Cooper University Hospital

Bridges to Excellence

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Neonatal Resuscitation: an Ethical Dilemma

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25 & 26 • Trauma Nursing Core Course (TNCC)

AUGUST 2009

3, 5, 7 • Basic Dysrhythmia Course

5 & 12 • Oncology Overview

11 or 25 • First Five Minutes Course

14 • Pediatric Oncology Overview

17, 25, 27 & 31 • Critical Care Course

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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

As you open this edition of *Bridges to Excellence* you will find articles that center on the important role of education in healthcare. From the teaching of new graduates, to educating patients and their significant others about new technologies, to the support of families as they experience an unexpected outcome with a newborn child or care for aging family members; we have multiple opportunities to make a difference in all aspects of practice. As we reflect on these, perhaps none is more powerful than the role of mentor. Have you had the opportunity to mentor or be mentored? As the nursing profession continues to change and grow the need for mentoring relationships become paramount. I believe it is one of the most rewarding gifts we can receive and in time, give to a colleague.

I hope you will find this edition informative and inspiring. As always, we are eager to hear your comments.

Best regards,

Elizabeth Bobulski RN, MPH
Senior VP Patient Care Services, CNO

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

Bridges to Excellence **Mission Statement:**

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

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Preventative Health Care

One Community Outreach Perspective: SENIOR FALLS

David Groves RN, MSN, CCRN

When one thinks of traditional nursing it brings to mind scenes of a doctor's office, a school nurse assessing children, or being cared for in a hospital for a more serious medical condition. As the profession of nursing has grown, so have the many opportunities for nursing practice areas. One area not often thought about is community preventative care. Usually, preventative care is thought of as a healthy diet, exercise, regular checkups, and following a physician's recommendations. However at Cooper University Hospital (CUH), community preventative care, coordinated by the Trauma Outreach Coordinator, means something completely different. Education programs are offered to all age groups to prevent injury. Most programs are presented to school-age students and cover topics such as safe driving and the possible outcomes related to various forms of risk taking like not using helmets or the illicit use of drugs and alcohol. After analyzing the mechanisms of injury seen with patients admitted to the trauma center a decision was made to develop and present a program on fall prevention to senior citizens throughout southern New Jersey.

Evidence continues to be collected to support the need for outreach programs such as fall prevention in the elderly population.

Evidence continues to be collected to support the need for outreach programs such as fall prevention in the elderly population (Table 1). Older adults may be more prone to falling for many reasons (Table 2). After reviewing data from the 2007 CUH Trauma Registry it was discovered that 637 patients were admitted due to a fall. Of those, 41% were 65 or older. Forty-four died from their injuries and of those deaths, 80% occurred in patients 65 years of age or older. These statistics are only for trauma admissions and do not include patients admitted via the emergency department.

After reviewing institutional, local, and national statistics, a program was developed to educate this population to become more aware of the dangers posed from falling. Members of the CUH trauma leadership team reviewed fall prevention programs from across the country and designed a program titled "Don't Fall For Us." The program includes a 30-minute presentation. During the program the seniors are taken on a "tour" of a typical home and potential fall dangers that can be found in each room. Suggestions are then provided on how to remedy the risks that are

Table 1 Fall Facts

Falls are the leading cause of injury deaths in seniors
Falls are the leading cause for injury in seniors
Falls are the leading cause for hospital admission among seniors
Every year 1/3 of the senior population suffers a fall
1/2 of all falls occur in the home
10% of all falls result in a serious injury
95% of all hip fractures are due to falls
Over 15,800 seniors died from fall related injuries in 2005
Falls are the most common cause of TBI
Falls are the leading cause of nonfatal injury
Falls are the 4th leading cause of mortality

CDC (2006)
CDC (2008)
CDC Fatalities and injuries from falls among older adults- United States, 1993-2003 and 2001-2005.
Jager et al
Stevens et al

Table 2 **Fall Risk Factors Seen In The Older Adult**

Natural Aging Process Factors:

- Decrease in muscle strength
- Vision and hearing problems
- Decrease in bone density (Osteoporosis)
- Decrease in flexibility
- Equilibrium problems

Other Factors

- Poor nutrition
- Multiple medications (> than 4)
- Lack of activity/exercise
- History of a previous fall

Factors In The Home

- Slippery flooring
- Throw rugs
- Improper lighting
- Clutter
- Exposed electrical cords
- Lack of assistive devices

commonly found. To help the seniors get started on making their home a safer place, a small "tool kit" of safety products is provided. The tool kit contains a flashlight, nightlight, and non-skid slipper socks, non-skid strips for the tub or shower, and a directory of the senior services available in their respective county. The importance of regular check-ups for health, vision, and hearing is stressed and the topic of safe senior driving is also discussed.

The senior citizen population is a unique group to interact with in an educational setting/environment and present many challenges to the nurse presenting. Challenges include hearing and vision problems, language barriers, and the ability to comprehend the material provided. Techniques to assist this population can include assistance with answering the pre and post program questionnaire. Assistance can take the form of reading the questions for them, making sure that all participants can understand the instructions and can hear the presenter. When needed, translators from the group's own members are utilized. During the presentation, the nurse can use examples from his/her own home life experiences, thus validating the material that is presented. The use of humor is also a great asset when presenting to the senior age group. By using fun examples from the presenters own life, making the seniors laugh, they become more at ease and engaged. This enables the nurse to form a bond with the audience and they are then more prone to listen and respond to the presented information in a more positive manner.

The New Jersey Trauma Center Council, a group of professionals from all trauma centers in New Jersey, has recognized the fall problem seen in senior citizens. The Council decided to review existing programs and create a state-wide initiative using a standard program. Many aspects of CUH's program were adopted, including the title, for this state-wide initiative. The committee announced the initiative in the beginning of 2009.

Community Outreach Prevention Programs are an important facet of nursing in the arena of community health. As the data indicates, the senior population is at increased risk for injury and death related to falls. Presenting an educational injury prevention program to the group at highest risk is an important factor to their well being. Presenting programs in a well designed manner, while at the same time respecting age, intelligence, and life achievements without "lecturing," is of utmost importance.

