were mowing the lawn and today they have right sided weakness. These patients have not adjusted to this acute insult and do everything possible to maintain their independence. You cannot visualize a patient's weakness and therefore these patients typically "look" fine. We also found these patients to be very good at convincing our staff and ancillary staff to allow them to walk independently only to have a fall. Based on the analytics, we did extensive education to our staff and to our ancillary partners on a tailored care plan for these patients. We now make every patient in our stroke unit high risk for falls regardless of the usual scoring system used. They immediately qualify for all the fall precaution measures based on their diagnosis. Stroke patients always have their bed alarmed and chair alarmed for safety. Stroke and fall risk are synonymous to our staff.

Finally, the two other measures implemented for fall reduction were real time root cause analysis (RCA) and a Fall Data Analysis Report. The real time RCA requires a phone call to the Clinical Director after any fall. The phone call is in real time and the nurse and the technician directly caring for the patient need to be on speaker phone. Together, we come up with the root cause of the fall and more importantly we come up with an immediate plan to prevent additional injury. Many of the RCAs have revealed a breakdown in compliance of a chair or bed alarm which required immediate corrective action. The Fall Data Analysis Report is emailed to staff and posted on the unit after every fall. This report is a running tally with the specific data points from every fall. The report supports education and builds a culture of transparency that is essential in a high reliability organization.

P7 is serious about safety and we are committed to strive for excellence in quality for every patient, every day. Just ask any P 7 staff member.

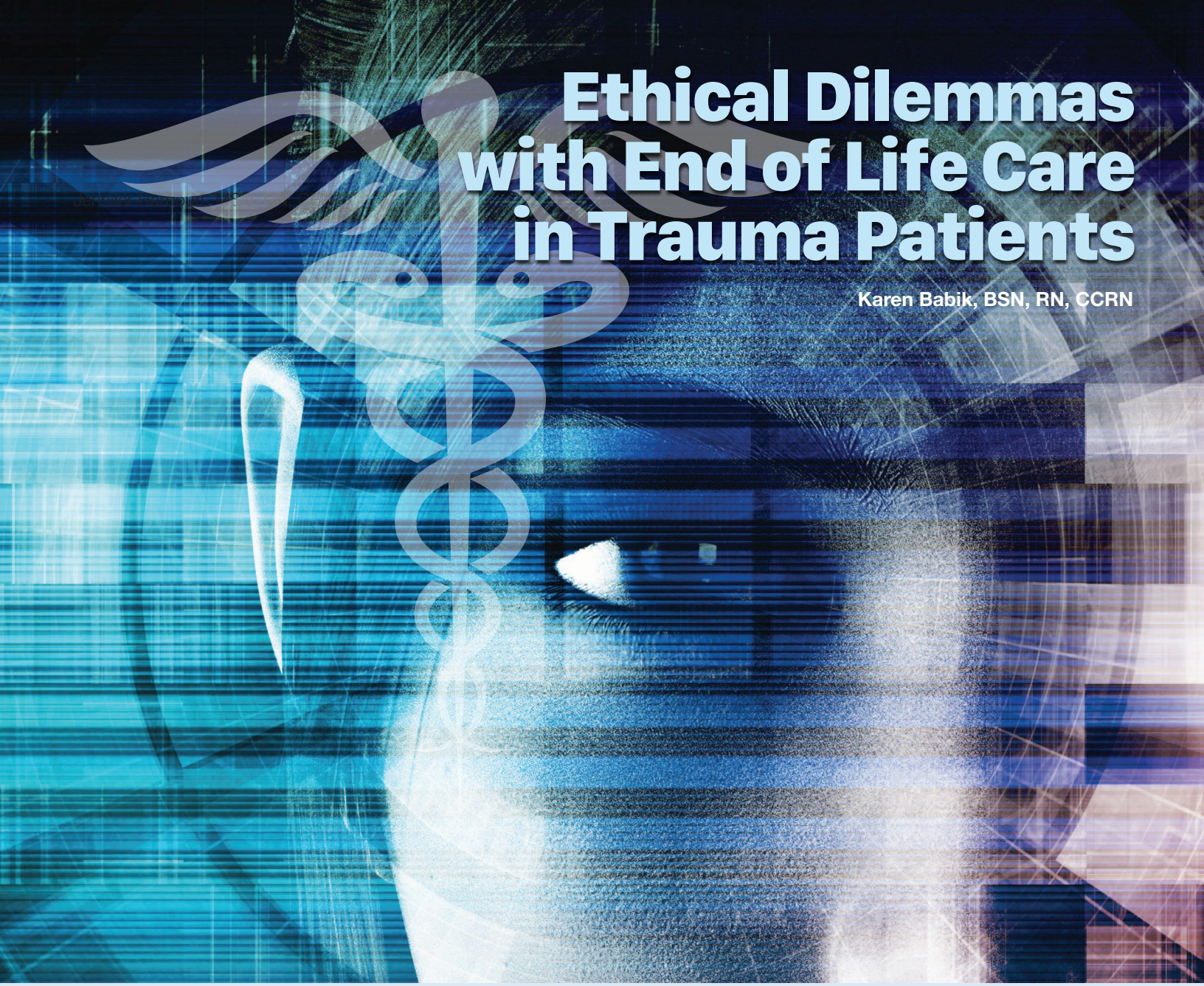
Email comments to **young-pamela@cooperhealth.edu**

References

Boudin, ED, Anderson, EM, Dunton, NE, Simon, M, Waters, TM, Liu, M…Shorr, RI (2013) Falls among adult patients hospital in the United States: Prevalence and trends, *National Center for Biotechnology information, 1, 13-17*. https://doi.org/10.1097/PTS.0b013e3182699b64.

