9TH ANNUAL REGIONAL CONFERENCE FOR HEALTH CARE PROFESSIONALS

21st Century Visions of Nursing

Proceedings Book

Excellence Through Knowledge

September 12-13, 2012 * 7 a.m. – 4 p.m. each day

John H. Ammon Medical Education Center
Christiana Hospital Campus, Newark, Delaware
Agenda

Wednesday, September 12, 2012 7:00 a.m. – 7:30 a.m.  Registration/Breakfast - Lobby
7:30 a.m. – 7:45 a.m.  Welcome – Diane Talarek, RN, MA, CNA
7:45 a.m. – 8:45 a.m.  Keynote Address - Auditorium
  Kathryn Roberts, MSN, RN, CNS, CCRN, CCNS
  “DARE TO” (page 2)
8:45 a.m. – 9:00 a.m.  Break/Vendor Displays/Poster Presentations – Lobby

9:00 a.m. – 10:00 a.m.  Breakout Sessions

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10:00 a.m. – 10:15 a.m.  Break/Vendor Displays/Poster Presentations – Lobby

10:15 a.m. – 11:15 a.m.  Breakout Sessions

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<td>Take Control! What You Need to Know About Basic Estate Planning,</td>
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<td>Make No Bones About It… The Truth About Bone Health</td>
<td>Jennifer Pugh</td>
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11:15 a.m. – 12:00 p.m.  Lunch/Vendor Displays/Poster Presentations – Lobby

12:00 p.m. – 1:00 p.m.  Mid-note Address - Auditorium
  Sharon Anderson, RN, BSN, MS, FACHE
  “The Cost of Harm” (page 32)

1:00 p.m. – 1:15 p.m.  Break/Vendor Displays/Poster Presentations – Lobby

1:15 p.m. – 2:15 p.m.  Breakout Sessions

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<td>Change Your Strategies – Change Your Outcomes</td>
<td>Gwen Ebbert, Susan Mascioli, Carmen Pal</td>
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<td>Cancer Survivorship: Navigating the Road to Wellness</td>
<td>Cynthia Waddington, Darcy Burbage</td>
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2:15 p.m. – 2:30 p.m.  Break/Vendor Displays/Poster Presentations – Lobby

2:30 p.m. – 3:30 p.m.  End-note Address – Auditorium
  Bonnie Osgood, MSN, RN-BC, NE-BC
  “IOM Future of Nursing” (page 41)
DARE TO

American Association of Critical-Care Nurses
Do You Dare To?

Kathryn E. Roberts, MSN, RN, CNS, CCRN, CCNS
President – The American Association of Critical Care Nurses
Clinical Nurse Specialist
Children’s Hospital of Philadelphia – Philadelphia, PA

Abstract/synopsis:

AACN President Kathryn Roberts’ theme “Dare To” as a framework, this interactive presentation will help participants identify what they can do to optimize their contributions to their patients and their families, their colleagues, and themselves.

Learning outcomes:

At the completion of this session, you should be able to:
1. Describe what daring looks like for you and discuss the barriers that frequently prevent us from pursuing our “Dare To’s”
2. Compare and contrast risk taking and engaging in risky behavior
3. Identify the “Dare To(s)” that will have the most impact for your own professional and personal life

Detailed outline:

I. Introduction

II. Daring

III. Common Barriers

IV. Risk Taking

V. Engaging in Risky Behavior

VI. Your Dare To(s)
   a. Name your Dare To
   b. Share your Dare To
   c. Act on your Dare To

VII. Conclusion
Bibliography:

Notes:
New Interventions for Fall Prevention in Hospitalized Older Adults
Barbara E. Harrison, PhD, GNP, BC
Associate Professor, School of Nursing
University of Delaware – Newark, DE

Abstract/synopsis:
This session will describe new interventions for fall prevention in acute care settings. Beginning with the significance and impact of falls in on health care outcomes for older adults, the speaker will explain the evidence for current fall prevention interventions, discuss the limitations to current fall prevention interventions, and identify new interventions for fall prevention.

Learning outcomes:
At the completion of this session, you should be able to:
1. Comprehend the significance and impact of falls in acute care settings on health care outcomes for older adults.
2. Understand the evidence for current fall prevention interventions
3. Recognize the limitations to current fall prevention interventions
4. Identify three new interventions for fall prevention

Detailed outline:
1. Significance and impact of falls in acute care settings on health care outcomes for older adults
   a. Prevalence of falls in acute care settings
   b. Injuries due to falls in acute care settings
   c. Impact on quality
   d. Impact on safety
2. Evidence for current fall prevention interventions
   a. Rounding
   b. Sitters
   c. Bed alarms
   d. Surveillance
3. Recognize the limitations to current fall prevention interventions
   a. Complex systems
   b. Reliability
   c. Sensitivity
   d. Environment

4. Identify new interventions for fall prevention
   a. Motion sensing devices
   b. Optical sensing devices
   c. Pressure sensing devices

5. Gait assist devices

Notes:
Heart Failure: Optimizing Therapies to Advancing Care Options

Carolyn M. Moffa, MSN, FNP-C, CFHN
Deborah Dougherty, MSN, RN
Heart Failure Program / VAD Program
Christiana Care Health System – Newark, DE

Learning outcomes:

At the completion of this session, you should be able to:

1. Discuss heart failure NYHA Classes and Stages
2. Apply the ACC/AHA Guidelines to a heart failure patient
3. Understand advanced options for Stage D/NYHA Class IV Heart Failure

Detailed outline:

1. Heart Failure Staging
2. Indications for LVAD
   a. Bridge to Transplant
   b. Destination Therapy
   c. Bridge to Decision
3. Case Study: 30 yo Female with Post-Partum Cardiomyopathy
   a. Diagnoses
   b. Treatment
4. Outcomes and the Path Forward

Notes:

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Families: Integral Team Members or “Just Visiting”?  
Kathryn E. Roberts, MSN, RN, CNS, CCRN, CCNS  
President – The American Association of Critical Care Nurses  
Clinical Nurse Specialist  
Children’s Hospital of Philadelphia – Philadelphia, PA

Abstract/synopsis:

The Patient and Family Centered Care movement began more than 15 years ago. Despite this, acute and critical care healthcare providers continue to struggle with family presence and determining what role(s) the family plays on the healthcare team. This session will provide an overview of the key concerns of healthcare providers related to family presence in acute and critical care settings, families’ perspectives on their role with the healthcare team and strategies for optimal integration of families into the healthcare team.

Learning outcomes:

At the completion of this session, you should be able to:

1. Identify the top three concerns that healthcare providers verbalize related to increased family presence in the acute and critical care settings  
2. Discuss the contributions that families of acute and critically ill patients can provide to the healthcare team  
3. Describe strategies for integrating families into the healthcare team

Detailed outline:

Introduction
What is the role of the family in the care of their child?  
• A “visitor” in the healthcare setting?  
• Integral member of the healthcare team?

Background
• How long have we been talking about this?  
• Why are we still talking about this?

Patient and family centered care (Institute for Family Centered Care)
• Dignity and Respect  
  o Health care practitioners (HCP) listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.  
• Information Sharing  
  o HCP communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making
• **Participation**
  - Patients & families are encouraged and supported in participating in care and decision-making at the level they choose

• **Collaboration**
  - Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

**Clinical Practice Guidelines for the Support of the Family in the Patient-Centered Intensive Care Unit (ACCM 2004-2005)**

- Decision Making
- Family Coping
- Staff Stress Related to Family Interactions
- Cultural Support of the Family
- Spiritual/Religious Support
- **Family Visitation**
  - Family Environment of Care
- **Family Presence on Rounds**
  - Family Presence at Resuscitation
- Palliative Care

**AACN Practice Alert: Family Visitation in the Adult ICU (2011)**

**Expected Practices:**
1. Facilitate unrestricted access of hospitalized patients to a chosen support person
2. Ensure that the facility/unit has an approved written practice document
3. Evaluate policies to ensure that they prohibit discrimination
4. Ensure that there is an approved written practice document for limiting visitors whose presence infringes on the rights of others or their safety

**Current State of Visitation:**

**Healthcare Provider Concerns**
- Increased physiologic stress for the patient
- Interference with provision of care
- Physical and mental exhaustion of family and friends
- Deleterious Impact on Family & Friends

**Families’ needs:**
- Maintain hope
- Have questions answered honestly
- Prompt notification of status changes
- Assurance that loved one is receiving quality care
- Continuity of care providers
- Allowed to visit anytime
- Families and rounds…
Families on Rounds:

Benefits:
- Increased patient/family involvement in care
- Allowed MDs to be better role models for trainees
- Improved patient/family understanding of discharge goals
- Resulted in effective team communication
- Efficient discharge, unit workflow & MD time management
- Perceived increased RN participation on FCR