Community Outreach Prevention Programs are an important facet of nursing in the arena of community health. As the data indicates, the senior population is at increased risk for injury and death related to falls.

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Neonatal Resuscitation: An Ethical Dilemma

Eileen Cabalo, RNC-OB, BSN

Introduction and Background

The constant advancement of technology in medicine has helped health care providers improve the outcomes of more and more patients. Prognoses are perpetually improving with the daily technology changes in health care. However, occasionally these advances cause more controversy and propagate more concerns and questions about outcomes for patients. Few questions plague the hearts of parents and their doctors than the decision of saving a child. Many babies are born extremely premature and severely underdeveloped. Even the best technology and knowledge cannot save them. Severely preterm neonates born between twenty-two and twenty-four weeks gestation, have very low success with resuscitation efforts. In these cases, parents and clinicians struggle with the decision to initiate resuscitation. What gestational age is it appropriate to perform resuscitative measures on a neonate? This debate has been an ethical dilemma disputed for many, many years. Although guidelines and criteria exist for neonatal resuscitation from the American Heart Association (AHA) and the American Academy of Pediatrics (AAP) (AHA & AAP, 2006), the judgment to proceed with these resuscitative measures is a troublesome subject among parents and professionals.

What gestational age is it appropriate to perform resuscitative measures on a neonate? This debate has been an ethical dilemma disputed for many, many years.

Ethical Dilemma

The questions facing professionals and parents regarding neonatal resuscitation are these: when is it appropriate or inappropriate to resuscitate a neonate, and what outcome is acceptable? In the 1970's, the public accused physicians of playing God with neonates in intensive care when the physician discontinued life support. In a United States Supreme Court case (Webster v. Reproductive Health Systems, 1988, 7), the American College of Obstetricians and Gynecologists (ACOG) and the AAP, in agreement with the American Medical Association (AMA) and other physician groups defined viability as "when a fetus reaches an 'anatomical threshold' when critical organs, such as the lungs and kidneys, can sustain independent life. Until the air sacs are mature enough to permit gas exchange into and out of the bloodstream, which is extremely unlikely until at least 23 weeks gestation, a fetus cannot be sustained even with a respirator.

It is the responsibility of the health care team, obstetricians, neonatologists, and nurses, to provide the parents with clear, unbiased and factual information regarding the risks and benefits of resuscitation, futile care, and noninitiation of resuscitation. To that effect, the health care providers must be supportive of the decision of the parents.

Respirators can force air into the lungs but cannot exchange gas from the lungs into the bloodstream. This definition of viability has essentially been maintained by the ACOG and the AAP and closely followed since that time. In accordance with this definition, the AAP and AHA, in conjunction and agreement with the International Consensus of Science (Contributors and reviewers of the Neonatal Resuscitation Guideline, 2006) established guidelines for cardiopulmonary resuscitation of neonates. They state that the provider needs to ask the following questions: "Was the baby born at full term gestation? Is the amniotic fluid clear? Is the baby breathing or crying? Does the baby have good muscle tone?" If the answer is yes to all of these questions, then resuscitation is not necessary per these guidelines. However, the neonate at the gestational age of 22 to 24 weeks usually causes the healthcare provider to answer no to all of these questions. These same groups also recommended that when gestation age is less than twenty-three weeks, birth weight is less than 400 grams, or congenital anomalies are associated with almost certain early death, and when unacceptably high morbidity is likely among the rare survivors, resuscitation is not indicated. Depending on accuracy and method of the determination of gestational age (i.e. last menstrual period, ultrasonography, or fertility intervention) the weight criteria for noninitiation of resuscitation could be present in a range of 22 to 25 weeks of gestation. Prematurity and very low birth weight are significant factors in the outcomes of the resuscitation of neonates and both have an impact on morbidity and mortality. Nonetheless, the decision whether or not to perform resuscitation usually determines and significantly affects the long-term prognoses of these babies.

With the objective of documenting a trend of the rate of mortality in neonates, Bennett, Macfarlane, and Wood (2003) observed the outcomes of the delivery of 20 to 23 week neonates. At 23 weeks gestation, 111 of 162 babies weighed greater than 500 grams at birth. At 22 weeks, only 29 of 84 neonates weighed greater than 500 grams at birth, at 21 weeks, only 3 of 37 weighed greater than 500 grams, and at 20 weeks gestation, no baby born alive weighed more than 500 grams. In this example, only 47 percent of the babies born alive would meet the weight criteria for resuscitation. Bennett et al. (2003) added that of the live births of 20 to 22 weeks that weighed below 500 grams, only 3 of 104 neonates were still alive at four hours of age. The Neonatal Resuscitation Program (NRP) Guidelines state that resuscitation is not indicated in cases where gestation, birth weight, or congenital anomalies are associated with almost certain early death and unacceptably high morbidity among rare survivors. These include newborns with a confirmed gestational age of less than 23 weeks or a birth weight less than 400 grams, anencephaly, or confirmed Trisomy 13 or Trisomy 18 syndrome (Kattwinkel, 2006).

Other groups have also researched the issue of morbidity and long-term outcomes in neonatal cardiopulmonary resuscitation of low birth weight, premature babies. The March of Dimes (2006) reported that the smallest or sickest babies die at birth or shortly after birth. They list the common medical complications that a premature baby can face, such as respiratory distress syndrome, intraventricular hemorrhage, necrotizing enterocolitis, and retinopathy of prematurity. In addition, The March of Dimes reported the following outlook for neonates born less than 26 weeks gestation:

> These babies typically weigh only one to two pounds, they require treatment with oxygen, surfactant – an agent to keep alveoli open, and mechanical assistance to help them breathe. They are also too immature to suck, swallow, and breathe at the same time so they must be fed intravenously, cannot yet cry, have little muscle tone, and move very little. Their skin is wrinkled and reddish-purple in color and so thin that blood vessels are visible. The face and body covered with lanugo. These babies are also very thin because they have no fat stores, and their eyes are closed and have no eyelashes. Most of these babies do survive one year, about 20 to 40 percent of very low birth weight babies develop serious chronic disabilities ("Complications of Premature Birth," n.d.).

