Cooper University Health Care

Cooper Bridges

A publication for nurses and healthcare professionals

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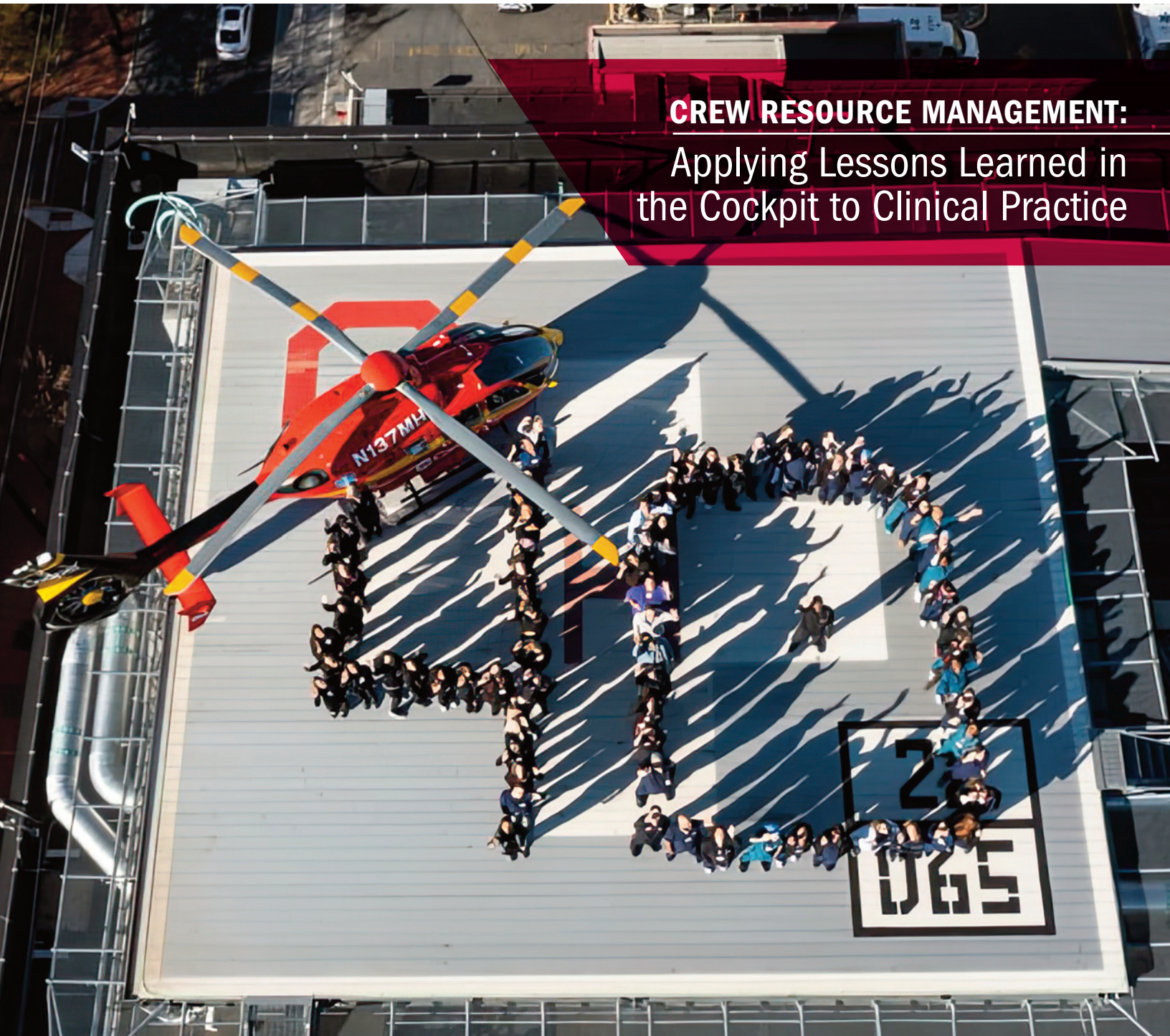

CREW RESOURCE MANAGEMENT:

Applying Lessons Learned in the Cockpit to Clinical Practice

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Cooper
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Our Senior Nurse Leaders

In each new edition, we will be highlighting one of our Senior Nurse Leaders. In this edition, it is an honor to share an interview with **Timothy Marks DNP, MBA, RN, CEN, NEA-BC, VP Patient Care Services & Associate Chief Nursing Officer**

Dr. Marks, welcome to your first interview in Bridges! Being a relative newcomer to Cooper, is there anything you would like Cooper Nurses to know about you?

Thank you! I am so happy to be back in the South Jersey area. I love nursing and like so many of you, I am a die-hard Philadelphia sports fan. I am glad to be local so I have the opportunity to attend games; Phillies, Flyers, Union, and Eagles. On a more personal note, I am very family oriented, so being back in the area has allowed me to share more regular meals with my mom, siblings, nieces, nephews and friends. It's nice to get more actual face-to-face time with my family vs. using Facetime.

Now that you have been at Cooper for almost a year, what are your initial thoughts?

If I had to describe my experience here so far, it would be awesome. The people here, the work we do, the entire place. What's done at Cooper can be demanding and difficult, and my hope is that everyone who does the work feels proud of themselves and what they accomplish for the patients and this community.

Coming into Cooper after more than a decade ago, I quickly realized that I had a lot to learn and really tried to absorb everything from people who have lived and breathed Cooper for much of their professional lives. For the last year, I have been on a journey of watching and listening so that I can help do my part with everyone's best interests as the top priority.

In your opinion, what is it about Cooper Nurses that gives us such a respected reputation in South Jersey?

Well, like our shirts say — "There are nurses... and then there are Cooper Nurses." I think it goes back to our three S's: Skilled, Steadfast, Strong. Nursing is difficult right now, due to national nursing shortages and the need to constantly innovate when it comes to staffing and recruitment. Our patient outcomes and hospital accolades speak for themselves. Cooper nurses are strong and are skilled and compassionate beyond measure.

What are your main priorities for Cooper Nursing in 2023?

We have been working so hard on multiple projects. For the rest of this year, I want to focus on aligning our work more efficiently and collaborating with the interprofessional colleagues. This will give us more room to grow and opportunity to focus on ways to improve our employee and patient experience.

Where do you see Cooper Nursing in five years?

I see Cooper Nursing continuing to excel in the professional environment and I foresee having such outstanding outcomes that we will have a waiting list for nurses of all specialties fighting to work here.

Dr. Marks, thank you so much for taking the time to chat with Bridges. Is there a special message to the readers you would like to end on?