Ethical Dilemmas with End of Life Care in Trauma Patients

Karen Babik, BSN, RN, CCRN



The Nursing Profession is guided by a Code of Ethics with interpretive statements put forth by the American Nurses Association. This code of ethics is essential in imparting the ethical foundation for nursing practice, and the nurse's obligation to the overall health and safety towards patients. This code serves as a guide to assist the nurse in performing nursing responsibilities in an ethical manner in terms of what they ought to do, be, and seek (Epstein & Turner, 2015).

There are nine provisions, that govern responsibilities and obligations to the nursing profession, nurse patient relationship, nurse to nurse, nurse to self, nurse to others and nurse to society. The first three provisions, detail the core values and obligations of the nurse (American Nurses Association [ANA], 2015). Provision one, implies that it is the nurse's duty to treat all patients with compassion, respect their dignity, consider their needs and respect their values. The nurse will develop a relationship of trust and provide the necessary services without bias or prejudice. Provision two emphasizes that the nurse's primary commitment is to the patient, even when conflict arises, the nurse is obligated to safeguard the patient's best interests. Provision three, the nurse advocates for the patient and protects their rights, health and safety (ANA, 2015).

This code of ethics is essential in imparting the ethical foundation for nursing practice, and the nurse's obligation to the overall health and safety towards patients.

Despite these established guidelines, nurses are challenged daily with ethical dilemmas, giving rise to conflicts in the way to approach quality care to patients. For nurses working in critical care and emergency environments, stress is a common occurrence where the expectations of the nurse, patient, families, physician and institution may be conflicting. The

nurse's relationship and close interaction with the patient and families at the bedside, can cause stress for the patient, family or staff when there is concern about unethical choices in care or treatment (Maiden, Georges, & Connelly, 2011). Maiden et al. (2011) describe moral distress as a threat to any nurse involved in patient care, which is recognizing that one's core personal values and ethical obligations have been violated. Schulter, Winch, Holzhauser and Henderson (2008) refer to moral distress as painful emotions and associated mental anguish brought about by being aware of a morally appropriate action, but despite all efforts cannot be implemented, secondary to organizational or other constraints.

Despite modern advances in resuscitative treatments and aggressive care, ten to twenty percent of trauma patients succumb to their injuries

Trauma nurses are particularly at risk for moral distress in an environment elevated with stress as they care for individuals with life threatening injuries. Trauma nurses experience greater levels of burnout than any other health care professional with extensive exposure to such stress (Munnanga, Dupiton, Boution & Angus, 2018). Hamilton-Houghtaling (2012) discuss futile care as being a cause of moral distress among trauma nurses, when the likelihood of survival is unlikely. According to Hamilton-Houghtaling, trauma nurses are expected to be strong and restrain themselves from exhibiting too much emotion when involved in patient care, as this contributes to a futile environment, where moral distress thrives among nurses (Hamilton-Houghtaling, 2012).

Patient Scenario

Mr. J.G. was a thirty-year old male, who arrived in the trauma resuscitation area of a level one, urban trauma center after sustaining multiple gunshot wounds to his chest and upper abdomen. He arrived moaning, diaphoretic, cool, clammy, hypotensive, with a decreased level of consciousness and weak peripheral pulses. He was immediately intubated and placed on mechanical ventilation. A unit of blood was hung and partially transfused while a massive transfusion protocol was implemented. His pulses became weaker, prompting the trauma surgeon to perform an open thoracotomy, to discover the bullet had penetrated his left ventricle. With the wound occluded and bleeding controlled, he was taken immediately to the operating room within ten minutes of arrival. Intraoperatively he went into cardiac arrest several times and remained in persistent hemorrhagic shock, despite receiving an excess of twenty units of blood and multiple additional blood products, including fresh frozen plasma, cryoprecipitate and tranexamic acid (TXA) to control excess bleeding and coagulopathy. To maintain central perfusion, a resuscitative endovascular balloon occlusion of the aorta catheter (REBOA) was placed.

Additional injuries included a grade five liver laceration and a pulmonary vein laceration. He was brought to the trauma intensive care unit post operatively, with his chest open and covered in surgical plastic, hypotensive, tachycardic and semi-conscious. The massive transfusion protocol continued as he received an additional twenty units of blood. He became pulseless several times, requiring internal defibrillation to regain vital signs. Although he remained semi awake throughout the extraordinary resuscitative efforts, he was displaying facial expressions of pain and fear. There was hesitation in giving extra analgesics or sedation, as his vital signs remained labile and were deteriorating. This was emotionally distressing for the staff and his primary nurse, as they felt distraught with the inability to alleviate his pain or fears.

Questions and thoughts arose of how much is too much? When should these "heroic" efforts cease when the likelihood of survival is minimal? Anticipating a poor outcome, a discussion took place about allowing the family to be present at the bedside during the resuscitation which was met with ambivalent feelings.

Mr. J.G. was an immigrant living in the United States for approximately one year with his only family support being his pregnant girlfriend and two cousins. He and his girlfriend spoke primarily Spanish, making their comprehension of the current situation and their health care decisions unknown. Mr. J.G. was unable to make his own health care decisions and they never discussed end of life care. The girlfriend was unaware of what an advanced directive was, but after an explanation, she stated that Mr. J.G. didn't have one, but she wanted everything done for him to survive.

Two ethical dilemmas emerged in this situation. First, when should heroic resuscitative efforts be halted and consider providing end of life compassion in the severely injured trauma patient? Second, is it appropriate to have family present during resuscitation recognizing that there may be an unfortunate outcome?