Perceived barriers:
- Size of rounding team
- Trainees’ fear: families’ loss of respect if they appeared not to know the answers
- Small room size
- Prolonged duration of rounds b/c of parent questions (perceived)
- Inefficient rounds
- Patient confidentiality concerns
- Perceived lack of buy-in by MDs & others
- Negative impact on work-flow

Families’ perspectives:
- Communicate with the healthcare team
- Understand the plan
- Participate in decision making about their child’s care
- Perceive that their presence improves their child’s care
- Being present increased confidence in HC team
- Preferred lay terminology
- Preferred inclusion of nurses

**Families may have different needs on day 1 of admission**

Family Presence Strategies – the “3 C’s”
- Communication
- Consistency
- Continuing education & evaluation

Strategies Continued:
- Communication of guidelines
- Consistency in interactions
- Consistency in dealing with issues
- Continuing education
- Evaluation
- Modification of guidelines as appropriate
- Room to be flexible
- Strategies
- Be prepared to establish limits
• Zero tolerance policy for unacceptable behavior
• Give families “permission” to leave
• Staff must have (or develop) skill in providing care in front of families
• Scripting
• Non-defensive attitude when questioned
• Provide frequent, accurate, current & consistent information
• Reinforce the importance of the family role & presence

Challenges:
• Inconsistency in the level of comfort with families
• Can wreak havoc on already struggling family members
• Perceptions of inconsistencies leads to mistrust
• Bedside providers may feel threatened
• Increased time with families may take away from patient care time
• Hyper-vigilant families
• Safe, confidential unit operations
• Traffic control
• Infection Control
• Families don’t always behave in the best interest of the patient

Conclusions:
• Continues to be a substantial culture change
• Ask patients, families AND the healthcare team what works
• Use evidence to guide practice

References/Resources:


**Notes:**
Head and Neck Cancers - Link to HPV
LaTonya E. Mann, BSN, RN, OCN, CRNI
Head and Neck Nurse Navigator
Helen F. Graham Cancer Center
Christiana Care Health System - Newark, DE

Abstract/synopsis:
Head and neck cancer is defined as tumors arising in the oral cavity, oropharynx, hypopharynx, nasopharynx, lip, larynx, paranasal sinus, salivary gland, and mucosal melanoma. It represents 3% of all cancers in the United States, with $3.1 billion spent annually on treatment. An estimated 650'000 new cases of head and neck cancer are diagnosed worldwide each year. Head and neck cancer was the tenth most commonly diagnosed form of cancer in men worldwide in 2008. Approximately 20% of patients with head and neck cancer are non smokers and nondrinkers. These figures indicate the presence of other risk factors.

Learning outcomes:
At the completion of this session, you should be able to:

1. Define head and neck cancer
2. Understand the epidemiology and pathophysiology of HPV related head and neck cancer
3. Discuss the risk factors and nursing implications for HPV related head and neck cancer

Detailed outline:

I. Introduction
II. Definition of head and neck cancer
   A. Location
   B. Staging classifications
III. Epidemiology and Pathophysiology
   A. Incidence
   B. Prevalence
   C. Risk Factors
IV. Implications for nurses
   A. Treatment choice
   B. Side effects for treatment
   C. Patient education
V. Discussion
   A. Case Report
   B. Conclusion
VI. References and Resources
Learning outcome:

At the completion of this session, you should be able to:

1. Participants will be able to identify 3 common treatments for OA in the elderly

Detailed outline:

1. Definition of osteoarthritis (OA)
2. Prevalence of OA
3. Common sites of OA
4. Signs and symptoms and physical findings of OA
5. Making the diagnosis of OA
6. Nonpharmacologic treatments for OA
   a. Diet
   b. Exercise
   c. Braces, splint
7. Physical and occupational therapy interventions
8. Nutritional supplements
9. OTC treatments: gels, patches
10. Mechanism of action of NSAIDS
11. OTC NSAIDS: ibuprofen, naproxyn sodium
12. Risk factors for GI adverse events
13. Side effects of NSAIDS
14. Analgesic therapy : Acetaminophen
   a. Dosing and indications
   b. Adverse effects
   c. Signs and symptoms of liver damage
15. Prescription NSAIDS
   a. Naproxen
   b. Etodolac
   c. Diclofenac
   d. Nabumetone
16. Black box warning for NSAIDS
17. Side effects of NSAIDS
18. Cox 2 inhibitor: Celebrex
19. Tramadol (Ultram)
   a. Mechanism of action
   b. Dosages
   c. Indications
   d. Side effects
20. Narcotic Analgesics: mechanism of action
   a. Tylenol with codeine
   b. Hydromorphone/acetaminophen
   c. Oxycodone/acetaminophen
   d. Oxycodone, oxycontin
   e. Black box warnings for narcotics
   f. Side effect profile for narcotics
21. Morphine: indications, dosages
22. Hydromorphone: indications, dosages
23. Fentanyl: indications, dosages
24. Adjuncts for pain management
   a. Lidoderm patches
   b. Duloxetine (Cymbalta)
25. Viscosupplementation: mechanism of action, brands
26. Intra-articular steroids: indications
27. Surgical options

References Available

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The Ups and Downs of Malignant Hyperthermia
Marianne Hess, MSN, RN, CCRN
Education Coordinator
George Washington University Hospital – Washington, DC

Abstract/synopsis:
Content intended to increase awareness of this life threatening disorder

Learning outcomes:
At the completion of this session, you should be able to:

1. Describe four triggers of malignant hyperthermia
2. Explain three signs and symptoms of malignant hyperthermia
3. Examine treatment modalities of malignant hyperthermia

Detailed outline:

I. Definition of malignant hyperthermia
II. Cause
   a. Cell defect
   b. Triggers
   c. Non-triggers
III. Statistics
    a. Occurrence
    b. Mortality
IV. Signs & Symptoms
    a. Temperature
    b. Muscle rigidity
    c. Respiratory
    d. Cardiovascular
    e. Skin
    f. Laboratory
V. Diagnosis
   a. Misdiagnosis
   b. Patient history
   c. Masseter muscle rigidity
   d. Caffeine Halothane
   e. Contracture Test
   f. Molecular genetic testing
VI. Treatment
   a. Teamwork
   b. Plan
   c. Initial treatment
d. Administration of dantrolene sodium  
e. Other medications  
f. Cooling  
g. Monitoring devices

VII. Post-event evaluation  
  a. Emotional support to patient  
  b. Report event to MHAUS  
  c. Evaluate team’s performance  
  d. Patient education  
  e. Utilize resources  
  f. Prevention

VIII. Conclusion

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Learning outcomes:

At the completion of this session, you should be able to:

1. Understand the ability to make informed decisions regarding estate planning for yourself and family members
2. Understand the importance of having proper estate planning documents in place
3. Minimize or eliminate federal estate taxes and probate fees on your estate

Detailed outline:

I. Introduction

A. What is Estate Planning?
   Arranging one's affairs to promote growth and preservation of assets during lifetime and the orderly distribution of wealth at death.

B. What is in your estate?
   All property in which you have an ownership interest: all property in your sole name, all property titled jointly with others, all beneficiary-designated assets, all assets titled in the name of your revocable trust, all TOD/POD assets.

C. Why is Estate Planning important?
   1) To control the Disposition of Property
      a. Certain property passes by operation of law
      b. Property passes through wills and testamentary trusts
      c. Property passes through revocable/inter-vivos trusts
   2) To Minimize/Eliminate the Probate Process and Fees
   3) To Minimize/Eliminate Transfer Taxes
      a. Estate tax
II. Controlling the Disposition of Assets

It is essential to understand how your assets will pass at your death (the consequences of the different types of property ownership) and to coordinate your asset ownership with your estate plan.

A. Solely-Owned Property
   Solely-owned property passes through your Will at your death.

B. “Jointly”-Owned Property
   1) Tenancy by the entirety (for married couples)
   2) Joint tenancy with right of survivorship (JROS)
      Property owned as tenants by the entireties and in joint tenancy with right of survivorship (JROS) will not pass through your Will but will pass by operation of law to the surviving joint owner.
      
      NOTE! As a general rule, it is not advisable to own assets jointly, with right of survivorship (JROS), particularly with someone other than your spouse. It does not avoid taxes, and it can destroy your estate plan.

   3) Tenants in common property
      Property owned as tenants in common is solely-owned property and does pass through your Will.

C. Beneficiary-Designated Assets
   Beneficiary-Designated assets not pass through your Will, but rather pass by contract to the named beneficiaries.

   1) Life insurance
   2) Annuities
   3) Retirement plan accounts including IRAs, TSAs, 401(k)s
   4) TOD/POD accounts
      So-called “transfer on death” or “payable on death” accounts are similarly problematic for same reasons as JROS accounts, and in addition are also subject to the claims of creditors.

D. If you do not have Will?
   If you do not have Will, your solely-owned property will pass in accordance with the
state intestacy laws.

E. What is in your estate?
All property in which you have an ownership interest, in your sole name, or jointly with others is “in your estate.”