Professional Position

The professional opinion of the author of this paper is that the overall picture of the patient and the long term outcomes need to be heavily weighed and an agreement made between the parents and physicians on a course of treatment. It is the responsibility of the health care team, obstetricians, neonatologists, and nurses, to provide the parents with clear, unbiased and factual information regarding the risks and benefits of resuscitation, futile care, and noninitiation of resuscitation. Health care providers must be supportive of the decision of the parents. However, in an effort to produce the most positive outcome for the baby, whether it is a positive prognosis or the least amount of suffering, the health care team must help the family effectively weigh both choices. As a

high risk labor and delivery nurse, the author of this paper feels that the provider team, when possible, should provide significant time and opportunity for the family to participate in conversation with obstetricians, neonatologists, nurses, and other resources appropriately.

Ethical Principles

Nonmaleficence in the form of futile care in the neonate is defined as medical care that prolongs suffering, does not improve quality of life, or fails to achieve a good outcome (Romesberg, 2003). Further, Romesberg described three types of futility: physiologic, imminent demise, and lethal condition, and stated that futility can be linked to the use of massive resources, such as ventilators, high dose medications, invasive procedures, in the final days of life (AHA and AAP, 2006). Aggressive and prolonged treatment of these babies can lead to many complications, such as:, respiratory distress syndrome, apnea, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis, retinopathy of prematurity, jaundice, anemia, chronic lung disease and infections (March of Dimes, 2006).

With regard to autonomy and beneficence, the Nuffield Council convened in 2003 and concluded that parents and physicians should agree on course of treatment. However, the question of how much pain neonates feel was raised (Nuffield Council on Bioethics, 2003). Though the Born Alive Infants Protection Act of 2002 defined being born alive as an infant who displays any of specific signs of life such as breathing, heartbeat, or definite movement of voluntary muscles, the recommendation of the AAP is not to change current practice and to continue to follow the guidelines set forth for neonatal resuscitation (Romesberg, 2003). Despite much legislature and stringent guidelines, there is still no universal answer for every low birth weight premature neonate. In a survey study of neonatologists in Rhode Island and Connecticut, conducted by Mercurio (2005), data indicated that even if requested, 11 percent of neonatologists surveyed would refuse to resuscitate at 23 completed weeks gestation, 67 percent would decline at 22 weeks, and 91 percent would refuse at 21 weeks.

Proposed Solutions and Political Strategies

Working in an environment where events occur that warrant decision-making, the author observes the difficult decisions that parents must make regarding the care of their babies. While ideally, health care providers should educate parents on prevention of preterm labor and should facilitate discussion regarding the care of a high risk neonate, the frame of mind of the parents does not allow these discussions to occur as most parents plan for a positive outcome with a healthy, full-term baby. This author recommends that if a parent is faced with a decision to resuscitate or not, the care providers are obligated, to the best of their abilities, to educate parents on all possibilities, including long term negative outcomes. Healthcare providers must also follow guidelines set forth by the Born Alive Infant Protection Act of 2002 if the circumstances do not preclude guidelines in place for neonatal cardiopulmonary resuscitation by the AHA and AAP. However, parental wishes should be respected and considered, even though care may be futile. Parents and family may be in denial, have unrealistic expectations and feelings of helplessness, and may believe that medicine can work miracles (Romesberg, 2003). Should this be the case, it is the responsibility of the physicians and nurses to counsel the family and provide further education, regarding resuscitation versus palliative care, enhancement of quality of life, symptoms relief, and bereavement support (Romesberg, 2003).

In conclusion, end of life decision-making should involve ongoing communication with the family, regardless of how trying this task may seem. It is also the responsibility of the nurse to be supportive of the family in their decision, regardless of personal bias. The nurse should also facilitate clear communication between the family and all healthcare providers by offering thorough education and reinforcement pertinent to each case. Nurses are in a position to incorporate different cultural and religious customs and attitudes that families have, in order to encourage frank dialogue, which is imperative to decrease futile care.

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Differences in Automated and Manual Blood Pressures in Hospitalized Psychiatric Patients

Lucy Suokhrie RNBC BSN MSHCA, • Carol Moriarity RNBC;MSN
Carolyn Emory RNBC • Rose White RNBC;MA • Jamie Bowen BSW

Purpose

Bedside nurses in Cooper University Hospital's (CUH) acute psychiatric care unit hypothesized that there would be a significant difference in blood pressure (BP) values using a manual sphygmomanometer compared to an automatic electronic BP device. The purpose of this study was to test that hypothesis.

Methods

A method-comparison design was used to compare different methods of BP determination. Each subject served as their own control, with manual and electronic measurements taken immediately after each other. The order in which manual or automated BP was taken was randomized using a computer generated list. Patients had not received medications within 30 minutes of measurements. Each subject's upper arm was measured to ensure proper cuff size. The study was approved by the IRB. All subjects gave informed consent. Patients who were confused or unable to give informed consent due to psychosis or who were in seclusion or restraints were excluded. Patients with a body mass index of >39 were also excluded. Data was analyzed using the Bland-Altman method. The initial sample included 42 acute care patients. Three outliers were removed according to the Bland-Altman criteria, resulting in a final sample of 39 subjects. BP readings were compared using paired t-tests.

Results

There was a significant difference in manual vs. automatic systolic BP readings ($p<0.05$) with the automated readings an average of 3.9 points higher than the manual. There were no significant differences in diastolic BP readings.

Discussion

Commonly administered medications on a psychiatric unit that have blood pressure implications include anxiolytic, anticholinergic, antiadrenergic, antiepileptic and opioid analgesic medications. Based on the findings the nurse researchers recommended that when giving medications with BP hold parameters on the CUH acute psychiatric unit, nurses should take BP manually.