End of life care in the trauma patient is a difficult issue to address. According to the National Trauma Institute, trauma is the leading cause of death among individuals 1-46 years old, accounting for forty-seven percent of all deaths (2015). Aggressive resuscitation is the central component in the care of the severely injured trauma patient. Despite modern advances in resuscitative treatments and aggressive care, ten to twenty percent of trauma patients succumb to their injuries (Mosethal et al., 2008). Trauma shows no boundaries and can affect anybody at any time, but often it is the healthy, younger population that is affected. This becomes complex, in the severely injured trauma patient when the goal of the aggressive treatment is to save lives and prolong life, especially when the individual is young. When does the aggressive treatment become futile? Mosenthal, et al., discuss the difficulty in delivering

end of life care in the trauma intensive care setting as the family is in a state of bereavement and unable to comprehend the notion of making end of life decisions (2008). An obstacle to ending futile care is that physicians perceive death as a failure (Gordy & Klein, 2011). As nurses, we are bound by the nursing code of ethics to provide compassionate care for all of the patient's needs, but also do no harm. This is a significant creator of moral distress. When is it harmful, what are the endpoints?

In the younger population, discussions regarding end of life, most likely never take place. The family must now be the surrogate decision maker, keeping the best interests of the patient in mind. The family's decisions may not always align with their loved one's wishes, especially if they have never been communicated (Gordy & Klein, 2011). It is vital to have honest communications with family members regarding the realistic outcomes of aggressive resuscitation. This is not always practiced, as reported in a study by Sunses and Ersy, where 36.4% of physicians and 36.4% of nurses state they were willing to comply with the demands of family members to continue futile care, although there were no benefits (Neville et al., 2015). Many states do not have laws and policies established to address futility. It has been suggested that nurses participate in the development of policies that could assist in the futile care resolutions, as close, direct providers (Olmstead & Dahnke, 2016).

The goal is to address sensitive issues and obstacles for the end of life care among trauma victims. This model, referred to as the Trauma End of Life Optimum Support (TELOS) puts forth and describes best practices for end of life care among trauma patients across the prehospital, emergency and intensive care setting.

The 1994 SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments), put forth by the Robert Wood Johnson Foundation, searched for a way to improve the quality of care towards the end of life. Through advocacy and public communication, the goal was to get more people involved in advanced care planning (Robert Wood Johnson Foundation website, 2010). Gordy and Klein affirm an increase in advance directives, from twenty-one percent to sixty-seven percent in 2010 among critically ill elderly patients, but this is not the case in younger populations. It is rare for individuals under the age of sixty-five to have advanced directives (2011). This demonstrates the importance of effective communication with families of the trauma patient. It is imperative to initiate and maintain conversations about future plans for treatment if the patient survives the initial injury and resuscitation. According to Gordy and Klein, communication with physicians has been regarded by families as most valuable (2011).

A best practice model in the trauma setting has been proposed through trauma leadership forums, supported by the American Trauma Society. The goal is to address sensitive issues and obstacles for the end of life care among trauma victims. This model, referred to as the Trauma End of Life Optimum Support (TELOS) puts forth and describes best practices for end of life care among trauma patients across the prehospital, emergency and intensive care setting. It encompasses six disciplines including decision making, communication, physical care, psychological care, spiritual care and culturally sensitive social care as appropriate in all settings. Highlights of the model include, communication to family, family presence during resuscitation, assisting in decision making when the patient is unable to do so and assessing spiritual, cultural values and beliefs (Burns, Jacobs, & Jacobs, 2011). The objective is to implement this model nationwide. As it is supported by the American Trauma Society, a manual has been constructed to provide guidelines for institutions that desire to implement a similar model (Burns et al., 2011).

Family presence during resuscitation (FPDR) has been a controversial issue for decades, particularly related to the concerns of healthcare professionals. Forte Hospital, in Michigan, was the groundbreaker in establishing this practice in 1982 and since that time, there has been a significant number of families expressing the need to be present at the bedside during resuscitation (Hung & Pang 2010). Although literature has shown that FPDR has been beneficial, there is little research on families present during a trauma resuscitation. Trauma is an unexpected phenomenon where devastating injuries can be sustained, requiring aggressive resuscitation, invasive procedures and admission to the intensive care unit. This can be a harrowing experience for the families, making it a sensitive subject to research (Leske, McAndrew Brasel & Feetham, 2017). The hesitancy of health care professionals to embrace FPDR, is secondary to the trauma that it may impose on families which may cause added stress and possibly becoming too emotional or disruptive. The staff may experience increased stress and anxiety as they are being watched and feeling scrutinized (Leske et al., 2017). Nurses have expressed fear of lawsuits, the interference of family members would impede care and there is lack of support for families through this ordeal (Tudor, Berger, Polivka, & Chebowy, 2014). Some healthcare professionals claim that the family would be unable to comprehend what was being done or that resuscitative efforts would be prolonged contributing to futile care, making it difficult in deciding when to terminate efforts (Hung & Pang, 2010).

A study of 375 nurses, evaluated their perception on FPDR and

although half of the nurses believed it was the family's right to be present, two-thirds stated that they have never invited family members to be present at the bedside (Tudor et al., 2014). Nurses have commented that a huge barrier to FPDR is the reluctance of physicians to have them present, but the nurses believed it should be handled according to nurse judgement and be situational (Tudor et al., 2014). A recent interview of health care professional attitudes towards FPDR, placed an emphasis on the strains of the staff, and the possible effects on families with a significant concern of lack of hospital policy on this issue (Leske et al., 2017). Despite the perceived notions of health care professionals, families have expressed interest and the need to be at the bedside during this critical moment of their loved one. Documented benefits to family presence have been assurance to the family that everything possible is being done, it may assist the family in making further decisions regarding resuscitative efforts and it can assist in the closure process (Hung & Pang, 2010).

In the case of Mr. J.G., end of life care issues were unable to be discussed. The trauma team granted the wishes of his girlfriend, continuing resuscitative efforts for an hour and a half until he succumbed to his injuries. As Mr. J.G.'s primary nurse, I did allow his girlfriend at the bedside during the end of the team's resuscitative efforts. Although I felt anguished, not being able to fully alleviate his pain and allay his fears, I do have comfort knowing that I was able to allow his girlfriend to spend those final moments with him. I am saddened that I was unable to completely support his girlfriend emotionally through this distressing ordeal.