1) Tangible personal property: auto, jewelry, precious metals, coins, personal possessions

2) Real property: house, real estate

3) All intangible assets: bank accounts, annuities, stocks, bonds, mutual funds, limited partnership interests, retirement plan proceeds (in some instances), life insurance

III. Wills

A. Why have a Will?

1) To control the disposition of assets

2) To create a trust for minor or disabled beneficiaries

3) To provide gifts to charities or friends

4) To minimize estate taxes

IV. What is Probate?

A. “Probate” is the winding up of your affairs at your death. The only way to avoid “probate” is to die having no assets.

1) “Marshall” and value the decedent’s assets

2) Pay the decedent’s debts

3) Prepare and file the decedent’s final personal income tax returns

4) Make distribution to the decedent’s beneficiaries

5) “Small” estates can be administered informally – a “Small Estate Affidavit” will be required to transfer/dispose of the decedent’s solely-owned assets.

B. The “Formal” Probate Process:
It is necessary to open a formal probate estate at the Register of Wills Office if the decedent owned in his sole name at the time of his death: non-real estate assets
having a value of $30,000 or more or real estate of any value. To the foregoing, the administration of the decedent’s estate through the Register of Wills office only adds:

1) Preparation and filing of an estate Inventory

2) Preparation and filing of an Accounting

3) The probate fees:
   Payable to the Register of Wills (DE): 1.75% of “probate assets”, which consist of the decedent’s solely-owned personal property: stocks, cash, bank accounts, tangible personal property, personal belongings, savings, bonds, etc. (real estate, pension benefits, life insurance, jointly-owned property and trust property are excluded).

4) How can you minimize “probate”?
   a. The probate process: You can’t eliminate it entirely
   b. The probate fees: You probably won’t eliminate them entirely, but you can minimize them significantly with a funded revocable trust

   ++ Caution: Pre-death transfers of appreciated assets “to avoid probate” nearly always have greater adverse tax consequences than if the assets passed through the decedent’s estate.

C. Preparation and filing of federal and state estate tax returns, inheritance tax returns, possible ancillary estate administration in other jurisdictions in which the decedent owns real estate, preparation of federal and state fiduciary income tax returns for the decedent’s estate and/or trust.

V. Trusts

A. What is a trust?
   1) A trust is a relationship established when one party (the trustor) transfers property to a second party (the trustee) who must use those assets solely for the benefit of a third party (the beneficiary).
   2) The same person can be the trustor, the trustee, and the beneficiary.

B. Types of Trusts
   1) Living v. testamentary trusts
   2) Funded v. unfunded
3) Revocable c. irrevocable

C. Why a trust?

1) Non-tax reasons
   a. Control disposition of assets beyond one generation
   b. Management of assets
   c. Privacy
   d. Spendthrift provision
   e. Plan for disability

2) Tax reason = avoidance of probate fees

VI. The Tax System.
There are essentially two death tax systems that may come into play when a person dies: the federal and the state estate tax, and the state inheritance tax. Effective for decedents dying on or after January 1, 1999, the Delaware inheritance tax has been repealed. Pennsylvania, Maryland, and New Jersey estates are still subject to state inheritance tax.

A. Federal Estate Tax.

1) Based on the total value of the decedent’s gross estate minus available deductions and credits

2) Rate: 35% for decedents dying in 2012

3) Unlimited deduction allows tax-free gifts between spouses (who are U.S. Citizens)

4) Personal unified credit exemption allows $5 Million to pass free from federal estate and gift tax to persons other than spouses (2012)

5) The personal unified credit exemption is scheduled to sunset back to $1 million in 2013 in the absence of further legislative action

B. Delaware Estate Tax
Delaware’s estate tax was effectively repealed beginning in 2006. The Delaware legislature adopted a statute, however, imposing an estate tax for persons dying on or after July 1, 2009 and before July 1, 2013. The exemption amount is the same as the exemption for the federal estate taxes: $5 million. The rates in the new statute range
from 5.6% to 16%, depending upon the size of the taxable estate.

VII. **Revocable Trusts.**

A. **Funded Revocable (living) Trust:** Created by written document in one’s lifetime.

   Purposes:
   1) To plan for disability during lifetime
   2) To allow the trustor to oversee the successor trustee’s management of the trust fund
   3) To avoid **probate fees** at death. Assets must be titled in the name of the trust prior to death to avoid probate fees

   **Probate fees:** Payable to the Register of Wills (Delaware): 1.75% of “probate assets”, which consist of the decedent’s solely-owned personal property: stocks, cash, bank accounts, tangible personal property, personal belongings, savings, bonds, etc (real estate, pension benefits, life insurance, jointly-owned property and trust property are excluded).

   4) To avoid the “formal” probate process at death

B. Income tax treatment when trustor (grantor) is trustee or co-trustee

C. Does not eliminate the need for a will.

VIII. **Ways to Minimize Death Taxes**

A. For married couples, utilizing the federal exemption from estate tax available to the estate of the first spouse to die

B. Lifetime or testamentary charitable gifts.

C. **Lifetime gifts to individuals**

   1) Tax-free gifts

      a. Annual Exclusion Gifts
         $13,000 individual/$26,000 for married couple, per donee/45% savings, adjusted for inflation after 1998, in multiples of $1,000 Lifetime exclusion of $5 million individual/$10 million couple (for 2012).

      b. Medical/education expenses directly paid
2) Choose the assets to be gifted wisely

   a. Gifts of highly appreciated assets will cause adverse income tax consequences to the done (carryover basis during lifetime v. stepped up basis at death).

   b. Gifts of assets expected to appreciate in the future removed the future appreciation from the estate of the donor

   c. Income tax deferred gift to charity

3) Delaware gift tax repealed for gift after 12/30/97. Transfer-tax-free gifts can be made in excess of the annual exclusion amount, using all or a portion of the donor’s federal unified credit exemption.

IX. Import Documents

A. Durable Powers of Attorney – The “new” Durable Personal Power of Attorney – the financial decision-making. There is a new form as of October 1, 2010. All Powers of Attorney executed before that date are valid, but any Powers of Attorney executed after that date need to comply with the new requirements.

   1) New execution requirements: Must be signed in the presence of one (1) witness and a notary, who may not be related to the principal by blood, married, or adoption and who is not entitled to any portion of the principal’s estate under the principal’s then existing Will or Trust Agreement.

   2) Notice of Principal

   3) Statement to Agent/Agent’s Certification

      a. The Agent will have no authority to act unless the agent has executed the certification

   4) Do NOT use the statutory form!

   5) JROS ownership is NOT an appropriate substitute for a Power of Attorney.


C. Will

D. Revocable Trust Agreement

E. Guardianship Designation for Minor Children/Children with a disability
X. Other Considerations

A. Guardianship May Be Required
   Take control! Everyone eighteen (18) years of age or older needs a Durable Personal Power of Attorney (for financial decision-making) and an Advance Directive for Health Care (for medical decision-making). Without both powers of attorney, if an adult becomes incompetent, a formal court-ordered guardianship may be required.

   1) A Power of Attorney enables a person to act for the principal, but it does not prohibit the principal from legally acting on his own behalf. If a person is acting in a manner that is harmful to himself or others, a court-ordered guardianship may be required for his protection.

   2) The Affidavit of a physician is required.

   3) It is not the ideal situation. It is not the same as a Power of Attorney. All assets must be titled in the name of the guardianship, withdrawals from the guardianship account can only be made with a Court Order, and there are continuing reporting and accounting requirements to the Court of Chancery.

   4) It is not the answer to dealing with a difficult person (to “make” him do what you think is best for him). The necessity of a personal relationship does not go away.

B. Planning for Families with Children with Special Needs

   1) Guardianship v. Power of Attorney for a person with a disability.

   2) Special Needs Trusts.
      The trustee is given the broadest possible authority to expend principal for the benefits of the person with a disability, while at the same time protecting the person’s eligibility to receive needs-based governmental benefits (SSI, Medicaid). Income and asset tests.

   3) The Pooled Trust – Delaware Care Plan, Inc.

C. Your Fiduciaries Must be Educated as to Their Fiduciary Responsibilities
   Avoid family problems, financial exploitation: educate your fiduciaries and your family as to the fiduciary’s role and responsibilities. It’s not intuitive!

   1) Educate fiduciaries as to their role

   2) Educate families as to what the fiduciary should be doing and as to what they can reasonably expect to happen in connection with the management of the affairs of the disabled family member.
3) **Fiduciary Consultations, Family Meetings with an Elder Law Attorney**

The ideal time for a “fiduciary consultation” and/or “family meeting” with an elder law attorney is before problems occur: before a person begins to decline or just when a person begins to decline, when the person named in the Power of Attorney is about to take over.

a. **Fiduciary Consultation.**
   Ideally this is a meeting of the principal and his/her fiduciary. The purpose is to educate the fiduciary (power of attorney for financial matters, medical power of attorney, executor, personal representative, trustee) as to his/her fiduciary obligations.

b. **Family Meeting.**
   Ideally this is a meeting of the principal and all of the family members he/she wishes to include, in person by phone. The purpose of the family meeting is to allow everybody to freely air their concerns and ask questions, and for an impartial elder law attorney knowledgeable in the law can give them the impartial answers. It is ideal when the principal can be part of the meeting and for the meeting to occur before the situation becomes adversarial.