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Gamma Knife Stereotactic Radiosurgery: *A Unique Nursing Experience*

Sheila McFarland, R.N., CNOR

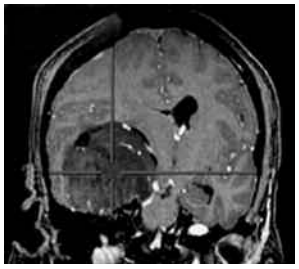
A surprise to many, Gamma Knife Stereotactic Radiosurgery has been in use for over forty years. It was developed in Sweden in 1968 by neurosurgeon Lars Leksell and his colleague, Börje Larsson as a noninvasive treatment for functional brain disorders. The Gamma Knife is a radiation delivery system that uses ionizing gamma radiation (Cobalt 60) to precisely target the culprit area in the brain. As the clinical use of the Gamma Knife increased it was found to successfully treat other brain conditions such as tumors and vascular abnormalities. As well, the equipment and applications also continued to be refined.

The first Gamma Knife came to the United States in 1987. Over the next twenty years, several new and improved models of the Gamma Knife were developed and put into clinical use each one with better features than the last. In 2007, the delivery system was, you could say, "perfected" for both patients and clinicians. The Gamma Knife Perfexion™ debuted in the United States. Cooper University Hospital was the first provider in New Jersey and the Delaware Valley to have the Gamma Knife Perfexion™. The Gamma Knife Perfexion™ focuses 192 beams of gamma radiation on the specific target area in the brain with precision accuracy. Each beam individually is not strong enough to damage the healthy tissue that it goes through; however, when the 192 beams converge on the isolated target the dose is concentrated enough to treat the targeted area.

Numerous brain disorders can be treated with the Gamma Knife and, in addition, the Perfexion™ has the capability to reach targets in the cervical spine and reach further out peripherally in the brain than any of the earlier models. The Gamma Knife can

be used to treat benign brain tumors, such as a meningioma or schwannoma, and malignant tumors either primary or metastatic in nature. It is especially useful in treating patients with tumors that are too close to delicate structures or blood vessels that would increase the risk of traditional surgery. Patients who are poor surgical candidates due to co-morbidities may also benefit from treatment with the Gamma Knife because general anesthesia is not necessary.

Other conditions include vascular abnormalities such as arteriovenous malformations (AVM) or arteriovenous fistulas (AVF). Pituitary tumors, vestibular schwannomas, trigeminal neuralgia (TGN) and movement disorders can also be treated with the Gamma Knife. Parkinson's disease, essential tremor, dystonias, and tremors from multiple sclerosis (MS) or brain injury have also been successfully treated.



The Gamma Knife is a radiation delivery system that uses ionizing gamma radiation (Cobalt 60) to precisely target the culprit area in the brain.

Contraindications for Gamma Knife treatment are few. There are limitations of tumor size; alternative treatments may need to be considered for tumors that are larger than 3 centimeters. There are also occasions that Gamma Knife may not be the appropriate treatment choice; one example may be a patient with multiple brain metastases. That is not to say that any patient with multiple lesions can not be treated successfully with Gamma Knife; each case is evaluated on an individual basis taking into consideration cancer type, previous treatments and control of systemic disease among other things. All cases are reviewed at weekly multidisciplinary tumor board conference when all treatment options can be discussed and a treatment plan with the best possible outcome for the patients can be agreed upon.

The treatment team consists of a neurosurgeon, radiation oncologist, medical physicist, a technician, and a nurse. As always, the nurse plays a vital role in the pre, intra and post procedure periods. When a patient is initially identified as a candidate for Gamma Knife Radiosurgery, the Gamma Knife nurse is immediately involved in the patient's course of treatment. At this point an education session is scheduled or if possible initiated on the spot. Patient and family education is a large part and often times the most important part of the nurse's role in Gamma Knife. When possible, a tour of the facility and demonstration of the equipment is provided. This meeting allows the nurse to establish a rapport with the patient and his family members on a more personal level before they are in the clinical setting, decreasing their apprehension and fear and enabling them to express their needs and concerns more freely. This interaction also allows for the assessment of patient needs both physically and emotionally so the nurse can implement an individual plan of care.

The nurse is the first line contact in all phases of a Gamma Knife treatment. On treatment day, the nurse monitors the patient, provides emotional support and maintains patient safety and comfort. The most frightening part for many patients is when the physician affixes the stereotactic frame to the head. They are given oral sedatives such as Ativan or Valium and the entry points of the pins that are used to attach the frame are injected with local anesthesia. Generally the only thing the patients feel is pressure when the screws are tightened. Once the frame is in place, the pressure eases and although the frame may feel awkward most patients have very little or no pain throughout the day.

The next step is imaging. Most times MRI is utilized, but CT and angiography can also be helpful. The images in conjunction with the Gamma Knife planning software create a 3-D image of the tumor allowing the physicians to "target" the radiation from any angle thereby ensuring that the total volume of the tumor is covered. This phase of the treatment is called the planning stage. The neurosurgeon, radiation oncologist and the medical physicist all collaborate in the planning and all specialists must agree on the final plan prior to initiating treatment. The planning phase can take anywhere from 15 minutes to a couple of hours, depending on the complexity, size, location and shape of the tumor(s); and, the proximity to vital structures.

During this time, the nurse is with the patient tending to his/her needs be it comfort, pain or questions. This is also a good opportunity for the nurse to "socialize" with the patient making it feel less like being in the hospital and taking their mind off of their illness or condition even if it is only for a short time. Making a patient smile or even laugh in spite of having screws in his head and dealing with a frightening diagnosis can make this a positive experience for the patient.

One reason that Gamma Knife nursing is rewarding is the personal level on which you interact with your patients. Most patients are in the treatment center for a minimum of 4 hours; some up to six and you are their sole frontline caregiver. Follow up is essential and goes far beyond the post procedure phone call. Gamma Knife nursing can also be very emotionally trying because a large percentage of the patients are in treatment for metastatic brain tumors. The most rewarding aspect of this type of nursing is making a difference in the life of a person if only for one day.