Yes, definitely. It's important that we don't forget our "why". Why you got into helping people, why you decided to become a healer. When you become overwhelmed, reflect on your why and what that means to you.

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: **curnew-jillian@cooperhealth.edu**

Breaking the Cycle of Gun Violence: A Hospital Linked Violence Intervention Program

Debra Williams MSN, RN, CCRN-K, TCRN

It was early evening in the Ross Trauma Admitting Area when a call came in to prepare for a seventeen-year-old male with a gunshot wound to the head. As I prepped the trauma bay, I recall thinking to myself, "What are these kids doing and why are they messing around with guns… again?! Why does another parent have to lose a child?" At the time, I was seven-months pregnant with my first child and I could not imagine how a mom would feel in a situation like this one.

As the primary nurse, I was standing at the bottom of the stretcher awaiting this young man's arrival. As the doors opened, I turned around and a mother ran into the trauma bay carrying her 17-month-old son who had been shot in the head. I vividly recall tears streaming down her cheeks and blood on the right shoulder of her yellow shirt where her son's head rested as she carried him. I took the child and the trauma team began the resuscitation of this baby. I had not prepared for an infant and I knew he was not going to survive his injuries. I wish I could say I was wrong. Sadly, this child, with flawless skin, precious chunky little arms and legs, and beautiful dark brown eyes, was caught in the crossfire. He did not survive the devastating head injury created by the bullet that penetrated his little head.

Dr. Joseph Sakron presented Gun Violence in America at the Templeton Pediatric Trauma Conference 2021 where he

identified that in the United States, there are more than 300 victims of gunshot wounds daily. In New Jersey, an average of 445 people die annually from gun violence (Gun Violence in New Jersey, 2021). Over the past four years, Cooper University Hospital (CUH) has annually cared for an average of 150 victims of gun violence over the age of 18, an average of twenty victims between the ages 12-18, and an average of one victim under the age of 12 (National Trauma Registry Data Base, 2021). In the United States, over $200 billion dollars are spent annually from direct and indirect consequences of gun violence (United States Joint Economic Committee, & Maloney, C. B.).

The first gunshot wound was when Billy (name changed to protect identity) was a teenager, according to his brother. He suffered a second gunshot wound the year prior and now at the age of 22, he was shot again for the third time. When the trauma attending and I went to speak to Billy's brother, he sighed and casually asked, "Where was he shot this time?" This time? This time was the last time. This time, he was shot in the chest and despite all the efforts of an expert prehospital team, the experience, clinical knowledge and expertise of the trauma team, and medical advances, this time, Billy died. I will never forget the look on his brother's face. He just could not believe that Billy was dead. He was completely blindsided and it was heartbreaking to watch. Each time Billy was treated, he received excellent care for his physical injuries. However, he was not necessarily treated for the disease of violence. Victims of gun violence should be treated as if the violence is that of a disease (Karraker, 2011). What if violence intervention programs were available that specifically focused on helping people like Billy? A program geared towards helping to make better decisions, providing psychological first aid, building trusting relationships and supporting an opportunity for education or job training?

The State of New Jersey has invested $20 million dollars in federal grant funds to address community violence. CUH along with Cure4Camden Center for Family Services (CFS) have partnered to provide specific support and services to victims of gun violence.

Today, a program exists that assists victims of gun violence. The State of New Jersey has invested $20 million dollars in federal grant funds to address community violence. CUH along with Cure4Camden Center for Family Services (CFS) have partnered to provide specific support and services to victims of gun violence.

I am confident that if you were to ask any nurse who works in the trauma bay or emergency department, they could share stories of patients who were victims of gun violence. Some are children, others are teenagers, and many are adults. They are all people, people who may have made poor choices, people who may be struggling with post-traumatic stress, and we need to remember that they are victims (Winfield, 2019). We, as front line healthcare workers, do not know what the victim is going through or has been through. We just know that they are injured and require intervention. Having been in the trauma department for almost twenty-four years, I have seen gun violence continue.

Our Hospital-Linked Violence Intervention Program (HVIP) was implemented in May 2021. The goal of this program is to decrease recidivism, provide support and services to victims of gun violence, and educate the Cooper community and the Camden community on the new HVIP. Inclusion criteria consists of any age victim of gun violence and the exclusion criteria includes self-inflicted, domestic violence, and severe mental illness.

What is required to break the cycle of violence? According to Karraker (2011), there is a need to offer quality screenings, interventions, discharge planning and follow up care. Hospital Violence Intervention Programs have been proven successful in decreasing gun violence by monitoring implementation and program outcomes. Programs such as Chicago's Cure Violence, Oakland's Youth Alive, and Baltimore's Safe Streets have seen a reduction in gun violence and homicides, and gun violence began to denormalize within the community (Butts, 2015).

For the past year and a half, the Trauma Department under the direction of Dr. John Porter and our medical liaison, Dr. Tonya Egodage along with CFS, have collaborated to develop a program that uses a public health approach to aid in addressing gun violence in Camden City. Together, CFS and CUH were awarded a grant to work in partnership to provide services to victims of gun violence. Our Hospital-Linked Violence Intervention Program (HVIP) was implemented in May 2021. The goal of this program is to decrease recidivism, provide support and services to victims of gun violence, and educate the Cooper community and the Camden community on the new HVIP. Inclusion criteria consists of any age victim of gun violence and the exclusion criteria includes self-inflicted, domestic violence, and severe mental illness. The HVIP supervisor oversees the Hospital Responders who meet with the patient in the hospital to provide psychological first aid and to assess patient's immediate needs. The hospital responders access patients through the CUH volunteer office. They wear a volunteer badge and the Cure4Camden lime green shirt so that they are easily identified within the organization.

The HVIP program is designed to offer victims of gun violence solutions to their immediate needs such as emergency housing, food, or clothing while preparing for a longer-term response to the needs of high-risk victims. The program includes legal services, emotional and behavioral health needs, transportation to appointments and follow up care, education, and job training. CFS already has a street team that builds relationships within the community to prevent retaliation and provide services and support for the residents of Camden. We are proud to be able to offer these collaborative services to our residents of Camden who are victims of gun violence. CUH and CFS has always been at the forefront of support for the city of Camden and this is just one more way to leave a footprint in preventing gun violence in our part of the country.