D. **Consider the (Capital Gains) Tax Consequences of Transferring Assets out of the Name of an Imminently Terminally Ill Person**

For gifts made during a person’s lifetime, the donee takes the donor’s “carryover basis.” Consequently when the donor makes a lifetime gift of an appreciated asset, when donee sells the asset, either before or after the donor’s death, capital gains taxes will be owing on the appreciation.

Appreciated assets get a stepped-up basis to date-of-death fair market value. Consequently, when a beneficiary sells an inherited asset the capital gains taxes on the appreciation to date of death is avoided.

E. **Medicaid Planning for the “Community Spouse”**

1) All assets are considered a “resource available to the Medicaid spouse,” whether solely-owned, jointly-owned by spouse, jointly-owned with someone other than a spouse, or whether owned by the spouse solely or jointly with another.

2) There is a 5 year “look-back” period. There is an exception to the 5 year look-back for transfers of a person’s home when “but for” the fact a child lives in the parent’s home the parent would have had to move into a nursing home 2 years earlier.

3) The income follows the individual. The community spouse may petition Medicaid to keep a portion of the Medicaid spouse’s income if he/she can show he/she needs it to live on.
4) Plain vanilla estate planning for the “community spouse”:

   a. Re-title assets in community spouse’s sole name

   b. Eliminate Medicaid spouse from community spouse’s Will

   c. Remove Medicaid spouse as beneficiary of beneficiary-designated assets owned by community spouse

   d. Possibly set assets aside in an information arrangement with family members

Notes:
Learning outcomes:

At the completion of this session, you should be able to:

1. Identify patients who are at risk for bone fractures and appropriate patient screening
2. Understand the pathophysiology of bone metastases and which types of cancers are most likely to metastasize to the bone
3. The learner will understand the treatments for osteopenia, osteoporosis, and bone metastases

Detailed outline:

Section I: Osteopenia and Osteoporosis

Osteopenia: a condition where the bone density is lower than normal, but not as low as osteoporosis. It is considered a precursor to osteoporosis.

Osteoporosis: a condition where there is low bone mass, deterioration of the microarchitecture, and increase fragility of the skeleton. It is defined as a Bone Mineral Density (BMD) 2.5 standard deviations or more below the average mean peak bone mass.

A. Who is at an increased risk of developing a bone fracture?

There are multiple risk factors that increase a person’s risk for developing a bone fracture in addition to their actual BMD including:

- Advanced age
- Personal or family history of a fracture as an adult
- Long term steroid use
- Low body weight
- Cigarette smoking and excessive alcohol consumption
- Medical Disease including: rheumatoid arthritis, inflammatory bowel disease, celiac disease, cystic fibrosis, hyperthyroidism, diabetes, and renal disease
- Vitamin D deficiency
- Reduced functional mobility
- Medications including: androgen deprivation agents, aromatase inhibitors, proton pump inhibitors, selective serotonin reuptake inhibitors, thiazolidinediones, and anticonvulsants
B. Screening for osteopenia and osteoporosis:

Screening is recommended for all women aged 65 years or older or any younger woman whose fracture risk is equal to or greater than that of a 65-year-old white woman.

Measurement of Bone Density:
- Dual-energy x-ray absorptiometry (DXA) gives a precise measurement of bone density. It is the screening tool recommended by the WHO.
- Risk Factor Screening Instrument:
  Fracture Risk Assessment Tool (FRAX) is a tool to predict the ten year probability of hip fracture or major osteoporotic fracture in an untreated patient. It combines the DXA measurement with specific clinical risk factors.

C. Treatment of osteopenia and osteoporosis

When should pharmacological treatment be initiated?
1. Nonpharmacologic Treatments
   - Lifestyle Modifications
   - Calcium and Vitamin D
2. Pharmacologic Treatments
   - Bisphosphonates
   - Selective estrogen receptor modulators (SERMs)
   - Estrogen/Progestin therapy
   - Parathyroid Hormone
   - Denosumab
   - Strontium Ranelate

D. Current Recommendations for Calcium and Vitamin D intake
- Premenopausal women
- Men
- Postmenopausal women

Section II: Cancer and Fracture Prevention

A. Bone Metastases

Most commonly seen in metastatic breast and prostate cancer but can occur in all advanced cancers.

Two types of bone mets:
- osteolytic lesions: the destruction of normal bone
- osteoblastic lesions: involve the cells that repair bone.

Complications of bone metastases include:
- Pain
- Skeletal events (SREs) including:
  - Spontaneous Fractures
• Spinal Cord Compression
• Hypercalcemia

Treatment of Bone Mets
• Bisphosphonates:
  o Decrease the prevalence of SREs
  o Work by inhibiting osteoclast activity and decreasing bone reabsorption
  o Common bisphosphonates in high doses used to treat bone mets include
    the following: pamidronate and zoledronic acid.
  o Potential side effects include infusion related reaction including fevers,
    chills, and bone pain.
  o Patients must receive dental clearance prior to initiating therapy to
    decrease the risk of osteonecrosis of the jaw.

• RANK Ligand Inhibitors:
  o Inhibit osteoclast formation by targeting receptor activator of nuclear
    factor kappa B ligand or RANKL.
  o Significantly prolong the time to a first SRE over Zeledronic Acid in
    patients with bone mets from advanced breast and prostate cancer.
  o Denosumab is the only RANKL inhibitor on the market presently.

B. Bisphosphonates and RANKL inhibitors in the adjuvant setting in patients with breast cancer

• There is some data to suggest that bisphosphonates and RANKL inhibitors given
  in the adjuvant setting decrease the risk of developing bone metastases, but they
  are not currently approved for this use.

• Women with estrogen receptor positive breast cancer on an aromatase inhibitor
  are at an increased risk of developing osteoporosis because of the suppression of
  their estrogen.
  o Women on an aromatase inhibitor are screened every two years with a
    DXA scan.
  o Treatment with a Bisphosphonate or RANKL inhibitor is recommended to
    prevent bone loss.
  o Another anti-estrogen option for women with osteoporosis is Tamoxifen.

Notes:
Cost of Harm
Sharon Anderson, RN, BSN, MS, FACHE
Sr. Vice President, Quality and Patient Safety
Christiana Care Health System- Newark, DE

Abstract/synopsis:
This presentation will give the audience an overview of the concepts related to preventable patient harm and the toll it has on patients and families, staff involved in adverse events as well as the financial implications at a local and national level.

Learning outcomes:
At the completion of this session, you should be able to:

1. Describe preventable patient harm and give examples
2. Understand how to prevent patient harm through the use of safe practice behaviors, high reliability concepts and just culture principles
3. Identify the ways in which health care reform is driving transparency and accountability to providers to reduce patient harm

Detailed outline:
The Cost of Harm:

- Definition of patient harm.
- Change in focus – harm nationally.
- Examples of error versus harm.
- Review of the amount of harm that is occurring.
- Impact of patient harm – patients and families – as it relates to morbidity and mortality
- Impact of patient harm – staff – explanation of the valuable role of debriefs and need for disclosure.
- Impact of patient harm – financial – role health care reform is playing in driving transparency and accountability. Controversial issues related to this approach.
- Just Culture Principles and the role that they play in changing culture.
- High reliability concepts and comparison of health care to air line industry.
- How interprofessional teams and use of technology is the future in harm prevention.
- Video – demonstrating the true cost of harm.