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Cultural Diversity: Healthcare Practices of the Dominican Culture

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As the ethnic profile in the United States continues to diversify, culturally competent healthcare requires practitioners to have a deeper understanding of the socio-cultural backgrounds of their patients and families. The provision of culturally competent care improves the quality of service and patient outcomes (Reiff, et al, 2003). This is essential to eliminating the long standing disparities in the health status of diverse cultures.

The words Hispanic and Latino are often used interchangeably in healthcare literature. This leads to the assumption that it is appropriate to blend all persons who speak any form of Spanish into the same ethnic group. However, this assumption could not be further from the truth. The misguided belief that all Spanish speaking persons have the same cultural background may contribute to healthcare disparities. The Dominican culture is where one might find these disparities. For example, some Dominicans may choose to go to institutions for their healthcare needs, while others go to private physicians because they have the monetary resources that assist them in paying for their care.

The Dominican people are descended from two racial groups and the majority are mulattoes or persons of mixed black African and white ancestry. Forty-three percent of all Dominicans live in poverty with 16% living in extreme poverty (Dominican Republic: Country Profile, 2007). The average yearly income in US dollars is only $2,850. Education is free and mandatory for all minors through 8th grade; however, the average grade level attained is fifth grade in rural areas and sixth grade in urban areas (Central Intelligence Agency, 2008). The country suffers from high unemployment and income inequality.

The Dominican definition of health is consistent with the World Health Organization (WHO) in that health is a complete and multidimensional state of well being. Illness is defined as physical disability, spiritual turmoil or both (Babington, et al., 2003). Family presence, respect and attention are essential.

Healthcare services are structured on three levels: primary care consisting of community/ambulatory care, secondary care consisting of intermediate care offered by area hospitals, and tertiary care that consists of advanced care provided by regional hospitals. The Dominican Republic has outpatient primary care centers, secondary care hospitals and specialized regional hospitals. The Essential Drug Program centralizes and purchases all pharmaceuticals for the public (World Health Organization, 2002).

Unsanitary water, inadequate housing and poor nutrition coupled with inadequate and inaccessible health services lead to self preserving measures. Severely ill patients may be transported to a nearby urban center where hospitalization is free. However, most families want to care for their own and only take that measure when death is already imminent This practice often makes it too late to reverse a potentially negative outcome (Health in the Americas, 2002).

The leading causes of death in the Dominican Republic include diseases of the circulatory system, infectious and parasitic diseases, cancer and respiratory illnesses (Pan American Health Organization, 2005). Malaria, Dengue fever (an acute febrile disease also known as "break bone fever"), and histoplasmosis (a disease caused by fungus that is common among AIDS patients) are endemic to the area. Tuberculosis and human immunodeficiency virus (HIV) have high incidence rates. Polio and diphtheria is common. Morality rates are high (Pan American Health Organization, 2005). The infant mortality rate in the Dominican Republic is 45 deaths per 1000 live births as compared to 7 deaths per 1000 live births in the United States. Frequency of filariasis (a parasitic infectious disease) is low secondary to a control program that includes massive treatment of the population once a year (Reiff, et al, 2003).

The Dominican people utilize both folk remedies and professional care practices to maintain health (Babington et al, 2003). Allen and associates (2000) noted that a significant portion of Dominican Emergency Department patients utilized alternative medicine. The use of native plants for medicinal purposes is commonplace (Reiff, et al., 2003). The leaves of certain trees and plants such as Tuatua, Guanabana, Copey, Anamu and Mama

When working with people of the Dominican culture, the nurse must respect, validate and incorporate the medicinal plants and religious beliefs into the plan of care. Late access to healthcare for this population may be linked to these beliefs and the self diagnosis and treatment that occur at home.

Juana (a mixture of various plants) are just a few of the more than 100 plants common to the area utilized for healing.

A curandero is the expert on the medicinal properties and uses of these plants and how to prepare these remedies (Estevez, 2007). A curandero learns his trade from his family; it is handed down from generation to generation. He or she must pass on the knowledge prior to death. These healers are easily accessible and if the person has no money, a healer will not charge. Curanderos are what could be termed traditional healers; however, they also incorporate emotional and spiritual aspects to care. They may prescribe prayer, teas such as chamomile for calming nerves, and lighting candles and/or incense. At times, they may sweep their hands over the patient's body to remove the illness (ensalmar). A santiguar or baptism with water may also be utilized to cleanse and purify the body. Drinks are made by soaking flowers, leaves and fruits. Herbal baths, massage, reducing intake of red meat, observing nature and meditation are all included in care (Reiff, et al., 2003).

According to Purnell and Paulanka (2003) health-care providers who have cultural knowledge can provide therapeutic interventions that are congruent to the culture of the client. The Registered Nurse should complete a comprehensive history that asks the right questions. He or she must learn the extent to which herbal therapies are being utilized and must then be meticulous in researching the possible reaction between those herbal remedies and the modern medicines utilized to treat the same ailments. The use of herbal and other remedies must be documented and communicated to other members of the healthcare team.

Interview

In order to gain a more personal insight into Dominican health-care, interviews of six Dominicans who currently live the United States were conducted. A family translator was utilized for two of the participants as they spoke no English. These participants felt that language was a barrier to adequate healthcare. All of them had lived with extended family at one point in time in the United States.

There were no restrictions on physical contact in relation to healthcare. All participants stated in different ways that a hug can go along way. All the participants noted the importance of family presence and involvement in healthcare.

While health was defined by all participants as an overall state of well-being, illness was defined as either physical or spiritual in nature or both. Medical problems noted were high cholesterol, high blood pressure, anemia, and hypokalemia. Both herbal remedies and conventional medicines were used in their treatment.

According to the Dominicans interviewed, health is considered feeling well, a sense of internal well being, and the ability to function without pain. Illness means you are not taking care of yourself. Illness may be caused by disease or by someone placing evil upon you. The "Evil Eye" is a self diagnostic practice in the Dominican culture that shows you whether your symptoms are caused by evil or impurities in your body. An egg is rubbed over your body with the shell intact. It is then cracked and placed in a cup of water. If the white parts of the egg attach to the yolk it forms the evil eye and your symptoms/illness are due to evil placed upon you.