Email comments to **Williams-Debra@cooperhealth.edu**

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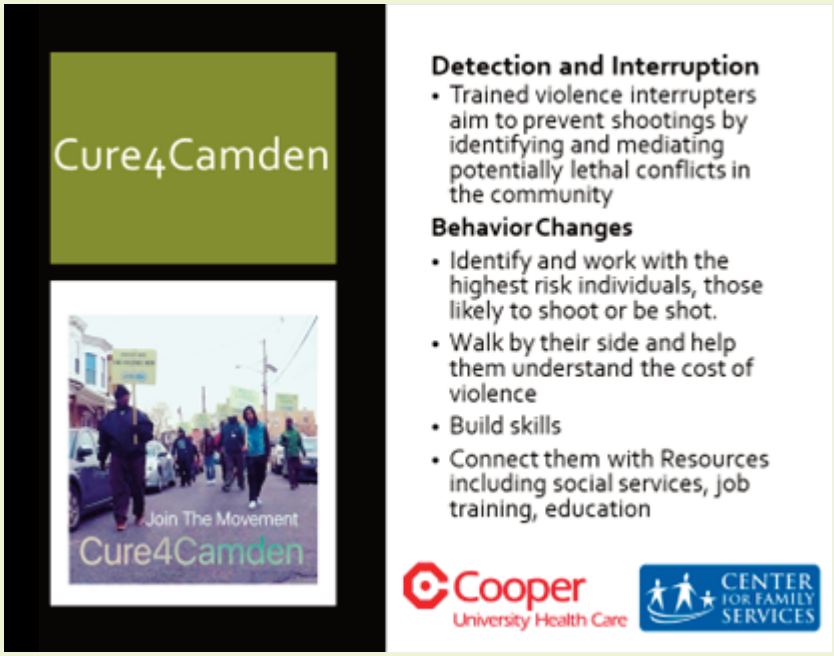

Crew Resource Management: Applying Lessons Learned in the Cockpit to Clinical Practice

Michael Carunchio, MS, NRP, FP-C, TP-C

Setting the scene: You are in your second year of working as a clinician and a patient is experiencing an asthma attack. The patient was given a nebulizer treatment and while he does not seem to be getting worse; he does not necessarily seem to be getting better. You are at the bedside with a respiratory therapist, a technician, and an experienced nurse when the attending physician briskly enters the room, takes a quick look at the patient and says, *"we've got to intubate him!"*

You're a little caught off-guard by this and think maybe we could try another nebulizer treatment? Maybe give him some magnesium sulfate? Perhaps some non-invasive ventilation would help? As the respiratory therapist retrieves the intubation supplies, the senior nurse begins to prepare a bag valve mask for the rapid sequence intubation. You think moving right to intubation is too aggressive but take note that all of the other staff in the room, who have been doing this longer than you, are preparing for intubation without hesitation. You remind yourself that you're new and that the attending physician is an expert and has an outstanding reputation.

The physician then asks how much the patient weighs.

"Uhh..112 kg."

"Ok…draw me up 0.3 mg/kg of etomidate and 1.5 mg/kg of rocuronium"

You watch the nurse do some mental medication math. The nurse draws up the medications, the induction drug is administered, paralytic agent follows. The attending physician cannot get the patient intubated; the patient's anatomy proves to be more complicated than predicted. The physician is attempting to intubate a second time when you point out to everyone in the room *"the patient's pulse ox has dropped from 89% to 54%."* The attending tells you *"Yeah I know, we've got to get this tube placed before we do anything else."*

As the physician is trying for a third time to intubate, he says out loud to no one in particular, *"Someone call anesthesia STAT."* You then notify him that the patient's heart rate has dropped to 40 beats per minute. The physician then exclaims *"Got the tube! Bag him up!."* However, the patient's heart rate continues to drop and eventually goes into pulseless electrical activity, a fatal heart rhythm. Despite a lengthy code the patient cannot be resuscitated and is pronounced dead.

You find yourself pondering the situation all day. Later in the shift you ask another nurse to debrief and tell her that you are stressed about the event. You didn't realize that the patient was as sick as he was and you didn't even consider that he needed to be intubated. To your surprise, the nurse tells you *"I was surprised that he wanted to intubate him too, but I didn't say anything because who am I to question the doc? Let alone him. He's like the grand poohbah of his specialty."* The respiratory therapist and technician also chime in and tell you that they were uncomfortable with how things progressed and the respiratory therapist said *"I really think some NPPV with an in-line neb could have turned him around. I should have said something."*

Meanwhile, the physician is back in his office and is deep in thought about what went wrong, what he could have done differently, whether he made the right

It is crucial that the flight paramedic, flight nurse, and pilot work as a team to constantly look out for one another, point out changes in the patient condition or flight environment even if they seem obvious, and communicate our needs and perceptions.

decisions, whether he did the procedure correctly, and what can be done to ensure that this doesn't happen again. The physician is not aware that the aviation industry has studied extremely stressful high-stakes situations, the limitations of human performance, and how to use effective team dynamics to maximize safety and accomplish goals.

In 1978, in what some may consider to be the most embarrassing aviation incident ever to happen, United Flight XXX experienced a landing gear malfunction on its approach to Portland, OR. While not a catastrophic malfunction, the crew spent so much time circling while trying to troubleshoot the problem that the plane ran out of fuel and fell out of the sky.

In 1993, Korean Air Flight XXX was making its final approach to Guam. The Captain took an extremely unconventional approach into the airport, perplexing the other members of the crew. However, the Captain is the Captain and you don't dare question the Captain. It wasn't until six seconds before the plane crashed, killing all on board, that the crew voiced concern and questioned the Captain.

After a string of devastating and avoidable aviation accidents, the aviation industry realized that there needed to be a paradigm shift. None of the pilots or crew members in these incidents were incompetent. Quite the contrary. All crew members in these incidents were experienced professionals with excellent training and thousands of hours in the cockpit. The aviation industry realized that something had to change, and blame could no longer be placed on the crew for "natural human factors." This is the realization that no matter how educated, qualified, or competent a professional may be; in times of stress, they are a human being and will make erroneous decisions, have degraded performance as workload increases, will inevitably make technical errors in the performance of their duty, can become task saturated, and are susceptible to fatigue.

The result of this paradigm shift was Crew Resource Management (CRM). The Federal Aviation Administration defines CRM as the effective use of all available resources for flight crew personnel to ensure a safe and efficient operation, reducing error, avoiding stress, and increasing efficiency. This resource is a multifaceted concept that recognizes human beings experience stress and have natural performance limitations. The CRM seeks to mitigate the impact of these factors through proactive hazard identification, teamwork, communication, utilization of checklists, and workload management processes. These processes can include delegation of tasks and allowing crew members to voice when they are physically fatigued and/or cognitively overloaded and require a break.