Notes:
Change Your Strategies – Change Your Outcomes

Gwen Ebbert, BSN, RN-BC
Susan Mascioli, MS, BSN, RN, CPHQ
Carmen Pal, BSN, RN, PCCN

Quality & Safety
Christiana Care Health System- Newark, DE

Learning outcomes:

At the completion of this session, you should be able to:

1. Verbalize how to develop successful strategies for change
2. Verbalize how to improve the potential for learning retention of an audience

Detailed outline:

I. Human Factors
   a. Understanding errors
      i. The problem
      ii. The reality
      iii. The goal
   b. Human Factors Engineering
      i. What is it?
      ii. Implication for Nursing Practice
   c. Strength of Strategies
      i. Strong vs. Weak

II. Adult Learning Principles
   a. Determinants of learning
      i. Assessment of learner
      ii. Learning styles
   b. Motivation
      i. Variables
      ii. Strategies
   c. Experience
   d. Level of Engagement
      i. Readiness to learn
   e. Retention

III. So You Have To Educate – Now What
    a. Why are people not engaged?
       i. Overloaded
       ii. Email – Junk vs. Value
    b. Focus Education on What They Need
       i. All About Them (the audience)
       ii. Know Your Audience
c. Develop a Focus
   i. Headlines
   ii. Say it Simply
   iii. Use all Senses
   iv. Tell a Story

d. Make it Visual
   i. Color
   ii. Layout
   iii. Font
   iv. Images

e. Be Yourself

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Learning outcomes:

At the completion of this session, you should be able to:

1. Describe three primary concerns in the post anesthesia patient
2. Discuss two complications seen in the post anesthesia patient
3. Describe a focused assessment for a patient recovering from general anesthesia

Detailed outline:

Introduction
   a. Indications
   b. Purpose/Rationale
II. Goal
   a. Return to baseline function
   b. Prevent complications
   c. Ensure clearance of anesthetic medications
III. Introduction to general anesthesia
   a. Induction agents
   b. Inhalation gases
   c. Neuromuscular blocking agents
IV. Primary Concerns
   a. Airway maintenance
   b. Hypoxemia/Hypoventilation
   c. Hemodynamic stability
   d. Thermoregulation
V. Complications of anesthesia
   a. Nausea & vomiting
   b. Pain Management
   c. Emergence delirium
   d. Malignant hyperthermia
VI. Admission process
   a. Report from anesthesia provider
   b. Standards for assessment
   c. Perform complete physical assessment
      i. Cardiovascular
      ii. Respiratory
      iii. Gastrointestinal
      iv. Renal
      v. Skin integrity
      vi. Musculoskeletal
vii. Neurological

VII. Conclusion

Notes:

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37
Transcatheter Aortic Valve Replacement (TAVR)

Deborah Dougherty, MSN, RN
James Hopkins, MD
Christiana Care Health System
Newark, DE

**Learning outcomes:**

At the completion of this session, you should be able to:

1. Describe indications of aortic valve replacement
2. Review treatment options for aortic valve replacement

**Notes:**

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38
Cancer Survivorship:
Navigating the Road to Wellness
Darcy Burbage, RN, MSN, AOCN, CBCN
Survivorship Nurse Navigator
Helen F Graham Cancer Center Christiana Care Health System
Cindy Waddington, RN, MSN, AOCN
Clinical Nurse Specialist & Certified Wellness Coach
Helen F Graham Cancer Center Christiana Care Health System

Abstract/synopsis:
According to the American Cancer Society (2012), there are more than 11 million cancer survivors in the United States; representing 4% of the population. Due to the advances in early detection, treatment and with the growth of the aging population, cancer is becoming a chronic health condition. With the increase in numbers of survivors, the effect of cancer treatment is often times associated with long-term effects. Nurses can help patients to learn new ways to cope effectively with the stress and adversity the physical and psychosocial effects which often upset a survivors health and well-being. The purpose of today’s presentation is to provide participants with an overview of common issues facing cancer survivors and how nurses from all disciplines can assist survivors in health promotion and wellness activities to improve their quality of life.

Learning outcomes:
At the completion of this session, you should be able to:

1. Describe the most common late and long term effects of cancer treatment along with management strategies
2. Discuss the process of navigating cancer survivors through various wellness related activities and programs
3. List the resources available at the Helen F Graham Cancer Center and in the community to assist patients and families

Detailed outline:
I. History of the Survivorship Movement
   A. Institute of Medicine (IOM) Report
   B. Commission on Cancer Accreditation Standards
II. Potential Late and Long-Term Effects of Treatment
   A. Physical
   B. Psychosocial
III. Survivorship Treatment Summary and Follow-up Guidelines
   A. Available on-line templates
   B. American Society of Clinical Oncology (ASCO) and National Comprehensive Cancer Network (NCCN) guidelines
IV. Domains of wellness affected by cancer diagnosis and treatment
A. Physical
B. Psychological
C. Social
D. Spiritual

V. Navigating wellness options
   A. Within CCHS
   B. Community-based

VI. Common evidence-based practices and indications
   A. Fear of Recurrence
   B. Fatigue
   C. Weight Gain
   D. Cognitive Changes

VII. Case Studies

VIII. Summary/Question and Answer session

Notes:

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Learning outcomes:

At the completion of this session, you should be able to:

- Identify 2 objectives of the Delaware Action Coalition

Detailed outline:

   
   I. Background
   
   II. Significance
   
   III. Relevance
   
   IV. Blueprint/Methods
   
   V. Lessons Learned
   
   VI. Challenges for the Future

B. Identify 2 objectives of the Delaware Action Coalition
   
   I. Background
   
   II. Current work
   
   III. Significance
   
   IV. Path Forward

C. Conclusion

Notes:
Agenda
Thursday, September 13, 2011

7:00 a.m. – 7:30 a.m. Registration/Breakfast - Lobby
7:30 a.m. – 7:45 a.m. Welcome – Janet Cunningham, RN, MHA, NEA-BC, CENP
7:45 a.m. – 8:45 a.m. Keynote Address – Kay Frances, MBA
   Auditorium The Funny Thing About Stress (page 44)
8:45 a.m. – 9:00 a.m. Break/Vendor Displays/Poster Presentations – Lobby

9:00 a.m. – 10:00 a.m. Breakout Sessions
   | Providing Palliative Care: Reality Checks & Balances |
   | IABP Therapy and the Cardiac Patient |
   | Neuro Intervention for Stroke |
   | Taking the Road Less Stressed |
   | Cindy Drew |
   | Ellen S. Hanley |
   | Sudhaker Satti |
   | Kay Frances |
   | Maria Ash |
   | |
   | Room 4 Page 46 |
   | Room 11 Page 48 |
   | Room 14 Page 49 |
   | Auditorium Page 50 |

10:00 a.m. – 10:15 a.m. Break/Vendor Displays/Poster Presentations – Lobby

10:15 a.m. – 11:15 a.m. Breakout Sessions
   | The What, the Who, and the When of Advanced Directives |
   | Acute Lung Injury and ARDS Complicated ICU Patients |
   | New Oral Anticoagulants and Antiplatelets: Where do They Fit? |
   | Frost My Heart and Hope Not to Die: Therapeutic Hypothermia |
   | Susan Conley |
   | Maureen A. Seckel |
   | Meredith Hollinger |
   | Mike Clumpner |
   | |
   | Room 4 Page 52 |
   | Auditorium Page 54 |
   | Room 11 Page 57 |
   | Room 14 Page 58 |

11:15 a.m. – 12:00 p.m. Lunch/Vendor Displays/Poster Presentations – Lobby

12:00 p.m. – 1:00 p.m. Mid-note Address - Auditoriorum
   Mike Clumpner, PhD(c), MBA, CHS, NREMT-P, CCEMT-P, PNCCT, EMT-T, FP-C
   WATCH: Workplace Awareness for Terrorism and Crime in Hospitals (page 60)

1:00 p.m. – 1:15 p.m. Break/Vendor Displays/Poster Presentations – Lobby

1:15 p.m. – 2:15 p.m. Breakout Sessions
   | Prediabetes: Diagnosis, Management, Treatment |
   | Lung and Heart/Lung Transplantation: It Takes a Village |
   | Tackling Skin in the Surgical ICU |
   | Effective Communication in Difficult Situations |
   | James Lenhard |
   | Tiffany S. Randolph |
   | Craig Martine |
   | Cynthia Diefenbeck |
   | Kyle Phillips |
   | |
   | Auditorium Page 62 |
   | Room 11 Page 63 |
   | Room 4 Page 64 |
   | Room 14 Page 66 |

2:15 p.m. – 2:30 p.m. Break/Vendor Displays/Poster Presentations – Lobby

2:30 p.m. – 3:30 p.m. End-note Address - Auditoriorum
   Brian Levine, MD
   Update on Drugs 2012 (page 68)
The Funny Thing about Stress
Kay Frances, MBA
Motivational Humorist
“America’s Funniest Stressbuster”
Wilmington, OH

Abstract/synopsis:

In this motivational and hilarious presentation that bears the same title as her book, Kay Frances, MBA, offers a healthy dose of laughter that can be just what the doctor ordered! With her energetic, upbeat presentation, attendees laugh while they learn without straining their brains. This presentation is clean, funny and relatable to a wide spectrum of people. In the frenzied world of health care, people need to be reminded of the importance of managing their stress, keeping a sense of humor and maintaining a positive attitude for good health, productivity and overall well-being.

Learning outcomes:

At the completion of this session, you should be able to:

1. Explain the causes and effects of stress on our overall well-being
2. Understand the importance of keeping your sense of humor
3. Know some useful tools for managing stress and keeping a spirit of optimism

Detailed outline:

Introduction

1. Maintain an inner oasis
   a. Anecdotes and examples
   b. Avoidance and handling of negative people, i.e. “Joybusters”

2. Monitor your reactions
   a. Anecdotes and examples
   b. Choose whether to let it “hit” or let it go.

3. Find the humor
   a. Humor defined
   b. Humorous examples of small stressors we all share in our day-to-day lives.
   c. Comparison of stress of modern times vs. stress of the past.