Depending on the illness, different incenses, candles, and charms are utilized to counteract and rid oneself from this evil and/or purify the body. Dominican women may wear special bracelets, bathe in AZZAUR with "holy water," and light candles and incense. Two of the participants lit candles and burned "Jerusalem" incense every Tuesday and Friday.

All of the participants denied the use of alternative medicine. However, when specifically asked about plants, incense, talismans and/or oils, more insight was obtained. Anise is used to cure stomach pain. Chamomile is utilized for general aches and pains. Monzanilla is a tea to stop nausea. Tilo is a plant that is used to cure pain or any ailment. Ruda is a plant to cure "bad spells."

Nurses need to incorporate the cultural dimension into the nursing process and must include the patient's family. Once nurses conceptualize the view of culture as basic to nursing, they move into a culturally informed clinical practice that is not only tolerant and understanding of the variations in health beliefs and behaviors but utilizes these variations to improve care.

When working with people of the Dominican culture, the nurse must respect, validate and incorporate the medicinal plants and religious beliefs into the plan of care. Late access to healthcare for this population may be linked to these beliefs and the self diagnosis and treatment that occur at home. More research is needed in this area in order to find ways to enhance earlier access to care. A collaborative approach between the nurse and the patient is key.

Email comments to **cornwell-cyndi@cooperhealth.edu**

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Purnell, L D.., & Paulanka, B.J. (2003). *Transcultural health care: A culturally competent approach.* Philadelphia: F.A. Davis Company.

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Preceptor or Mentor: What's the Difference?

Cheryl Koehl RN MSN APN

Long gone are the days when nurses were expected to go to work, care for the patient, give report and go home. With the advent of self-governance via nursing councils and committees, nurses play a more active role in their functions within their units. A greater number of nurses assume leadership roles in and out of hospital environments. Consequently, nursing as a profession must develop the skills to assume these new responsibilities. One way to cultivate future leaders is through a mentoring process, but what is a mentor and how is that role different from a preceptor?

A preceptor is defined as a person who teaches, supports, and inspires a new nurse. The experienced nurse serves as a role model for the novice as they transition from a student to a staff nurse.

A preceptor is defined as a person who teaches, supports, and inspires a new nurse. The experienced nurse serves as a role model for the novice as they transition from a student to a staff nurse (Young, Billay, Myrick, & Luhanga, 2007). A mentor may share some of the same attributes as the preceptor, but also focuses on long term professional development. Some functions of a mentor include teaching, providing moral and emotional encouragement, and offering career advice for short and long-range planning goals (Gordon, 2000). Unlike a precepting relationship that has a short and specific length of time, mentoring relationships generally last longer, anywhere from 2 to 10 years. Mentors are usually but not always older than the learner, allowing them to leverage a career's worth of experience, wisdom, and professional networks in facilitating the growth and promotion of the learner.

Mentor relationships can be formal or informal. Formal mentoring occurs within the constructs of a larger organization, with predetermined objectives and steps to achievement. For example, to develop future leaders, some businesses pair junior employees with older, more experienced managers. Big Brother/Big Sister program applies the same logic to their systematic process for pairing children with adults.

By contrast, informal mentoring relationships lack the overarching structure of formal mentoring, often developing out of a young nurse's search for advice or insight. The initiate typically chooses a mentor who has qualities the nurse admires or wishes to emulate. Inversely, an experienced nursing leader may see potential for great professional growth in a younger nurse, and offer to guide him or her along the way. Both methods will grow and develop through mutual planning to meet the needs of the novice.

Mentoring relationships are often very rewarding for both parties, despite the time, focus, and energy required. As the nursing profession continues to change and grow, the need for mentors will increase. If you have long-range professional goals, or have a desire to take on more leadership responsibilities, it would be worthwhile to investigate developing a mentoring relationship with a nurse leader you admire. Likewise, if you are an experienced nurse who can give guidance and share your expertise, look around and consider offering to act as an informal mentor to a nurse who you think might make a good nursing leader. By mentoring, nurses can ensure that strong development continues with our newer professional colleagues, strengthening the profession as a whole.

Email comments to **koehl-cheryl@cooperhealth.edu**

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Younge, O., Billay, D., Myrick, F., & Luhanga, F. (2007). Preceptorship and mentorship: Not merely a matter of semantics (Electronic version). *International Journal of Nursing Education Scholarship.* 4(1), Article 19.

Gordon, P. (2000). The road to success with a mentor. *Journal of Vascular Nursing*. 28(1) 30-33.

Professional News

(continued from back cover)

LADDER APPOINTMENTS:

Level 3

Renee Smith,RN BSN	NICU
Mary Villanueva, RN BSN	TSDU
Kristen Mangeney, RN	PICU
Keri Grigsby, RN	N/S9
Jacqueline McCloskey, RN	Cath Lab
Jody Szalma, RN BSN	INCU
Seema Shah, RN BSN	S10
Tiffany Henderson, RN BSN	PCU
Maureen Anderson, RN	PCU
Sandy Durflinger, RN	Cath Lab
Debbie Shannon, RN	Cath Lab
Veronica Kaiser, RN BSN	PCU
Kelly Jakubowski, RN	PCU

Level 4

Hannah Louise Birch, RN BSN	Peds
Gennellen Bona, RN BSN	NICU
Carolyn Emory, RN ANCC	Psych
Diana Hays, RN CPN	Peds
Melissa Campbell, RN BSN	L&D
Denise Urevick, RN RNC	NICU
Keli Sita, RN BSN	NICU
Cheaw Li, RN BSN RNC	L&D
Julie Gillis, RN BSN RNC	NICU
Kathleen Fee, RN RNC	NICU
Caitlin Stevens, RN BSN	NICU

Level 5

Mary Greeley, RN BSN NASPE	Cath Lab
Cyndi Cornwell, RN BSN CCRN	TICU
Mary Mathews, RN BA CCM	Case Mgmt
Stacey Weber, RN BSN RNC	NICU
Audrey Bennett, RN BSN NCC	L&D

Level 6

Jean Zoll, RN MSN CCRN	Mt. Laurel Echo

The Story Behind the Picture

Michael-Lin Tronco RN BSN
Pediatric Intensive Care Unit

The Pediatric Intensive Care Unit (PICU) is a very intense place to work. Staff would agree that there are good days as well as challenging ones. In the summer of 2005 it seemed like our challenging days definitely outweighed the good days. The staff on our unit appeared to be depressed, unmotivated, and sad. Fellow co-workers, Barbara DeFrance, Janine Rousseau, and I were determined to change the unit's morale. We came up with an idea to boost the morale in the PICU and lift our colleagues' spirits.