As a trauma nurse for twenty-eight years, my view on FPDR has evolved. I am an advocate for supporting the families through this process and encourage my colleagues to do the same. I have had family members not present during resuscitation, where they felt "locked out" of the unit, not aware of what was happening and missing the opportunity to say goodbye. Some family members have expressed anger towards the staff, particularly if they were unable to see their loved one alive in those final moments. I have found family members are much more appreciative, as they see the dedication of the staff in attempting to keep their loved one alive.

Family presence at the bedside during trauma resuscitation and end of life care for the trauma patient, lacks extensive research, since it is such a sensitive subject. The unexpected occurrence of severe traumatic injuries does not prepare the family to mourn and prepare for death, as compared to someone who has become terminally ill.

Family presence at the bedside during trauma resuscitation and end of life care for the trauma patient, lacks extensive research, since it is such a sensitive subject. The unexpected occurrence of severe traumatic injuries does not prepare the family to mourn and prepare for death, as compared to someone who has become terminally ill. Literature reflects a need for

supportive guidelines for all heath care professionals in the care of trauma victims. Nurses are significant providers in caring for dying patients and those burdened with severe traumatic injuries. Compassion and dignity are vital in providing care to the trauma victim and their families. Nurses can possess a significant role in remodeling guidelines for compassionate end of life care in the trauma patient. Advocating communication regarding advanced directives, end of life decisions and family presence during resuscitation, to health care professionals and the public may result in implementing compassionate guidelines and practice models. The statistics of trauma related deaths are staggering, it would benefit the population as a whole if a study similar to SUPPORT was initiated and focused on the younger population.

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References

American Nurses Association. (2015). Code of ethics for nurses with interpretive statements. Retrieved July 9,2018, from https://www.nursingworld.org/coe-view-only

ANA Center for Ethics and Human Rights. (2016). Nurses role in ethics and human rights: Protecting and promoting individual worth, dignity and human rights in practice settings. Retrieved November 10,2017, from www.nursingworld.org

Burns, K. J., Jacobs, B. B., & Jacobs, L. M. (2011, April/June). A time for trauma end-of-life optimum support: The TELOS best practice model. *Journal of Trauma Nursing, 18,* 97-101. http://dx.doi.org/10.1097/JTN.0b013e31821f182e

Emergency Nurses Association website. (2015). www.ena.org

Epstein, B., & Turner, M. (2015, May 2015). The nursing code of ethics: It's value, its history. *Online Journal of Issues in Nursing, 20*. http://dx.doi.org/10.3912/OJIN.Vol20No02.Man4

Epstein, E. G., & Hamric, A. B. (2009, Winter). Moral distress, moral residue, and the crescendo effect. *The Journal of Clinical Ethics, 20*(4), 330-342. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3612701/

Gallagher, A. (2011, May). Moral distress and moral courage in everyday nursing practice. *The Online Journal of Issues in Nursing, 16*. http://dx.doi.org/10.3912/OJIN.Vol16No02PPT03

Gordy, S., & Klein, E. (2011, July - December). Advance directives in the trauma intensive care unit: Do they really matter? *International Journal of Critical Illness & Injury Science, 1*, 132-137. http://dx.doi.org/10.4103/2229-5151.84800

Hamilton-Houghtaling, D. L. (2012, October - December). Moral distress, an invisible challenge for trauma nurses. *Journal of Trauma Nursing, 19*, 232-239. http://dx.doi.org/10.1097/JTN.ObO13e131826d2dc

Hung, M. S., & Pang, S. M. (2010, September 6). Family presence preference when patients are receiving resuscitation in an accident and emergency department. *Journal of Advanced Nursing, 67*, 56-57. http://dx.doi.org/10.1111/j.1365-2548.2010.05441.X

Leske, J. S., McAndrew, N. S., Brasel, K. J., & Feetham, S. (2017, March-April). Family presence during resuscitation after trauma. *Journal of Trauma Nursing, 26*. http://dx.doi.org/10.1097/JTN.000000000000271

Leske, J. S., McAndrew, N. S., Evans, C. D., Garcia, A. E., & Brasel, K. J. (2012, September). Challenges in conducting research after family presence during resuscitation. *Journal of Trauma Nursing, 19*, 190-194. http://dx.doi.org/10.1097/JTN.0b013e318261d041

Maiden, J., Georges, J. M., & Connelly, C. D. (2011, November-December). Moral distress, compassion fatigue, and perceptions about medication errors in certified critical care nurses. *Dimensions of Critical Care Nursing, 30*, 339-344. http://dx.doi.org/10.1097/DCC.ObO13e31822fab2a

Mosenthal, A. C., Murphy, P. A., Barker, L. K., Lavery, R., Retano, A., & Livingston, D. H. (2008, March). Changing the culture around end-of- life care in the trauma intensive care unit. *The Journal of Trauma, Injury and Critical Care, 64*, 1587-1593. http://dx.doi.org/10.1097/TA.0b013e318174f112

Munnanga, S., Dupiton, L., Boutin, A., & Angus, L. G. (2018, January-February). Burnout, perceived stress and job satisfaction among trauma nurses at level 1 safety net trauma center. *Journal of Trauma Nursing, 25*. http://dx.doi.org/10.1097/JTN.000000000000335

National Trauma Institute website. (2015). www.nattrauma.org

Neville, T. H., Wiley, J. F., Yamamoto, M. C., Flitcraft, M., Andderson, B., Curtis, J. R., & Wagner, N. S. (2015, September). Concordance of nurses and physicians on whether critical care patients are receiving futile treatment. *American Journal of Critical Care, 24*. http://dx.doi.org/10.4037/ajcc2015476