4. Keep a spirit of optimism
   a. Results of studies on the effects of optimism on our health
   b. Make a conscious decision to stress less.
   c. Effects of chronic negativity

5. Stress Defined
a. Physical responses  
b. Physical effects  

6. Take care of our health  
a. Exercise, water, proper diet, adequate sleep  
b. Statistics re: stress on our health  

7. Find the inspiration  
a. Example of everyday heroes  

8. Closing and summary  

Notes:
Providing Palliative Care: Reality Checks and Balances

Maria Ash, MSN, GNP-BC, ACHPN
Cindy Drew, MS, APRN, GNP-BC
Advanced illness Nurse Practioners
XL Health – Dover, DE

Abstract/synopsis:

What is Palliative Care and what does it look like in today’s healthcare environment? This presentation overviews the basic principles of Palliative care, historical and current trends, the critical role nursing plays in improving the provision of Palliative Care.

Learning outcomes:

At the completion of this session, you should be able to:

1. Identify at least three benefits for the recipient of good Palliative Care
2. Describe basic principles of Palliative Care
3. Define the Current Realities of Palliative care in America
4. Participate in discussion of how nurses can improve Palliative Care in our reality

Detailed outline:

Introduce Jim Cooper & Palliative Care
- Locations: clinic, home, inpatient
- Benefits to patients: quality of life, length of life, life resolution, end-of-life planning, symptom management

Principles of Palliative Care
- Define “A Good Death”
- Concept of Suffering
- Life Closure: a Personal Experience
- Dying Well: Goal of Hospice & Palliative Care
- Quality of Life Model
  - Physical well-being
  - Psychological well-being
  - Social well-being
  - Spiritual well-being
- Nurses are the constant

Historical Context of End-of-Life Care
- Cause of death and social trends
- Illness/Dying Trajectories
- Limits of medical technology
- Site of death
- Nursing homes as locations for Palliative Care
- Hospice and Palliative Care
- Definition of Palliative Care
- PC: Continuum of Care

Reality Checks and Future Balance
- Current availability of Palliative Care
- Current payment sources for Palliative Care
- Room for improvement

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Learning outcomes:

At the completion of this session, you should be able to:

1. Application of use of the IABP with the Cardiac Patient

Detailed outline:

- Sizing, Placement and Troubleshooting of the IAB Catheter
- Troubleshooting Alarms on the IABP
- Analyzing the augmented arterial waveform and troubleshooting of the arterial waveform
- Review of Journal Articles related to the cardiac patient and the IABP

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Neuro Intervention for Stroke

Sudhaker Satti, MD
Neuro-Interventional Surgery, Stroke Program
Christiana Care Health System – Newark, DE

Abstract/synopsis:

Learn about acute ischemic stroke diagnosis treatment and initial management

Learning outcomes:

At the completion of this session, you should be able to:

1. Know initial BP management goals
2. Know time windows for treatment of acute stroke patients in terms of IV or IA therapy
3. Know how to identify an acute stroke patient and how to activate emergency treatment

Detailed outline:

1. Review presentation of acute ischemic stroke
2. Review high risk factors
3. Review initial medical management
4. Review initial imaging workup
5. Review inclusion criteria for IV and IA stroke
6. Review outcomes data
7. Review basics of IA stroke treatment

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49
Taking the Road Less Stressed!

Kay Frances, MBA
Motivational Humorist
“America’s Funniest Stressbuster”
Wilmington, OH

Abstract/synopsis:

This is a fun and informative breakout session designed to help participants understand the causes and effects of excessive stress on their health, productivity and well being. This session delves into the nuts and bolts of stress management. It is fun and lively with the added benefit of having participants understand stress, work to identify their own stress factors, and develop an ACTION PLAN for better managing their stress.

Learning outcomes:

At the completion of this session, you should be able to:

1. Develop a deeper understanding of your stress
2. Identify personal and job stressors
3. Formulate an action plan for managing your stress

Detailed outline:

Introduction

1. Primary Stressors
   a. Fear
      i. Examine our fears
   b. Change
      i. Review of Top 10 Stressors
2. Take care of our health
   a. Detailed review of earlier discussion re: exercise, water, proper diet, adequate sleep.
   b. Rate yourselves in these areas
   c. Share best practices
   d. Elements of a healthy diet
3. Stressbusters
   a. Solution to stress is to find the solution
4. Maintain a good support system
   a. Who is in your circle of support?
   b. What are their roles?
5. Specific job stressors
   a. Options for resolution
   b. The BEST solution
   c. Get into groups and discuss
d. Discuss as a large group.

6. Action plan
   a. Three things you will do to better manage your stress
   b. Target date for implementation

7. Summary, Review and Q & A.

Notes:

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The What, the Who, and the When of Advance Directives

Susan Conley, MSN, RN-BC, ACNS-BC
Clinical Nurse Specialist for Orthopaedic, Nurosurgical, Spine and Surgical
Bayhealth Medical Center, Kent General Campus
Dover, DE

Abstract/synopsis:

Advance Directive discussions have been in many facets of the media, political and healthcare since their birth in the 1990’s. Families sometimes struggle with the fact of making decisions for their loved one when advanced planning has not occurred. Healthcare workers also struggle with who can make decisions when a patient cannot make them for themselves. Hospitals are required by regulatory agencies to aid patients in making their advance directives. Various avenues exist to aid a person in making their final wishes known and to be carried out.

Learning outcomes:

At the completion of this session, you should be able to:

1. Describe advance directive planning regarding end of life decisions
2. Verbalize methods to establish an advance directive(s)

Detailed outline:

I. History of advance directives
   a. State regulations
   b. Federal regulations
II. Definitions/Documentation
   a. POA
      1. Medical
      2. Financial
      3. Durable
   b. Living Will
III. Statistics
   a. Ethnicity
   b. Socioeconomic status
IV. What to do when
   a. Family meeting
   b. Risk Management
   c. Ethics consult
V. Legal
VI. Downloads
   a. National Health Care Decision Day
   b. MOLST
c. 5 Wishes

d. Dr. OZ

VII. Regulations for Hospitals
  a. CMS

VIII. Joint Commission

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Acute Lung Injury and ARDS: Complicated ICU Patients
Maureen A Seckel, RN, APN, MSN, ACNS-BC, CCNS, CCRN
Clinical Nurse Specialist Medical Pulmonary Critical Care
Christiana Care Health System- Newark, DE

Abstract/synopsis:
Patients with Acute Lung Injury (ALI) / Adult Respiratory Distress Syndrome (ARDS) are present in every critical care unit with a high mortality rate of ~ 40%. What are the best ventilator strategies to care for these complex patients? How can we protect them from ventilation-induced injury? This session is designed for all nurses who desire evidence-based information on the best patient outcomes. A review of ventilatory and non-ventilatory strategies will be included.

Learning outcomes:
At the completion of this session, you should be able to:

1. Define and discuss the definitions and pathogenesis of Acute Lung Injury and Adult Respiratory Distress Syndrome
2. Identify ventilator management strategies to improve patient outcomes

Detailed outline:
I. Introduction and Background
   A. Statistics
   B. Definitions
      1) 1994 American-European Consensus Conference
      2) 2011 Berlin Definition
   C. Pathogenesis
II. What the Research Shows
   A. Ventilatory Strategies
      1) Positive End-Expiratory Pressure
      2) Lung Recruitment Maneuvers
3) Pressure-Controlled Ventilation
4) Pressure-Controlled Inverse-Ratio Ventilation
5) Airway Pressure Release Ventilation
6) High Frequency Oscillatory Ventilation
7) High-Frequency Percussive Ventilation

B. Non-Ventilatory Strategies

1) Neuromuscular Blocking Agents
2) Vasoactive Therapies
   a. Nitric Oxide
   b. Phenylephrine
   c. Inhaled Prostacyclins
3) Prone Positioning
4) Extracorpeal Life Support
5) Fluid Management
6) Corticosteroids
7) Nutrition

III. Conclusion and Discussion

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**Contact:**

mseckel@christianacare.org

**Notes:**
New Oral Anticoagulants and Antiplatelets: Where do They Fit?

Meredith Hollinger, PharmD, BCPS
Clinical Pharmacy Specialist Cardiology/Critical Care
Christiana Care Health System- Newark, DE

Abstract/synopsis:

To discuss the new agents on the market and compare them to agents already available. Comparisons of mechanisms of action, adverse drug reactions, and indications will be covered in this presentation.