With the advent of concepts like ***high reliability,*** healthcare organizations have looked to the aviation industry as a guide and have incorporated many tenants of CRM into the cultural fabric of the organization to strive for ***zero harm.***

The air medical team here at Cooper University Health Care has CRM as the foundation of our operational culture. It is extremely easy to get task saturated in the air medical environment. We manage critical patients while flying in a cramped space with various external environmental factors like noise, vibration, motion stimulus, and low light conditions. Additional to the clinical responsibilities, there is a flight safety component where we must maintain additional eyes and ears for the pilots. This includes listening to various communications systems like Fire/EMS dispatch, statewide Medevac dispatch, and air traffic control frequencies in the area.

It is crucial that the flight paramedic, flight nurse, and pilot work as a team to constantly look out for one another, point out changes in the patient condition or flight environment even if they seem obvious, and communicate our needs and perceptions. This is the situational awareness component of CRM. One must never assume that your partners see or perceive the same thing.

Communication must be direct: respectful yet assertive. CRM recommends using an "assertion statement" that grabs attention, states the concern, states the problem as you see it, provides a solution, and seeks agreement. An example would be if an air medical crew member felt an odd vibration while flying, the crew member would verbalize something to their partner and pilot like the following, *"Hey, listen up. It feels like the helicopter has a weird vibration back here. I've never felt something like this before and am concerned there may be a mechanical problem. Once we land can you (the pilot) do a safety check and call the mechanic? Sound good?"*

CRM eliminates hierarchies so that everyone can speak up for safety concerns. This does not mean that everyone gets to make a decision or tell the other discipline on the aircraft how they should be doing their job. For example, as a flight paramedic, I am encouraged to speak up with questions about operations in-flight and alert the pilot to clarify things that may be confusing, unfamiliar, or abnormal. This means that in the event of a safety concern, I am free to voice my opinion and ask for clarity, regardless of my role on the crew.

The work management flow of CRM requires assigning of

tasks and using checklists. For example, if we are going to be loading a patient with an intra-aortic balloon pump into the helicopter, we decide what roles each member will assume before moving the patient. For example: *"Pilot: you help to guide the cables to make sure nothing gets snagged, Paramedic: you are the strongest person on the crew; you can lift the patient and stretcher into the aircraft, Nurse: you can lift the balloon pump and secure it into the locking mechanism."* We will then re-check to ensure that everything is secured, followed by a "walk around" of the helicopter to confirm that there are no obvious abnormalities or damage prior to take off. Prior to taking off, the pilot will go through and verbalize a checklist to ensure that he or she is following the proper procedures exactly as prescribed by the checklist. The crew then confirms understanding that the checklist is complete, and that all are secured and ready for departure.

When I entered the field twenty years ago, it was seen as a weakness to use checklists and reference guides. I was once told by a supervisor that we were not allowed to use calculators during a quarterly medication math quiz because *"you need to know how to do this stuff without having to resort to using a calculator or a reference."* While I am now highly trained, experienced, and comfortable in my medication math abilities, I realize that this type of thought process is a latent hazard and an ingredient in a recipe for disaster.

On the Air Medical team, we utilize checklists and references for all of our rapid sequence intubations and pediatric patient encounters. These are considered high risk/low volume situations and we need to maximize our ability for peak performance.

Thankfully, the paradigm has shifted and the health care industry recognizes the limits of human performance during times of stress. As renowned surgeon Atul Gawande wrote in *The Checklist Manifesto (2009)*. "In the modern world we make mistakes because we don't make proper use of what we know and that things like missing a step or failing to ask a key question are inevitable because we are humans with limitations."

Using a checklists, computers, and reference guides takes the competent professional through key steps of complex procedures. On the Air Medical team, we utilize checklists and references for all of our rapid sequence intubations and pediatric patient encounters. These are considered high risk/low volume situations and we need to maximize our ability for peak performance.

As a clinician, I am a proponent of CRM because it understands that I am only one person and that I can only do so much. Using workload management, checklists, and having the ability to voice my opinions and recommendations reduces cognitive load, helps me maximize my performance, and reduces the burden of the situation on me by using other professionals to help get the job done.

Let's rewind and apply CRM to the asthmatic patient scenario. The physician enters the patient's room and makes a judgement based on his perception of the situation; the patient requires intubation. The newer clinician, despite her relative inexperience stops and says *"I need some clarity. We are proceeding to intubation? He has gotten one nebulizer treatment. Should we consider administering magnesium sulfate or try him on non-invasive first? I'm concerned that we may overlook a simpler and less invasive method."*

Again, the clinician is not dictating how to treat the patient. She is providing her input and stating a concern. The physician should consider the clinician's concerns and factor it into the decision-making process.

If the physician does indeed wish to continue with the intubation, he should employ good CRM and review his thought process succinctly and directly with the staff. Employing good CRM would look something like this:

"Good thinking with the mag and NPPV but I still want to intubate the patient based on X, Y, and Z. Let's call anesthesia to standby because asthmatics tend to be sometimes difficult patients to intubate. I'll also want respiratory therapy standing by with these vent settings programmed and I want you to draw up etomidate and rocuronium. Based on the dosing checklist I'm using it says that this patient should receive 30 mg of etomidate and 180 mg of rocuronium so please double check me, draw that up and label those syringes. I want you to please put a non-rebreather mask on this patient in preparation for intubation."

Following this kind of good CRM optimizes preparation and reduces the incidence of natural human error during performance in stressful situations. The physician would then proceed with an intubation preparation and procedure checklist and proceed with the procedure with the help of the team.

The days of considering that clinicians are any kind of super-humans who function flawlessly every time in extremely stressful high-stakes scenarios are over. An organizational culture of effective stress management, hazard identification and mitigation, effective and realistic workload management, along with a culture of communication and teamwork, we can mitigate errors and capture prior to reaching patient. CRM is not just a corporate "buzz-term" that managers and health care administrators share with staff in an in-service presentation. This is a best practice for culture and operations that each member of the organization should strive to employ every day while delivering excellent patient care, a high-degree customer service, and ***zero harm.***

Email comments to **Carunchio-Michael@cooperhealth.edu**

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Orientation Roundtable: Innovative Paths to Learning

Jennifer Colona MSN, RN, CCRN, TCRN

Recently, healthcare has seen an increase in the number of new to practice registered nurses (RN) into the critical care workforce. There are many things to consider in the onboarding process of new RNs in any area of nursing, especially critical care. Some challenges that face the new graduate RN, particularly in the critical care area, include critical thinking skills, technology, high patient acuity, dealing with frequent deaths and family communication; as many patients in the intensive care unit are unable to speak (Baudoin, McCauley & Davis, 2022). This leads to stress, decreased job satisfaction and burnout for the newly graduated RN. The clinical skill of the emerging workforce is also limited due to the COVID-19 pandemic. Many students had reported that much of the clinical experiences were simulated leading to fear of missing details in providing patient care (Smith, Buckner, Jessee, Robbins, et al., 2021). Research has shown that addressing the emotional well-being in this nursing population is an integral part of achieving clinical competence, reducing anxiety, and increasing retention (Reebals, Wood & Markaki, 2021).