Olmstead, J. A., & Dahnke, M. D. (2016, December). The need for an effective process to resolve conflicts over medical futility: A case study and analysis. *Critical Care Nurse, 36*, 13-23. http://dx.doi.org/10.4037/ccn2016472

Ozden, D., Kargrozoou, S., Yidirim, G., & Tabek, E. (2013). Opinions of intensive care professionals about futile treatment. *Turkish Journal of Research and Development in Nursing, 15*, 42-55. Retrieved from web.b.ebscohost.com.mylibrary.wilmu.edu

Robert Wood Johnson Foundation website. (2010). www.rwjf.org

Savel, R. H., & Munro, C. L. (2015, July). Moral distress, moral courage. *American Journal of Critical Care, 24*(4), 276-278. http://dx.doi.org/10.4037/ajcc.2015738

Schluter, J., Winch, S., Holzhawser, K., & Henderson, A. (2008). Nurses moral sensitivity and hospital ethical climate: A literature review. *Nursing Ethics, 15*, 304-321. http://dx.doi.org/10.1177/0969733007088357

Tudor, K., Berger, J., Polivka, B. J., & Chebowy, R. (2014, November). Nurses' perceptions of family presence during resuscitation. *American Journal of Critical Care, 23*, e88-e96. http://dx.doi.org/10.4037/ajcc2014484

The Quality Improvement Team

Nancy Davies-Hathen, MSN, M.ED, RN, NEA-BC; Martha Stefaniak, MPH; Janet Tridente, MSN, RN, CCRN-K

The Quality and Patient Safety Department consists of clinical and non-clinical team members; Quality Outcomes Managers, Clinical Effectiveness Managers, Patient Safety Manager, Data Abstractors, Data Base Coordinator, Health Economist and an Administrative Assistant. Our department is under the direct Leadership of Nancy Davies-Hathen, AVP, Quality and Clinical Effectiveness. The majority of the team is comprised of individuals with extensive nursing backgrounds. Our breadth and depth of experiences, includes bedside patient care, educators and other nursing leaders, data management, data entry and analysis. These attributes ensure a team well qualified to drive organizational improvements and meet state and federal regulatory reporting requirements.

The imperative to achieve quality improvement and cost containment is resulting in healthcare organizations making better use of existing health information.

Our Quality Department utilizes a multidisciplinary approach to provide unique contributions to the health care continuum. The team applies a systematic methodology and incorporates evidence based improvement principles. We are unified by a shared goal of identification of opportunities, improving patient care delivery and the quality of care provided at Cooper University Health Care. The imperative to achieve quality improvement and cost containment is resulting in healthcare organizations making better use of existing health information. Healthcare delivery is often inefficient and uncoordinated, thereby wasting resources and potentially leading to patient safety issues (Berwick & Hackbarth, 2012; Institute of Medicine, 2001; Osborn, et al., 2016).

Clinical data, coupled with administrative data, strengthens data systems and offers the greatest opportunity to achieve improved cost-effectiveness and quality outcomes that translate into improved public rankings (Jordan et al., 2007). The organization's quality outcomes data are disclosed through public reporting requirements established by the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC), as well as state regulatory governing bodies.

Members of the quality team who have changed from bedside to quality roles still rely extensively on their nursing knowledge and processes. These systematic processes are the core of nursing practice that ensures delivery of compassionate and quality patient care and focuses on key communication to inform colleagues about specific opportunities in systems and processes. The fundamental principles and skill set of critical thinking, patient centered care, evidence based practice recommendations, and nursing intuition support the ability to identify and close gaps between our current system and our ideal system. Additionally, the Outcomes Managers have specialized clinical experiences in the institutes that they support.

Deep dives into the data analytics, from a clinical standpoint, allow for identification of gaps in care, and thus opportunities for improvement. Clinical team members partner with non-clinical team members for further data analysis to identify contributing variables, outliers, as well as the trending of performance over time. The combination of quantitative data, qualitative data and clinical narrative allow for the best decision making to drive clinical effectiveness projects.

Cooper University Healthcare is on the High Reliability

Front Row L-R: Jeremy Gordon, Laura Bolt, Rebecca Eckardt, Anne Rudolph, Angela Murphy, Linda Hartsough, Suzanne Gould. **2nd Row:** Casey Dalsey, Bob Marburger, Nancy Davies-Hathen, David Spurrier, Ken Travis, Martha Stefaniak, Chris Unander, Janet Tridente. **Not Pictured:** Karen Santore, Karen Rosoff, Pam Crabtree, Deb Buck and Jessica Haines.

Organization (HRO) journey and the team members are trainers in HRO principles and behaviors for employees across the organization. These principles and behaviors support and serve as the foundation for all initiatives designed to improve safety, clinical effectiveness, publicly reported data, Event and Activity Reporting System (EARS) reviews, mortality reviews, the quality portion of the physician compensation plan, and responses to quality of care concerns from insurance carriers. The core nursing fundamentals remain rooted throughout all of these assignments. Clinical knowledge and experience, coupled with quality data analytics results in optimum process and patient outcomes across the organization. Together as the Quality team, we contribute to the organization by evaluating, informing, and monitoring practices to achieve the best quality of care for our patients.

The Quality Department's Journey began in 2012

Beginning in the fall of 2012, Senior Leadership created a vision for a centralized quality model. Planning began with an assessment of organizational quality and concluded that (Quality Improvement QI) activities were isolated within departments. Core functions were identified by Leadership and key Stakeholders.

Job accountabilities and qualifications were reviewed, and standard job descriptions created. A budget neutral plan was developed for reassignment of decentralized staff to the central QI department. Affected staff were informed of the new quality model and were then transferred to the quality department.