Learning outcomes:

At the completion of this session, you should be able to:

1. Describe the mechanisms of action for oral anticoagulants and antiplatelets
2. Discuss the advantages and disadvantages of the new oral anticoagulants and antiplatelets
3. Identify therapeutic options for reversal of oral anticoagulants

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Frost My Heart and Hope Not to Die:  
Therapeutic Hypothermia  
Mike Clumpner, PhD(C), MBA, CHS, NREMT-P, CCEMT-P, PNCCT, EMT-T, FP-C  
NIMSHI International – Charlotte, NC

Abstract/synopsis:
Despite numerous technological advances in medicine, cardiac arrest survival statistics remain relatively unchanged over the years. Out of hospital cardiac arrests occur in one out of every 1,500 adults worldwide every year, with a mortality rate near 95%. We have often thought the hypoperfusion damage caused during cardiac arrest can be fixed with reperfusion. However, research indicates that anoxic neurologic injury prior to, during, and post-resuscitation contributes to significant mortality and morbidity. Hypothermia induction has been used since the 1800’s, but has since regained popularity with the results of numerous research studies, and endorsement by the American Heart Association in 2005.

This lecture will discuss how hypothermia induction has been shown to be beneficial on the three primary stages of post-cardiac arrest resuscitation. Hypothermia induction has been used frequently in the intensive care setting, but now success is being directly attributed to hypothermia induction in the pre-hospital setting. In early 2005, Regional One Air Medical became the first pre-hospital provider in the world to initiate clinical hypothermia induction for post-cardiac arrest resuscitation patients as a non-trial protocol in the pre-hospital setting. This lecture will discuss the lessons learned both in the pre-hospital setting and in the intensive care units.

Learning outcomes:
At the completion of this session, you should be able to:

1. Describe the indications, contraindications, rationale and techniques for hypothermia induction in adult post-cardiac arrest patients.
2. Describe the incidence of increased survivability with the implementation of hypothermia induction.
3. Describe post-hypothermia induction patient management including pain management, sedation, and continued cooling.
4. Educated about Regional One’s results since protocol implementation as well as lessons learned.
Abstract/synopsis:

The Federal Bureau of Investigation and the Department of Homeland Security have identified specific terrorist threats that have been made against United States hospitals. Suspected international terrorists have been found with material that describes hospitals as major targets. This presentation will look at the major terrorist threats to hospitals, and will identify specific strategies to harden hospital targets. Lessons learned from Israeli hospitals will be described including pre-event and post-event strategies. For terrorism healthcare preparedness, the Federal government has been given a grade of D+, and the nation’s emergency medicine system as a whole has been given a grade of C-. How will your hospital rate?

In 2010, hospital emergency departments were identified as the most dangerous work setting for healthcare workers. Violent assaults have increased dramatically on all hospital staff members. A recent survey found that in their career, 97% of nurses will be verbally assaulted, 94% will receive verbal threats, and 66% will be physically assaulted. This presentation will review hospital crime statistics, and discuss methods for increasing security and decreasing the number of violent crimes that occur inside healthcare facilities. This lecture will also review preparation and response for an assortment of other crimes that can occur in hospitals including active shooter, infant abductions, cyber-crimes, and gang violence.

Learning outcomes:

At the completion of this session, you should be able to:

1. Describe specific threats that have been made against healthcare institutions in the United States, and warnings that have been issued by the Department of Justice and the Department of Homeland Security.
2. Describe the clinical impacts on hospital response to weapons of mass destruction (WMD) in chemical, biological, radiological, nuclear, and explosive (CBRNE).
3. Describe lessons that have been learned from Israeli and United States hospitals during terrorism response.
4. Describe the prevalence of violence against hospital staff, particularly those working in the emergency department.
5. Discuss identification and response to gang violence in the hospital.
6. Describe the actions that they must take in the event of an active shooter in the hospital.
7. Describe strategies to prevent infant abductions from the hospital.
8. Understand how to perform a critical infrastructure vulnerability analysis on their facility.

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Learning outcomes:

At the completion of this session, you should be able to:

1. Describe the scope, definition and implications of prediabetes

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Abstract/synopsis:

Case presentations for a heart/lung transplant patient and a lung transplant patient will be briefly reviewed.

Learning outcomes:

At the completion of this session, you should be able to:

1. State general indications for heart/lung transplantation
2. Recognize the need for expediency in proceeding to transplant in critically ill patients
3. Identify members of the multidisciplinary team involved in transplantation

Notes:
Tackling Skin in the Surgical ICU
Craig A Martine RN, BSN, CCRN
Staff Development Specialist – Surgical Critical Care
Christiana Care Health System – Newark, DE

Abstract/synopsis:
Critically ill patients are at increased risk for pressure ulcer development. The risk are higher acuity, increased length of stay, poor tissue perfusion, use of vasoactive medications, skin maceration due to moisture, immobility, and poor nutritional status. Therapy related devices such as T-pods, splints, collars, and traction further compromise our patients’ skin. In October ‘10, the unit began experiencing an upward trend in unit acquired pressure ulcers reaching a prevalence rate of 20.1%. The goal of this project was to reduce our unit acquired pressure ulcers by utilizing a multidisciplinary team approach. A multidisciplinary team addressed the increase in unit acquired pressure ulcers. Our first meeting included a brain storming session attended by staff and a Wound Ostomy and Continence (WOC) nurse. A Skin Resource Team (SRN) was developed and each of the members of the team attended an eight hour Wound Care Workshop. This team also spent time mentoring with the WOC nurses. Additionally, skin rounds were increased to twice per week with the manager, unit educator, and/or members of the SRN and the WOC nurse to evaluate current skin assessments, wound documentation, and education processes. All staff members were required to complete an online training module to help them gain a better understanding of skin impairments and to participate in the biweekly skin rounds. Additional findings during biweekly rounds identified patients on rotational therapy to have an increased incidence of skin breakdown. With all of the opportunities for growth identified, we developed a unit based “skin bundle”. This skin bundle incorporated a thirty minute off loading of potential sacral pressure areas every two hours for patients on rotational therapy. Because of our interventions, we have appreciated a steady decline in unit acquired pressure ulcers ending FY11 with 0% prevalence. Results indicate that a multidisciplinary approach to this challenging patient population aligns the unit in standard with the institution’s commitment to patient safety and focus on excellence. There is an increased confidence in the staff for recognition of skin related issues and improved compliance with the Wound and Skin Record. The findings for patients on rotational therapy led to a change in the Clinical Practice Guideline for the institution.

Learning outcomes:
At the completion of this session, you should be able to:

1. The learner will have an understanding of how and why a skin resource team was developed
2. The learner will learn how a team approach to tackling complex skin issues changed practice in one ICU that eventually changed in the whole institution

Detailed outline:

1. Brainstorming session to uncover the reasons why skin became a huge issue
2. Lessons learned from past behaviors
3. Team member selection
4. Training process for the team members
5. Vigilance with skin care provides for great outcomes
6. Resource staff members are valuable tools to assist others in identifying skin issues and how to treat them
7. Practice changes are easy to achieve when the team sees the good outcomes

Notes:
Effective Communication in Difficult Situations
Cynthia Diefenbeck, PsyD, APRN, BC Assistant Professor
University of Delaware – Newark, DE
Kyle Phillips, BFA, BSN, RN
Behavioral Health Case Management
Union Hospital – Dover, DE

Abstract/synopsis:
Effective communication is the cornerstone of quality patient care. Difficult patient situations encountered in healthcare settings are sometimes the result of or exacerbated by ineffective communication between the patient and provider. These difficult situations can be usually be handled by the deft use of effective communication skills.

Learning outcomes:
At the completion of this session, you should be able to:

1. Analyze underlying causes of difficult patient encounters
2. Practice and demonstrate effective communication techniques useful in difficult situations

Detailed outline:
1. Presenters will guide participants through an interactive exercise – “Small annoyances”.

   Participants’ packets will contain a numbered envelope, each envelope containing one small annoyance that can happen to a patient during their stay (such as getting the wrong meal tray or having to get labs drawn twice because the sample was misplaced or family not visiting). Participants will be called up to the front of the room in numerical order and will have to follow the instructions in their envelope. One of the presenters will serve as the “patient,” and will begin to escalate. This interactive exercise will demonstrate how numerous small annoyances by a variety of providers and by the patient’s own personal situation/family can lead to tension and anger. The interactive nature of the exercise also serves to engage all participants and sets the expectation that this session will be an interactive one.

2. Presenters will lead a discussion about difficult situations faced by selected participants.

   As a follow-up to the introductory exercise, the presenter will get feedback from participants about difficult patient/family interactions they have observed or experienced in the clinical setting and will query participants about how either effective or ineffective communication helped or hindered the situation.

3. Participants will perform self-evaluation of their own vulnerabilities and strengths as it relates to communicating effectively in difficult situations.
Participants will be asked to reflect on their own communication strengths and weaknesses. Presenters will develop a tool or discussion questions that will elicit this information.

4. Presenters will educate participants about the escalation cycle and demonstrate effective de-escalation techniques.

   Presenters will educate participants on the escalation cycle via handout or powerpoint slides. Presenters will discuss de-escalation techniques for each stage of escalation and will demonstrate to the group.

5. Presenters will guide participants through an interactive de-escalation exercise.

   Participants will be provided cards with common interpersonal conflicts one might experience in the healthcare setting. Participants will role play providers and patients in order to practice communication techniques.