The Question

The question of how to achieve this support for the RNs in a purposeful, productive way was raised to a preceptor group in the Trauma/Surgical Intensive Care Unit (TSICU). A program was needed that would lend emotional support to new hires, while implementing teaching strategies based on content that would be the critical care unit does not often allow time for in-depth learning outside of skill sets, the program would also reinforce concepts addressed at the bedside. This would then allow for learning of critical care concepts outside of the clinical area, where time constraints can impede the preceptor's ability to fully explain concepts surrounding patient care. Learning styles of the new RNs would also need to be taken into consideration to achieve the best engagement and satisfaction with the program (Mangold, et.al, 2018). Additional considerations include:

- How to bring new hires together to create peer support
- How to determine critical thinking competency in addition to competency in task-based skills
- How to empower new hires to have a voice and become comfortable speaking with all members of the health care team
- How to create a safe space for new hires to ask questions and make mistakes

The Roundtable Answer

Taking into account all the above considerations, it was determined that a workgroup was needed. The workgroup would contain hands-on, visual and discussion pieces to be able to address different learning styles. Simulation (SIM) lab time would be utilized for hands-on learning to reinforce techniques used at the bedside and assess critical thinking skills of the nursing staff. This would also create a safe space to allow the RN

processes leading to decision-making. By using this approach, performance gaps can be identified and immediately addressed in a non-threatening environment (Lei & Sikon, 2022). Additional discussion determined the benefit of initiating a learning style of creating a flipped classroom. Using this method, the RNs would lead and guide the discussion with the educator as a moderator and clinical content expert. Implementation of this teaching method has been found to improve RNs' knowledge, skills, and attitude as well as help to determine "assessment performance of core skills, problem-solving, communication, critical thinking, self-directedness, motivation, engagement, confidence, satisfaction and joyful learning" (Youhasan, et.al, 2021). These were all the qualities that preceptors, unit leadership and the educator wanted to achieve. As a result, the Orientation Roundtable was adopted into the orientation schedule of new graduate RNs to the TSICU. The term roundtable was decided upon to represent that the new RNs were to lead this education time; there was no hierarchy, and that unit leadership was acting as facilitator during this time.

A monthly workgroup was initiated. The framework of the group was to utilize an open forum. New graduate RNs would spend the time with their peers and the nurse educator as facilitator. This would create a positive learning environment free from judgement and pressure that exists while on the unit. All group members understand that all questions and information discussed during the group would not be disclosed outside of the group unless any unsafe practice is identified by the facilitator. RNs would be paid one 8-hour shift with the educator which would be split between hands-on clinical activities and group discussion. An additional 4 hours, which would complete a 12-hour shift, would be paid for time spent preparing materials for the roundtable discussion. The discussion topics would be determined by the RNs. When unsure, the RNs were prompted by the educator to think of a clinical experience or topic that piqued the RN's interest in the past month.

SIM Component

SIM lab activities have ranged from code simulation to intravenous (IV) and urethral catheter placement, leveling of External Ventricular Drains (EVD), chest tube and tracheostomy care. Activities done in SIM lab were guided by the new graduate RNs by polling what they need further exposure with. All activities in SIM have been completed using high-fidelity simulators with pre- and post- briefing periods where strengths and weakness of the group are discussed. This has thus far remained a fluid process and is ever evolving determined on the nurses' needs.

Flipped Classroom Discussion

From a nursing education standpoint, the flipped classroom discussion has been one of the most useful pieces of roundtable. Topics are to be submitted to the Educator the Friday before roundtable to ensure that there are no duplicate topics. What and how to present the information is left entirely up to the nurse. To date no topics have been denied. Topics have ranged from types of IV fluid and the IV fluid's mechanism to arterial line placement and care, to the need for continuous renal replacement therapy. New hire nurses have also taken care of some unique patients that have undergone procedures not usually seen in the TSICU patient population such as bubble studies and white blood cell tagging, which discussion has been useful to the nurses and the educator alike. Nurses have created handouts for peers and PowerPoint presentations, have looked up policy and procedures, and discussed the need for using evidence-based practice. Documentation standards and communication with families and end-of life considerations have also been discussed. This process has been a very efficient way to also determine how invested each nurse is in the orientation process and personal educational needs.

Conclusions

Feedback from the nursing staff has been overwhelmingly positive. The nurses enjoy roundtable and look forward to the monthly meetings. Nurses have been able to see that there are others experiencing the same challenges, achievements, and aggravations. Time has been set aside to discuss frustrations with orientation. Topics such as issues with patient population, communication with other practitioners, and preceptors have been discussed as well as strategies to deal successfully with these issues. It has fostered comradery amongst the nurses new to the unit who otherwise may not have the time to talk to each other and has helped to forge relationships that become supportive and positive both at and away from the workplace.

Addressing the emotional well-being of the new to critical care nursing staff in addition to the educational needs of orientation has been a rewarding experience. Working to ensure teaching methods and topics are useful and purposeful can be challenging, but allowing the new staff to determine content themselves has proved useful to their growth and understanding and helps keep content diverse. While more evidence and time is needed to determine if this part of orientation increases retention, the hope is to continue roundtable and address the emotional well-being, as well as educational needs in a useful, timely manner that remains meaningful to nursing staff.

Email comments to **Colona-Jennifer@cooperhealth.edu**

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Retail Therapy

Deborah Byrd, MSN, RN

Code blue, code white, rapid response, behavioral rapid response (BRRT), multiple alarms, and people screaming are all "normal" happenings in the day in the life of a healthcare worker. The amount of overstimulation can be compared to the equivalent of an entire pot of coffee with extra caffeine. When days roll into weeks and the workload never decreases, we all look for ways to reduce the stress and stimulation that we endure as healthcare workers. Some go to the gym, some to the bar, some find quiet time in their homes, and some of us go shopping. Retail therapy is not usually the norm for me to decrease stress, but on this particular day, it was meant to be. You could even say it was a divine intervention for me.