Core competencies were identified and staff were trained in the following areas: Six Sigma Principles knowledge & Manage Variability; Crucial Conversations and Premier Training. Team building activities were designed, including Myers-Briggs sessions so that members of the team could appreciate the different contributions made by the personality profiles representing the team.

The quality department initially focused on alignment of mandatory quality reporting with the institute level leadership and ensured coordination of reporting. The reporting consisted of the traditional core measure reporting. Process mapping was conducted with staff to understand data flow. During this time, stakeholder consensus was that Premier, Inc.'s data warehouse was identified as the benchmarked group for Cooper comparison. Cooper University Health Care's patient outcomes data became aligned with publicly reported outcomes via Premier, Inc.'s Quality Advisor data, consisting of coded, publicly available data.

The new model was based on an easily communicated concept, namely the Quality staff member serves as the 'Pitcher' to the institute's Quality resource 'Catcher.' The Quality staff work to compile outcomes data from internal/external sources which they then pitch to their partnered catchers who disseminate the data to institute leadership. The expectation was also established that all institutes create QI committees supported by the QI staff.

Institute specific, high level monthly/quarterly dashboards are populated with the ability to drill down and focus on identified defects and trends. The Quality staff also assure that there is data coordination between their department and all data producing departments, such as Infection Prevention, Population Health, Patient Safety, the Process Improvement Department, the Medical Staff Office and the Clinical Documentation Improvement Department. The Quality Department has evolved from a focus on regulatory institute alignment to expanded oversight for multiple data sources. The department has been positioned to meet the challenges of regulatory agencies, payers, purchasers of healthcare and the public.

The multi-disciplinary Quality staff are focused on data driven processes, populating over 100 dashboards for institutes and the organization. In addition to institute support, the quality staff continue to provide abstraction and reporting for CMS and TJC's core measures which have increasing clinical complexity. The QI staff pull EPIC provider data for CMS's Merit-based Incentive Payment System metrics. They also prepare the quality dashboard for Cooper's Accountable Care Organization. Additionally, the QI team work closely with the Medical Staff Office to ensure data availability for On-going Professional Practice Evaluations (OPPEs).

In conclusion, the Quality Department is designed to be a valuable organizational resource, founded on the principles of process improvement through multi-disciplinary teamwork. The department's goal is to improve patient outcomes by practicing the philosophy of continuous improvement.

Email comments to **Davies-Hathen-Nancy@cooperhealth.edu**

References

Berwick, D. M., Hackbarth, A. D., (2012). Eliminating Waste in US Health Care. *JAMA, 307*(14), 1513-1516. doi:10.1001/jama.2012.362.

Institute of Medicine. 2001. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: The National Academies Press. doi:10.17226/10027.

Osborn, R., Squires, D., Doty M. M., Sarnak, D.O., Schneider, E.C., (2016). In New Survey of Eleven Countries, US Adults Still Struggle With Access To And Affordability Of Health Care. *Health Affairs, 35*(12), 2327-2336. doi: 10.1377/hlthaff.2016.1088.

Pine, M., Jordan, H., Elixhauser, A., Fry, D., Hoaglin, D., Jones, B. Gonzales, J. (2007). Enhancement of claims data to improve risk adjustment of hospital mortality. *JAMA, 297*(1), 71-76. doi: 10.1001/jama.297.1.71.

A Day in the Life: An APN in Thoracic Surgery

Ella Hawk MSN, AGACNP-BC, RRT, TNCC

Thoracic Surgery involves surgical repair of organs of the chest but extends to the esophagus and chest wall. The service manages and surgically treats diseases, congenital anomalies and tumors in the neck, lung, esophagus, trachea, pleura, mediastinum, chest wall and diaphragm through a variety of endoluminal, minimally invasive and maximally invasive means (Wigle, 2018).

In October 2017, Cooper University Health Care opened the Lung Nodule Clinic. The Lung Nodule Clinic was created to identify and assess patients in the local community with incidentally found lung nodules as a screening for lung cancer with the goal of early diagnosis and treatment. Lung cancer remains the leading cause of cancer deaths in the United States (Wigle, 2018). An evidence-based research study completed in 2011, the National Lung Screening Trial found a 20% reduction in relative risk of lung cancer death in patients who were screened using low dose chest CT scans (LDCT). Utilizing the eligibility criteria of age 55-74 years, smoking history of current 30 pack year or have quit within the last 15 years, we identify and monitor lung nodules via LDCT scan surveillance. The Nodule Clinic team takes a multidisciplinary approach for which a patient has access to our full team if deemed at risk. In conjunction with the Nodule Clinic, the team offers a smoking cessation program. Tobacco dependent patients are offered counseling by a certified smoking cessation specialist. Overall, the program helps meet the needs of the community with these lifesaving screening programs (Wigle, 2018).

Being a new APN is both challenging and rewarding. I have the pleasure of working with an amazing team of Surgeons, Oncologists, Radiation Oncologists, Pulmonologists, Physician Assistant, Resident Team, Nurse Navigator and Administrative office staff that help to make Thoracic Surgery a great success. The team believes in a patient centered model utilizing a multidisciplinary team to help facilitate a comprehensive, innovative and supportive approach to ensure the best outcomes for our patients.

What makes being a Thoracic Surgery Nurse Practitioner unique for me is being afforded the opportunity to manage patients preoperatively in the outpatient office setting as well as in the inpatient hospital setting. This allows me to incorporate preoperative patient education while managing post-surgical expectations and or complications. We utilize evidence based Early Recovery post Thoracic Surgery (ERATS) pathways along with thoracic surgery protocols designed to minimize the impact of surgery on patients' recovery, to reduce postoperative complications and to allow an early discharge thus reducing hospital costs (Scarci, Marco, et al., 2015). I feel fortunate to work with a fantastic team of dedicated professionals who go above and beyond to make the patient-centered model an everyday practice.