We hoped to help our colleagues and ourselves by making the PICU an inviting place. We wanted to wake up in the morning and feel good about coming to work again We agreed to create monthly themes with decorations, activities, and education for the PICU. August was the first month we began. The staff agreed that a Luau theme would be appropriate for the last month of summer. We were full of energy to embark on our special task. We went to the party store and bought grass skirts, coconut bras, tiki masks, imitation totem poles, leis, coconut cups, and even umbrella straws. We decorated the unit the best we could. The unit looked so lively and un-intimidating. Our managers loved it and soon our co-workers were commenting on how much it uplifted their spirits. Our patients and their families couldn't get enough of it.

The Luau theme included an education board located on the unit. The board for August contained information about summer food safety. We placed child-friendly pictures and explanations for everyone to see. The board also included educational activities such as coloring pages, crossword puzzles, and word-finds. Not only were these activities informational but they also came in handy when our patients or their siblings became unruly. A calendar could also be found on the walls of our unit including staff birthdays, holidays, local sports games, and our monthly activities.

The Luau theme also included monthly activities such as "Fruit Drink Fridays" and "Hula Tuesdays." On Fruit Drink Fridays a designated staff member poured fruit drinks into coconut cups decorated with fresh fruit kebobs and umbrella straws. We decorated a Hula cart and went around room to room offering the festive drinks to patients and families. This was also an opportunity to talk one on one with our patients and to give their families a much deserved break from all the stress that being in a hospital entails. Hula Tuesdays included dressing up in grass skirts, coconut bras, and leis. Staff gave patients a chance to dress up as well. Hawaiian music played as the staff danced in their patient's rooms. As you could imagine, the children loved it!

One particular patient stood out during our entire Luau month. Her name was Kelly. Kelly was 8 years old and had recently been in a horrific car accident. She was being co-managed by the PICU and trauma teams. Kelly's accident left her paralyzed from the waist down. She also suffered a traumatic abdominal injury and was on bed rest her entire hospital stay. During Kelly's critical hospitalization she also needed a tracheostomy to help her breathe. Kelly stayed on the unit for 2 months before going to a rehabilitation center. Kelly got to know all of the PICU nurses and became very familiar with the PICU routine. As she began her long road to recovery she learned how to talk with her tracheostomy and her abdominal injury healed. Kelly especially loved our Hula Days. We got to dress her up in all the traditional Hula fixings and we hula danced around her room singing and laughing. Her mom even got to dress up and sing with us, which Kelly particularly loved. Through all of Kelly's trials and tribulations she was able to smile, laugh, and have fun. Kelly's injuries were life changing but she was able to turn every negative into a positive. She had a remarkable outlook on life and was determined to make the best of her situation.

Our monthly themes, decorations, and educational activities have been a staple in the PICU over the last 4 years. We now have two staff members who volunteer to be in charge each month. This activity has brought back motivation, fun, and happiness to the unit. It is definitely something that has improved our morale and is here to stay.

The PICU is a remarkable place to work. Children always leave you speechless. Just when you are about to give up, they surprise you and never look back. A child truly does see the world in a different light. I am so happy that I get to observe this on a daily basis.

Email comments to **tronco-michael@cooperhealth.edu**

Professional News

DEGREES:

Jennifer Innes, RN MSN MBA
Wilmington University
Ralph Daggan, CRNA MS
Medical College of Pennsylvania
Laura Ho, CRNA MS
Medical College of Pennsylvania
Donna Messina, CRNA MS
St. Joseph's University
Dawn Wassinger, CRNA MS
St. Joseph's University
Phyllis DiCristo, RN-BC BSN OCN
Drexel University

CERTIFICATIONS:

Certified in Medical Surgical Nursing:

Adella Foster, RNC
Dora Johnson, RN-BC BSN
Lynette Jones, RN-BC BSN
Christina Hunter, RN-BC BSN OCN
Ana Denton, RN-BC BSN OCN
Van Hoang, RN-BC BSN
Phyllis DiCristo, RN-BC OCN
Norma Rowello, RN-BC OCN
Beverly Jiminez, RN-BC
Jennifer Zane, RN-BC
Marjorie Theilig, RN-BC
Jacklynn Keegan, RN-BC
Stacy Carr, RN-BC
Devyn Berry, RN-BC
Mary Thomas, RN-BC
Keri Grigsby, RN-BC
Dawn Ogden-Forsyth, RN-BC
Jennifer Bonafiglia, RN-BC BSN
Erika Orfe, RN-BC

Certification in Psychiatric/Mental Health Nursing:

Lucy Souhkrie, RNC BSN MSHCA
Carol Moriarity, RNC MSN

Certification in Perioperative Nursing:

Lynn Kirk, RN CNOR

Certified Clinical Research Coordinator:

Clare Hansen, RNC BSN CCRC

Certification in Critical Care Nursing:

Tracy Iglesias, RN CCRN
Johanna Nehring, RN BSN CCRN
Jennifer Groves, RN CCRN
Kevin Capritti, RN BSN CCRN

Certification in Emergency Nursing:

Donna Schultice, RN CEN
Beth Sherman, RN BSN CEN

Certification in Chemotherapy:

Mary Dibenedetto, RN OCN
Karen Polaski, RN OCN

Certified in Inpatient Obstetric Nursing:

Barbara Murphy, RNC-OB

Certification in High Risk Neonatal Nursing:

Dale Beloff, RNC
Kathleen Fee, RNC
Lois Meyer, RNC
Joei Fekete, RNC
Julie Gillis, RNC
Anna McCausland, RNC
Patricia Pearlman, RNC
Sharon Stratton, RNC
Jeanine Tuzi, RNC
Denise Urevick, RNC
Diane Wachter, RNC
Stacey Weber, RNC
Donna Wood, RNC

Re-Certified in Neonatal Nursing:

Michelle Basile, RNC CCRN
Joanne Fox, RNC
Valerie Gibson, RNC
Jane Hasson, RNC
Vicki DiGiambattista, RNC
Liz Canders, RNC
Linda Wicker, CCRN

PRESENTATIONS:

Kathleen C. Ashton, PhD APRN BC
"Teaching Research as an Online Course for RN to BSN Students: Best Practice" presented with Dr. Cecilia Borden at the FINE International Nurse Educators' Conference, Plovdiv, Bulgaria, October 2008

Mary Francis, RN MSN ACNP-BC
Poster presentation "Women and Violence" presented at Drexel University's 33rd Annual Women's Health Conference in Atlantic City February 11-13, 2009.

Kathy Devine, RN BSN CCRN and **Stacey Staman, RN MSN CCRN**
"Trauma Mastery Session: Trauma Case Studies" presented at Trends in Trauma and Cardiovascular Nursing Conference in King of Prussia, March 26, 2009.

APPOINTMENTS:

Kathleen C. Ashton, PhD APRN BC
Appointed National Research Committee Chair by the AALNC, Fall 2008.

PUBLISHED:

Kathleen C. Ashton, PhD APRN BC
Ashton, K.C. (2008). Career success strategies: The LNC and nursing practice. Available at http://www.aalnc.org/members/networknews/2008/november.cfm
Sheehan, B., Speweik, C., and Ashton, K. C. (2009). Celiac disease approaches the bench: A case study. *Journal of Legal Nurse Consulting*, 20(1); 19-22.

Sharon Byrne, RN MSN APN,C AOCNP and **Evelyn Robles-Rodriguez, RN MSN APN,C AOCN**
Byrne, S. and Robles-Rodriguez, E. (2009). Educational parties as a strategy to promote breast health awareness and screening in underserved female populations, *Oncology Nursing Forum*, 36(2), 145-148.

AWARDS:

Jennifer Innes, RN MSN MBA
Wilmington University 2008 Master of Science in Nursing Award for Academic and Professional Excellence
Induction into Sigma Beta Delta Business and Management Honor Society

Nursing Excellence Awards Winners 2009:

Charlotte E. Tobiason Memorial Award for Excellence in Obstetrical Nursing Practice: **Regina Chavous-Gibson, RN** – Labor and Delivery

The Sara Hirsch Memorial Award for Excellence in Oncology Nursing Practice: **Tracy Reynolds, RN** – North/South 9

Research Nurse Excellence Award: **Lucy Suokhrie, RN BC BSN MSHCA** – South 5

Jean Patterson Memorial Award for Excellence in Nurse Mentorship: **Lois Meyer, RNC BSN** – NICU

Ruby Gross Leadership Award in Nurse Excellence: **Mary Jo Cimino, RN BSN CCRN** – ICU/CCU

Excellence in Clinical Practice Award: **Barbara Wenning, RN RCIS** – Cath Lab

Ronald Bernardin Memorial Award: **Janine Rousseau, RN BSN CPN** – PICU

Excellence in Trauma Nursing Practice Award: **Elizabeth Haviland, RN** – TSDU

The Theodore and Sara Hirsch Memorial Award for Excellence in Patient Care (non-nurse): **James Reeve, NA MST** – Cooper Digestive Health

Theodore Hirsch Memorial Award for Excellence in Cardiovascular Nursing Practice: **Dino Ripa, RN BSN** – Cath Lab

The Carol G. Tracey Compassion Award: **Mary Perocho, RN BA** – TICU

The Moorestown Auxiliary Memorial Award for Excellence in Outpatient Nursing Practice: **Kathleen Sailor, RN** – Same Day Surgery

John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing Practice: **Julie Gillis, RNC BSN** – NICU

The Moorestown Auxiliary Memorial Award for Excellence in Geriatric Nursing Practice: **Mary Thomas, RN BC** – North/South 9

The Excellence in Perioperative Nursing Practice Award: **Deborah Cutrona, RN BSN CCRN** – PACU

The Award for Excellence in Perioperative Surgical Technology: **Pamela Hunt, CST** – Operating Room

Nurse of the Year 2009 – Sponsored by the Associated Auxiliaries: **Dino Ripa, RN BSN** – Cath Lab

Nominees for Cooper's Annual Nursing Awards:

Excellence in Clinical Practice:
Christine Connelly, RN-C OCN
Carol Moan, RN OCN
Linda Sullivan, RN CCRN

Jean Patterson Memorial Award for Excellence in Nurse Mentorship:
Linda Rowan, RN
Stephanie Jennings, RN
Kevin O'Brien, RN CCRN
Precy Dsouza, RN

Ronald Bernardin Memorial Award
Janet Ezekiel, RN
Kimberly Vaughan, RN BSN

Ruby Gross Leadership Award in Nurse Excellence: **Susan Baseman, DrNp(c) APRN BC**

Excellence in Perioperative Nursing Practice Award: **Lisa Passero, RN**
Marla Janor, RN BBA

Moorestown Auxiliary Memorial Award for Excellence In Outpatient Nursing Practice:
Carol Moan, RN OCN
Tony Solomon, RN
Bernadette Malinowski, RN BSN

The Sara Hirsch Memorial Award for Excellence in Oncology Nursing Practice:
Carol Moan, RN OCN

Theodore and Sara Hirsch Memorial Award for Excellence in Patient Care (non-nurse): **Tasha Thomas, NA**
Brenda Rodriguez

Theodore Hirsch Memorial Award for Excellence in Cardiovascular Nursing Practice:
Mary Beth Palkon-Krytzer, RN BSN
Lauren Neiss, RN BSN

(continued on page 14)

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