On any given day, healthcare workers are inclined to perform emergent actions to save someone's life or only prolong it for a short period. We are called to help people and we are often the recipient of physical or verbal abuse by the same people we are called to help. These are the days when we need to find outlets for the stress endured at work.

At the end of this one particular week, multiple factors triggered an increased need for me to find that outlet. "Retail therapy," I say to myself. That will make it all better. As I joke with friends before I left work for the weekend, I said I just really need to get shampoo and conditioner. Not a very exciting plan for a retail therapy afternoon. I set out to purchase the shampoo and conditioner and then realized that I never had the opportunity to eat lunch. My stomach was growling, more than ever since I am still in process an intermittent fasting schedule. I see that there is a Playa Bowl store nearby and head straight to the door. Once I have my bowl, I sit in my car and consume about half of it immediately. Oh, they are so good. I know I will be able to freeze the rest once I get home. I am starting to feel so much better already. This gives me the incentive to continue the retail therapy trail. Even after the delicious bowl, my stress and attitude still needed a huge adjustment.

As I enjoy the sunny afternoon drive home, I realize I have Kohl's cash. "That's it; I will go to Kohl's and use my cash". The drive is pleasant and the traffic is not too bad for a Friday afternoon in late August. I pull into a parking spot and head to the entrance. I set my sights on the sale racks. This will be the best way to utilize Kohl's cash. More "bang for my buck" kind of thinking. I cannot believe the items I find. So very excited with my findings, I head to the checkout line. I see there are three people at the cash registers. One young woman, one young man, and a very mature man. I think to myself, I really do not have the energy to have the men wait on me. Why I had this feeling, not sure, just wanted to be done and get the other half of my lunch in the freezer so it did not spoil. Again, the stress and bad attitude I harbored were lingering. I see that the line is moving in the right direction for me not to have this young male as the cashier. Then suddenly, no, there is a problem, and the nice young man is waving me towards his area. I say to myself, "well it figures". I will just have to make the best of it.

Matt was so pleasant and joyful, yes joyful. He was asking me about myself, how was my day, and how he could help me. As soon as I got close to him (well, COVID close), I noticed he had a scar on his throat from having a tracheostomy. We were having such a good conversation I decided it was safe to ask him how long ago he had a trach. He said, joyfully, "Do you want to also see my craniotomy scars"? He turns his head and points out the scars on his head that are missing hair at the scar lines. He then proceeds to tell me that he had a bad car accident in 2012 and that these scars are the result. I ask if he was taken to Cooper. He says yes, how did you know? I tell him I work at Cooper, and he gets more excited. Do you know my doctors? Did you take care of me? I did know his surgeon, but I did not take care of him. He is just so joyful about being alive, likes to tell his story, and gives praise to the care he received at Cooper.

I now feel a connection to Matt. Here I went to get "retail therapy", but I got more than what I set out to acquire. I got to meet this young man who is just so happy to be alive and be a cashier at Kohls. What he gave me that day during those few minutes was the realization that finding the little things in life is so important. The fact that I have a job, I was able to drive to a store, and breathe without a tube in my neck. We need to remember that sometimes the best therapy is not from "things". Life is full of so many frustrations and disappointments, but not for Matt. He is so grateful to be alive and is making everyday count and every encounter memorable.

As I start to leave, I ask if I can give him a hug. As we give a friendly hug to each other, I tell him that he has changed my whole mood and outlook from the problems of the week. After our encounter, I realized I couldn't think of a single thing was that previously bothering me.

The human connection is important and can heal. Maybe Matt was an angel in disguise. Thank you, Matt.

Email comments to **Byrd-Deborah@cooperhealth.edu**

Trauma Momma

Shaye Deopp, BSN, RN, TCRN, CCRN, CMSRN

Last year marked a huge milestone for Cooper Trauma as we celebrated our 40th anniversary of being one of the busiest Trauma centers in the region. In that last year, Cooper University Hospital's Trauma team had 15 consecutive pregnancies, from just trauma surgeons and intensive care nurses alone. When Michael Brumbach, previously the Clinical Director of Cooper Hospital's Trauma Intensive Care Unit and Ross Trauma Admitting, was asked about how he felt having so many trauma mommas on his floor he stated,

"We are proud to be comprised of so many talented women in every aspect of care provided to our patients. In addition to being amazing providers at work, so many of these women are also amazing mothers to children not yet school-age. In a time where being a working mom is a must for most households, that aspect hits differently when working in the busiest Trauma Center in the region, caring for the highest level of acute patients, and seeing the morbidity and mortality of patients of all ages. What happens within these walls of our Level 1 Trauma Center is what makes us the best of the best and what happens outside these hospital walls is why we continue to be the best of the best."

In 2011, the New Oxford American Dictionary defined the word Trauma as "a deeply distressing or disturbing experience." Being a healthcare provider, specifically in trauma, can be exactly that, heartbreaking to the heart and soul. At Level One trauma centers, we see concentrated chaos; we see the sickest of the sick. What keeps the Cooper trauma family going is the support we provide to each other. This support is what keeps the nurses and doctors wanting to stay in trauma and continue to help our community and loved ones. Over the last year, this family support has been so extraordinary to its own staff of pregnant and postpartum moms.

Imagine, it's your first month back to work and you just figured out how to integrate your handsfree breast pumping schedule into your work routine. You become comfortable enough now to put your pumps on and go back on the floor to finish documenting or bathing your patients. Suddenly a trauma alert gets called: "Trauma alert to Ross Trauma admitting". You are the nurse that needs to respond to the alert. You look around, no other nurse is in sight. You look at your watch and think to yourself, "It's 11am on a Saturday afternoon, it can't be anything too crazy. I'll be fine." So, you respond to the alert and as you reach the bay you hear Emergency Medical Services (EMS) shouting, "Young male shot!". You don't think twice; you lead up, gown up, and jump in. You and the team help stabilize this young man enough to rush him to emergent surgery, thus saving his life. As you're leaving the operating room (OR), you exhale, say a prayer for that patient and then you remember you still have your pumps on. You chuckle and give yourself a mental high five, not one person knows. Trauma Momma.

Imagine the pregnant trauma surgeon who's working alongside the pregnant trauma nurse responding to a pediatric trauma alert. This is not a good one. The baby loses pulses a couple of times, requiring multiple rounds of life saving medications, but now there is a strong pulse. You pack them up and take them to CT scan. The nurse, six months pregnant, leads up and goes to "hold pulse", (while quietly singing them a lullaby) during the scan. You get back to the trauma bay and the pregnant trauma surgeon tells the team that this injury is insurvivable. The nurse and the trauma surgeon lock eyes and feel the unspoken hurt as both expectant first-time moms. We don't even have an official name for this child. Someone then yells that the mom is on the way.