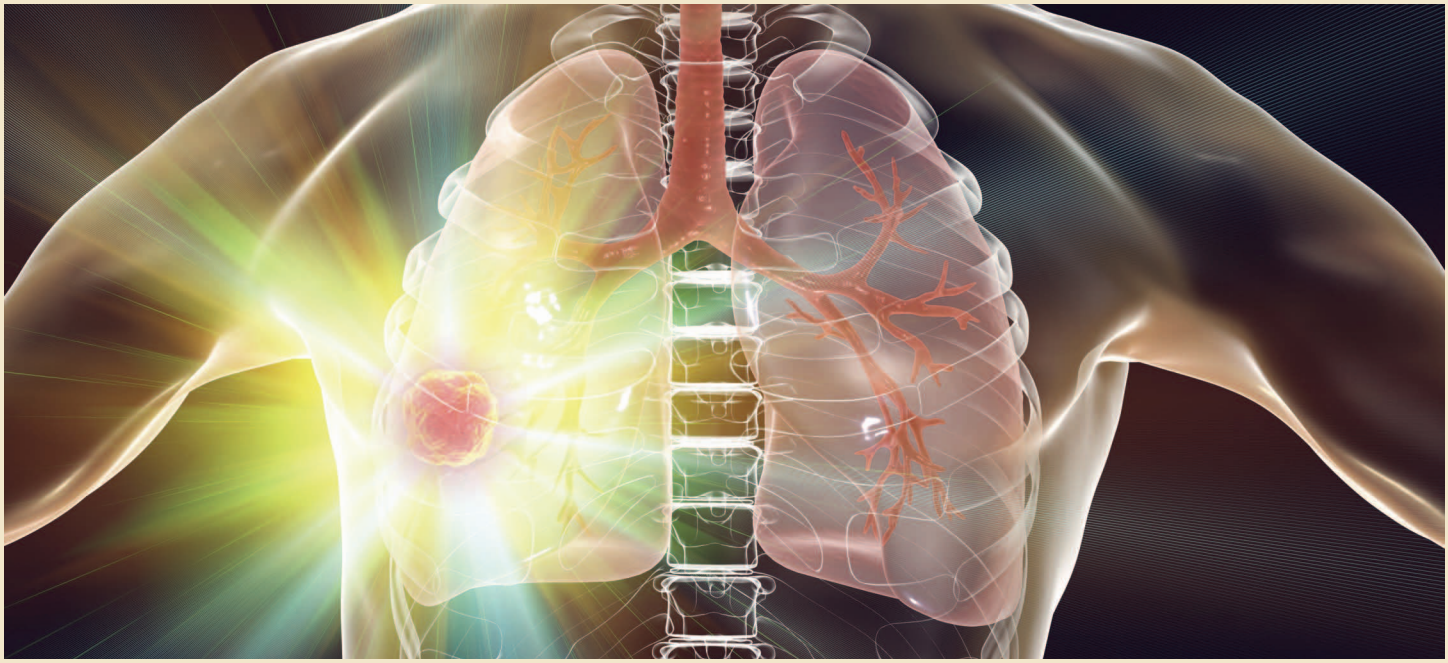
Email comments to: **hawk-ella@cooperhealth.edu**

References

Aberle, Denise R, et al. "Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening." *New England Journal of Medicine*, vol. 365, no. 5, 2011, pp. 395–409., doi:10.1056/nejmoa1102873.

Scarci, Marco, et al. "Enhanced Recovery Pathway for Thoracic Surgery in the UK." *Journal of Thoracic Disease*, 14 Oct. 2015, www.ncbi.nlm.nih.gov/pmc/articles/PMC4756243/pdf/jtd-08-S1-S78.pdf.

Wigle, D. "Thoracic Surgery." *Mayo Clinic*, Mayo Foundation for Medical Education and Research, 9 May 2018, www.mayoclinic.org/departments-centers/thoracic-surgery/sections/overview/ovc-20421043.



Professional News

DEGREES:

Kristen Mangeney, BSN, RN, graduated from Seton Hall University with a BSN.

Deborah Byrd, MSN, RN, graduated from Wilmington University with a MSN in Leadership on May 2019.

Maria Eastlack, MSN, RN, graduated from Wilmington University with a MSN in Leadership in 2019.

Jenny Ramos, MSN, RN, graduated from Wilmington University with a MSN. In May 2019.

CERTIFICATIONS:

Kayla Schweighofer, RN, CPN, has obtained the certification in pediatric nursing.

Virginia Carson, BA, RN, CPN, has obtained the certification in pediatric nursing.

Taylor Barger, RN, CPN, has obtained the certification in pediatric nursing.

Pamela Iannello, BSN, RN, CPN, has obtained the certification in pediatric nursing.

Cari Rinaldo, BSN, RN, CPN, has obtained the certification in pediatric nursing.

Emily Schwalm, BSN, RN, CPN, has obtained the certification in pediatric nursing.

Meredith Duffy, BSN, RN, CPN, has obtained the certification in pediatric nursing.

Amy Nielsen, BSN, RN, CBC, has obtained certification in breast feeding counselor

Anna Hernandez, BSN, RN, CBC, has obtained certification in breast feeding counselor

Suzanne Butler, BSN, RN, CPN, CCRN, BC, has become board certified in pediatric nursing

Chelo Sipaco-Ong, AGACNP, ANP C, received a post-masters degree for Adult-Gerontological Acute Care Nurse Practitioner from University of Pennsylvania and passed the AGACNP boards and is now dually certified Adult Primary Care and Acute Care Nurse Practitioner.

Ivette Duncan, MSN, CPNP, PMHS, CMI-S, has obtained a certification as a Primary Care Mental Health Specialist through the Pediatric Nursing Certification Board.