The pregnant trauma surgeon makes a game-time decision and leads the team; planning to keep this child alive until the mother gets there. While the child didn't survive, we made it possible for her mother to hold her in her arms as she took her final breath. The trauma mommas are hurt to their core but are so thankful to be able to provide this closure for another mother. Trauma momma.

Imagine the anxious pregnant charge nurse managing the hectic Trauma Intensive Care Unit (TICU) who was told that she should abort her baby because of the risk of her child having a poor quality of life due to a potential exposure to rubella, but the doctors can't be sure. The pregnant trauma surgeon carrying triplets who is still running the trauma bay on a busy Friday night. The pregnant trauma nurse who's working up to her due date because she doesn't have enough hours to make the Family Medical Leave of Absence requirements and can't afford to go without a paycheck. The postpartum trauma surgeon who's pumping in between rounds, OR cases, and managing the crew of new residents. The postpartum nurses and trauma surgeons who are trying to navigate two under two. Being a trauma momma is not easy but it's something to be proud of.

Trauma mommas wouldn't make it too far in this field if it wasn't for the support from our other team members. It's the trauma poppa that volunteers to change assignments because he recognizes the look of pure exhaustion in the nine-month expectant trauma nurse's eyes. It's another trauma poppa who steps in front of the postpartum trauma nurse to block the disturbing image of a suspected child abuse case (who is the same age as their child) and discretely directs their care to another patient across the bay. It is the seasoned trauma mommas on the floor who help new moms process the anxiety and fears of handling pediatric traumas. It is the nurses without kids who jump in between the pregnant nurse and the combative traumatic brain injury patient. It is the rest of the trauma surgeons who take extra call during their colleagues' maternity leave.

Working in healthcare may be arguably one of the most physical and emotionally demanding jobs out there, but Cooper Trauma's team takes it to a whole other level. Being pregnant and postpartum is a whirlwind of a journey on its own. Being a part of the trauma team while pregnant and postpartum takes a level of skill, respect, and a whole lot of family support. While we are taking care of your babies, we are simultaneously having and taking care of our own. We are the healthcare providers of Cooper University Health Care Shock Trauma.

Email comments to **Deopp-Shaye@cooperhealth.edu**

2023 Nursing Excellence Award Winners & Nurse of the Year

NURSE OF THE YEAR

Kelly Campbell, BSN, RN, Mother Infant Unit, is the recipient of *The Charlotte Tobiason Memorial Award for Excellence in Obstetrical Nursing*

Regina Callahan, BSN, RN, CPN, Pediatrics, is the recipient of *The Dr. Ronald Bernardin Memorial Award for Excellence i n Pediatric Nursing*

Lauren Duffy, BSN, RN, Emergency Department, is the recipient of *The Lynn Nelson Award for Excellence in Emergency Nursing*

Stacey Hogan, Patient Care Services, is the recipient of *The Barbara and Jack Tarditi Award for Excellence in Service* (Non-Nursing)

Kendra Blackshear, MSN, RN, AGACNP-BC, CCRN, Intensive Care Unit, is the recipient of *The William and Eileen Archer Award for Excellence in Critical Care Nursing*

Kyle Counsellor, BSN, RN, MD Anderson Cancer Center at Cooper, is the recipient of *The Franklin Morse Archer, Jr. and Mary Joy Reeve Archer Memorial Award for Excellence in Outpatient Oncology Nursing*

Beth Falkenstein, BSN, RN, CEN, TCRN, Emergency Department, is the recipient of *The Philip and Carole Norcross Award for Nurse Leadership*

Jamie Jefferson, BSN, RN, Neonatal Intensive Care Unit, is the recipient of *The John Henry Kronenberger Memorial Award for Excellence in Neonatal Nursing*

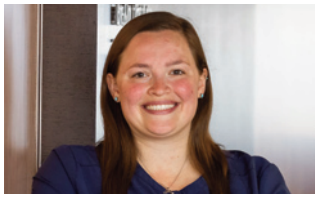
Dean Bligh, BSN, RN, Clinical Decision Unit, is the recipient of *The Lori Osinski Rising Star Award*

Brittany Leigh Cucunato, BSN, RN, Cardiac Cath Lab, is the recipient of *The Cooper Heart Institute and The Heart House Award for Excellence in Cardiovascular Nursing*

Adina Farcas, BSN, RN, TCRN, Trauma Surgical ICU, is the recipient of *The Award for Excellence in Trauma Nursing*

Zofia Kapron, BSN, RN, Pavilion 5, is the recipient of *The Rose Smith and Sue Zamitis Memorial Award for Excellence in Inpatient Oncology Nursing*

Patty Budic, RN, CGRN, Cooper Digestive Health Institute, is the recipient of *The Lori Osinski Award for Excellence in Procedural Nursing*



Melissa Cunningham, BSN, RN, Pavilion 7, is the recipient of *The Barbara and Jack Tarditi Award for Excellence in Nursing Mentorship*

Joe Halin, BSN, RN, Kelemen 9, is the recipient of *The Carol G. Tracey Compassion Award*

Vivek Kulkarni, MD, MHS, EdM, FACC, Cardiology, is the recipient of *The Nursing Alumni Excellence Award for Nursing-Physician Partnership*

Alyssa Burns, BSN, RN, Cooper Digestive Health Institute, is the recipient of *The Women's Board of Cooper University Health Care Award for Excellence in Ambulatory Nursing*

Madison DiGioia-Ruiz, BSN, RN-BC, Kelemen 9, is the recipient of *The Selma and Martin Hirsch Award for Excellence in Medical Surgical Nursing*

Sue Hoffman, BSN, RN, CCRN, TCRN, Neuroscience ICU, is the recipient of *The Philip and Carole Norcross Award for Nurse Leadership*

Chitra Lalwani, BSN, RN, Trauma Surgical Intensive Care Unit, is the recipient of *The Shaina Horton Memorial Award for Excellence in Service*

(continued on page 15)

2023 Nursing Excellence Award Winners & Nurse of the Year

(continued from page 14)

Patrick Matlack, MSN, RN, CNL, Clinical Education, is the recipient of *The Barbara and Jack Tarditi Award for Excellence in Nursing Research*

Laura McMaster, MSN, APN-C, ACNP, CCRN, TCRN, Trauma APN, is the recipient of *The Moorestown Auxiliary Award for Excellence in Advanced Practice Nursing*

Erin Radomicki, BSN, RN, CNOR, Operating Room, is the recipient of *The Philip and Carole Norcross Award for Excellence in Perioperative Nursing*

Yolanda Smith, Pavilion 9, is the recipient of *The Women's Board of Cooper Hospital Allied Health Professional Excellence Award* (Non-Nursing)

Kelly Van, BSN, RN, Kelemen 10, is the recipient of *The Ruth Parry/ Moorestown Auxiliary Award for Excellence in Geriatric Nursing*

Professional Development and Recognition Council, Professional Nursing Council, is the recipient of *The Lori Osinski Award for Excellence in Self Care and Wellness*

Kelemen 10 is the recipient of the *Outstanding Team Award*

ROLE SPOTLIGHT

An interview with Steven Di Blasi, Certified Surgical Technologist

Hi Steven! Thank you so much for taking the time to chat with us today! We wanted to highlight your role as a Certified Surgical Technologist (CST) in the Operating Room (OR). This is such an important role with so many different opportunities available, we want everyone at Cooper University Health Care (CUHC) to get a better idea of what you do. Can you describe what a day in the life of a CST looks like for you?

Usually, the first thing I do after getting my assignment and finding out the OR schedules for the day, is to prepare myself mentally. A big part of that is finding out which team I'll be working with that day. Teamwork and comradery are so important in the OR. The OR can't function without all the roles, you need everyone to have a successful day. Anything from dropping an instrument to positioning a patient, you need the whole team. The bond that you have with your team is irreplaceable, no other job in the world even comes close!

What do you love most about your role?

Definitely the opportunity to work as a team and being able to contribute to that particular surgery. I also work as a firefighter and we have strong bonds, but it's nothing like the bond we have in the OR.

In this role, you really get to see patients through all stages of their care; you see patients on their worst days, all the way to their best days. It's more direct-care, patient interaction than most people probably think. Another reason I love my role is that I get to work with so many interdisciplinary teams when teaching medical students and peri-operative nurses. The surgeons will listen to us and ask for suggestions. We are the MacGyver's of the surgery! We are always thinking "how can we make this surgery have the best possible outcome."

What do you wish more people knew about your position?

The CST field can be hard to market in comparison to nursing — we are not the nurse. You can scrub any of the specialties that we have at CUHC. There is a lot of variability and opportunity, it's just something I'm passionate about. This role is really hands on with the patient and their experience.

For more information about Certified Surgical Technologist career opportunities, please visit jobs.cooperhealth.org

Ladder Appointments

LADDER APPOINTMENTS:
2nd Quarter 2023

Level 2

Kelsey Berglund . . . . . NICU
Deanna Checchio . . . . . OR
Brittany-Leigh Cucunato CCL
Ramona D'Souza . . . . . CCU
Christine Fitzpatrick . . . . . NICU
Taylor Forrest . . . . . PACU
Mercy Kuye . . . . . CCU
Marcella Lomonaco . . . . . PACU
Laura Matysiak P7
Casey McGovern K10
Samantha McQueen . . . . . NICU
Giana Moffa P9
Maureen Obidike P7
Dana Reimers . . . . . ED
Shanta Rembert K9
Susan Snuffin . . . . . PACU
Elizabeth Thackston P9

Level 3

Chad Astemborski . . . . . CCU
Kacie Brien . . . . . CCU
Peter Carmody-Burns K3
Daria Christensen . . . . . SCU
Nicole Coryell . . . . . CCU
Tess Elanni . . . . . ED
Melissa Hirsh . . . . . ED
Kimberly Kurtz P6
Alena Pascucci . . . . . CU

Level 4

Alena Pascucci . . . . . CCU
Olivia Barry . . . . . L&D
Tara Berwick . . . . . TICU
Michelle Brown . . . . . ICU
Samantha Brown P9
Patty Budic . . . . . CDHI
Alyssa Burns . . . . . CDHI
Colleen Carr . . . . . CDHI
Candis Christopoulos . . . . . ED
Kyle Counsellor . . . . . MDA
Vincent Cucunato CCL
Shakella Davis . . . . . CDU
Shaye Deopp . . . . . TICU
Madison Ruiz K9
Devon Donaghy . . . . . TICU
Juliet Esposito K9
Adina Farcas . . . . . TICU
Samantha Frampton . . . . . MDA
Eva Gelernt . . . . . CCU
Lindsay Giordano . . . . . TICU
Casey Glatts . . . . . TICU
Michael Hannings CCL
Chelsea Hunter . . . . . CDHI
Donisha Jones . . . . . MDA
Nicole Kipp . . . . . MDA
Chitra Lalwani . . . . . TICU
Alyssa Lopane . . . . . NICU
Haylee Loveland P5
Nicole Magargal . . . . . TICU
Lauren Meiselman . . . . . TICU
Diane Myers . . . . . VSC
Brittnay O'Hara . . . . . ED
Danielle Pecora . . . . . TICU
Liza Pogozelski . . . . . TICU
Lynn Pyle . . . . . Peds
Amanda Rader . . . . . TICU
Amanda Roma . . . . . TICU
Suzanne Schmidt . . . . . TICU
Dipti Shah . . . . . CDHI
Madeline Bisbiglia . . . . . Endo
Brandon Simpkins P5
Barbara Smith . . . . . CDHI
Dana Thames . . . . . CCU
Glory Veluz CCL
Brenna Vitarelli . . . . . CDHI
Christine Wadehn . . . . . CDHI
Diane Yerkes . . . . . VSC

Level 5

Suzanne Butler . . . . . PICU
Deihann Cooper . . . . . CSC PACU
Carolyn Decina . . . . . OR
Marie Eagan . . . . . VSC
Michael Filipczak . . . . . AIR
Catherine Hassinger . . . . . CDHI
Kay Joseph P7
Kelsey Maugeri . . . . . TICU
Susan McClane . . . . . VSC
Janine McNamara . . . . . CDHI
Elizabeth Moriarty P7
Henry Muzones CCL
Rachael Peters . . . . . TICU
Alexis Postorivo . . . . . AIR
Caitlin Press . . . . . POOL
Jean Rabbutino . . . . . CDHI
Kathryn Reifsnyder . . . . . CDHI
April Socarras CCL
Jodie Szalma . . . . . ICU
Steve Teitelman . . . . . AIR
Genalyn Vargas . . . . . TSDU
Samantha Wirsch . . . . . TICU

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