PRESENTATIONS:

Sharon Byrne, APN, presented "Cultural Humility: Can it be developed or is it Innate?" and "Cancer Screening in the Asian Female Population: A Targeted Clinic Approach" at the 3rd World Congress on Public Health and Health Care Management (Public Health-2019) on April 19, 2019, in Dubai, UAE.

Eileen Campbell, MSN, APN, and **Steven Torres, MBA, BSN, RN,** presented a poster" Emergency Severity Index Level 2 Patients" at the ANA Quality and Innovation Conference on April 25, 2019, in Orlando FL.

Janice Delgiorno, presented "Special Populations in Trauma across the Lifespan" and "Marching On: Implementing what we have learned from Iraq and Afghanistan into Civilian Trauma Centers" at the NJ ENA Conference in Atlantic City in March 2019.

Janice Delgiorno and **Diana Filipek** presented "Blood transfusion Reactions" at the NJ ENA Conference in Atlantic City in March 2019.

Janice Delgiorno presented "Marching On: Implementing what we have learned from Iraq and Afghanistan in Civilian Trauma Centers" at the AACN's National Teaching Institute in Orlando, FL in May 2019.

Anthony Angelow, DNP, presented "Chest X-ray Interpretation," "Identification and Management of Sodium Disturbances" and "Acute Care: Case Study Approach" at the American Association of Critical Care Nursing's National Teaching Institute (NTI) in Orlando, FL in May 2019. AANP is Indianapolis June 16-20

APPOINTMENTS:

Anthony Angelow, DNP, was appointed as a Fellow in the Emergency Nurses Association in April 2019.

AWARDS:

Alexa Barile, BSN, RN, – Registered Nurse, Emergency Department, is the recipient of The Lynn Nelson Award for Excellence in Emergency Nursing.

Irma Beasley, BSN, RN, – Registered Nurse, Short Procedure Unit, is the recipient of The Women's Board of Cooper University Health Care Award for Excellence in Ambulatory Nursing.

Kelli Bradley, BSN, RN, RNC-NIC, – Registered Nurse, Neonatal Intensive Care Unit, is the recipient of The John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing.

Heather Brown, BSN, MSN, – Associate Clinical Director, Pavilion 5, is the recipient of The Philip and Carole Norcross Award for Nurse Leadership.

Michael Colona, BSN, RN, – Registered Nurse, Trauma, is the recipient of The Barbara and Jack Tarditi Award for Excellence in Nursing Mentorship.

Keren Dalsey, BSN, RN, – Registered Nurse, Trauma Surgical Intensive Care Unit, is the recipient of The Award for Excellence in Trauma Nursing.

Sean Deiter, BSN, RN, – Registered Nurse, Intensive Care Unit, is the recipient of The William and Eileen Archer Award for Excellence in Critical Care Nursing and Nurse of the Year Award.

Ana Denton, RN, BSN, OCN, – Nurse Navigator I, MD Anderson Cancer Center at Cooper, is the recipient of The Rose Smith & Sue Zamitis Memorial Award for Excellence in Oncology Nursing.

Meredith Duffy, BSN, RN, CPN, – Registered Nurse, Pediatrics, is the recipient of The Dr. Ronald Bernardin Memorial Award for Excellence in Pediatric Nursing.

Morgan Ford, RN, ASN, – Registered Nurse, Kelemen 10, is the recipient of The Ruth Parry/Moorestown Auxiliary Award for Excellence in Geriatric Nursing.

Jennifer Halliday, BSN, RN, – Registered Nurse, Post Anesthesia Care Unit, is the recipient of The Carol G. Tracey Compassion Award.

Ella Hawk, MSN, AGACNP-BC, RRT, TNCC – Military Employee of the Year Award.

Susan Lieberum, BSN, RN, RFNC, IBCLC, – Registered Nurse, Mother Infant Unit, is the recipient of The Charlotte Tobiason Memorial Award for Excellence in Obstetrical Nursing.

Carolyn Liu, BSN, RN, – Registered Nurse, Pavilion 9, is the recipient of The Cooper Heart Institute & The Heart House Award for Excellence in Cardiovascular Nursing.

J. Byron Lu, MD, – Hospitalist, Hospital Medicine, is the recipient of The Nursing Alumni Excellence Award for Nursing-Physician Partnership.

Trisha McFarlane, DNP, CRNA, – Certified Registered Nurse Anesthetist, Anesthesia, is the recipient of The Moorestown Auxiliary Award for Excellence in Advanced Practice Nursing.

Linda Nguyen, BSN, RN-BC, – Registered Nurse, Pavilion 6, is the recipient of The Selma and Martin Hirsch Award for Excellence in Medical Surgical Nursing.

Tara Pettit, DNP, CRNA, – Certified Registered Nurse Anesthetist, Anesthesia, is the recipient of The Barbara and Jack Tarditi Award for Excellence in Nursing Research.

Deborah Snyder, – Infusion Schedule Coordinator, MD Anderson Cancer Center at Cooper, is the recipient of The Barbara and Jack Tarditi Award for Excellence in Service (Non-Nursing).

Lorraine Sweeney, BSN, RN, – Community Outreach Coordinator, Community Health, is the recipient of The Shaina Horton Memorial Award for Excellence in Service.

Melena Tyler, BSN, RN, – Registered Nurse, Post Anesthesia Care Unit, is the recipient of The Philip and Carole Norcross Award for Excellence in Perioperative Nursing.

Allison Wills Nevitt, MSW, – Transitional Navigator, Transitional Care – Pediatrics, is the recipient of The Women's Board of Cooper Hospital Allied Health Professional Excellence Award (Non-Nursing).

Voorhees Surgery Center Team is the recipient of The Outstanding Team Award.

Cooper University Health Care