6. Presenters will introduce participants to and demonstrate the process of “debriefing.”

   Presenters will demonstrate debriefing by using the last group of participants to role play in the prior section. Presenters will discuss the importance of debriefing along with its essential components. A handout will be provided. The session will end by asking the participants to consider how they will grow (from an interpersonal communication standpoint) following this seminar.

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Update on Drugs of Abuse 2012
Brian Levin, MD
Associate Program Director - Attending Physician
Christiana Care Health System
Newark, DE

Learning outcomes:

At the completion of this session, you should be able to:

1. Understand the epidemiology of the drug problem of the United States
2. Understand the effects of drug abuse

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Poster Abstracts
Restructuring the SCCC/NCCU Orientation Process

Teresa Panchisin, MSN, APN, ACNS-BC
Christiana Care Health System – Newark, DE

Abstract:

The opening of the Neurologic Critical Care Unit (NCCU) in June of 2011 demonstrated to the Surgical Critical Care Complex (SCCC) Preceptor Committee that a transformation was needed in their orientation process for the newly hired surgical/trauma/neurologic critical care nurse. In order to provide a more effective, comprehensive critical care orientation experience, the SCCC orientation restructuring was deemed necessary. The SCCC nurse’s patient population includes surgical, trauma and overflow neurologic patients, with the primary neurologically diagnosed patients in the NCCU. Prior to the opening of the NCCU, the orientation process consisted of an 8 to 12 week orientation depending on prior clinical experience with no specific time solely dedicated to the neurologic population. Orientees and preceptors were assigned one to two patients with no consistency in the patient population. This inconsistency interfered with the development of strong assessment skills and comprehensive management required for our neurologic population. With the opening of the new six bed neurological unit, expansion of neuroscience services offered at Christiana Care Health System and the changing educational needs of the nursing staff, it was apparent that there was an opportunity to redesign the orientation process for new nurses to provide a more consistent and organized approach. The team utilized to institute this change consisted of preceptors, the SCCC/NCCU nurse manager, staff development specialist and patient care coordinators.

Interventions were instituted to provide the orientees with the opportunity to develop the detailed neurological assessment skills as well as the skills necessary to care for the surgical/trauma critical care population by implementation of a neurologic specific portion to the orientation process. In order to accomplish this, there is now a dedicated four week orientation period for each of the surgical/trauma and neurologic population. Orientees on a 12 week rotation would then experience a comprehensively blended group of patients during their last four weeks of orientation. Additional interventions included the SCCC unit based website updated and added more user-friendly resource and a preceptor site was added where preceptor biographies can be accessed. To further the streamlining, specifically with preceptors, two groups were created. The primary team consists of our full-time nurses who are currently certified or in process of obtaining certification, and are actively involved in both facility and unit based initiatives. There is a second team of preceptors who are part-time, interested in precepting, who are able to fill in for the primary preceptor.

The outcomes of the intervention implementation were assessed via feedback from the novice nurse to the SCCC/NCCU, where they state that they feel increasingly prepared to care for both neurosurgical and surgical patients. Additional assessment of the implementation from the staff has shown an increased number of SCCC nurses interested in precepting and mentoring. Challenges remain during the orientation process where flexibility is necessary due to the fluctuating acuity level and census in the SCCC. Preceptors at times must seek out learning opportunities for the orientee that offer a challenge and encourages critical thinking strategies that are orientee-specific.
In conclusion, critical care nursing is in a state of constant change. Redesigning the SCCC/NCCU orientation process will provide the new or experienced ICU nurse with the foundation they will need to succeed in this dynamic environment. The goal of restructuring the orientation process has been completed and in place since March 2012.
Low-Frequency Ultrasound (MIST Therapy) Accelerates Wound Healing

Kathy E. Gallagher, MSN, FNP-C, FACCWS
Acute Surgical Wound Service

Erica D. Harrell-Tompkins, BSN, RN
Wound Ostomy Continence Nurse

Christiana Care Health System – Newark, DE

Background:
The rising number of acute and chronic wounds threatens patients’ quality of life, increases morbidity, and significantly impacts hospital resource consumption. With no national standardization of wound care and the recent focus on biofilm as a contributing factor to the chronicity of wounds, health care providers are challenged to intervene early to prevent deterioration of potential and existing wounds. Clinical studies have shown that MIST therapy, a non-contact low-frequency ultrasound delivery system, accelerates wound healing and prevents wound progression by interrupting biofilm formation, increasing wound bed circulation, reducing inflammation, cleansing, and debriding.

Interventions:
The Surgical Critical Care Complex, Transitional Surgical Unit, and 2C were chosen to implement an eighteen-week trial based on their trauma patient population, varying degrees of severity of illness, and staff collaboration. Skin resource and staff development nurses were initially trained to provide the treatments. Surgeons, advanced practice nurses, physician assistants, and residents were educated. The protocol was to implement the therapy five times a week then two-three times a week depending on patient/wound assessment until healed, or discharged. Treatment times were three to a maximum of twenty minutes, determined by wound size. Inclusion criteria were: suspected deep tissue injuries (SDTI), open surgical incision sites with/without infection, pressure ulcers, and wounds without improvement in two weeks. Exclusion criteria were: malignancy at wound site, lower back or uterus wounds during pregnancy, and over/near electronic implants.

Results:
Twenty-three patients received MIST therapy. Four patients were transferred off trial units necessitating premature discontinuation of treatments. Other patients who may have benefited from the therapy were unable to participate because they were not located on the trial units. Open abdominal wounds treated with MIST and negative pressure wound therapy had a significant reduction in size and were able to be surgically closed faster, therefore reducing length of stay. SDTI’s were no longer detectable after a few treatments. Significant pressure ulcers healed in four weeks or less. Immediately post treatment, pale granulation beds appeared pinker. Patients reported that the treatment was painless; some requested its use on their other wounds. The nursing staff embraced the implementation of this treatment modality and was engaged in fostering optimal outcomes.
Conclusion:
Noncontact low-frequency ultrasound, MIST therapy, appears to have accelerated the healing process of both acute and chronic wounds in our population. No negative consequences were reported. Larger prospective studies are warranted.
Mission Impossible: Educating an ED Nurse

Patricia A. Loreen Evans, RN MSN CEN
Crozer Chester Medical Center – Chester, PA

Abstract:

As an Emergency Department (ED) nurse, finding time to familiarize oneself with A-line monitoring or a new piece of equipment is often impossible. A group of staff nurses recognized the need for more “hands on” learning and pursued a method to make our education more meaningful.

Hospital general nursing skills day offered little benefit to our ED nursing staff who are tasked with more specialized skills. With staff nurses dedicated to spending more time at the bedside with their patients, it was imperative to develop a process to prepare the ED nurses to provide best practice and care to their patients. A program was developed by staff, with the assistance of the ED educator and ED director to host annual skills fair to aid nurses in completing their department specific competencies. This method of education was found to be useful to staff and also helped reach department goals of staff competencies.

Thirteen skills were identified as high risk low volume items. Education and objectives were prepared to improve nurse competency levels on these topics including: Trauma, Stroke, PICIS(Computer documentation), ESI(triage system), Vigilio (hemodynamic monitoring), CVP/Sepsis, Level 1(rapid infuser), Chest Tubes, IO (Intraosseous) access, Burn care and Emergency Birth.

A post survey was completed by the staff in attendance. On a five point Likert scale, all of the participants rated the day as “good” or “excellent”. There was a lot of positive feedback and our staff looks forward to the next skills day sessions.
Since the beginning of the open-heart surgery program at Christiana Care in 1986, the nurses of the Cardiovascular ICU have traditionally applied restraints to 100% of patients post-operatively. This practice was perceived to provide nurse and patient safety, despite the fact that patients have self-extubated with restraints in place. In light of Joint Commission standards that call for minimal restraint usage, an opportunity for improvement was identified. The project was initiated with the goal of reducing the percentage of patients that are restrained during the recovery phase of open-heart surgery from 100% to 75%. The recovery phase is defined as the time of patient arrival from the OR until the patient is extubated or 0700 the following day, whichever occurs first.

A multi-disciplinary team was formed to identify any issues that may affect the need for restraints. The team utilized the LEAN Process to identify gaps in current practice that impede the ideal future state. The practice of automatic restraint application to post-operative patients was eliminated. Nursing interventions such as comfort measures, pain control, family presence, use of mitts, etc., were implemented instead, prior to seeking restraints. The presence of a dedicated Respiratory Therapist on the unit was prioritized to ensure rapid ventilator weaning and timely extubation. Nurses were provided with training, reassurance and mentoring to support the change in practice. In order to track data and provide alternatives to restraint usage, a paper survey/tracking tool was provided.

The direct key measure was percent restraint usage. The final two months of data collection indicated a 3% restraint use on post-operative patients in the Cardiovascular ICU. With the reduction in restraint use, there is a projected cost savings of over $1000 per year. Other tracked measures included intubation times, medication use, and reportable adverse events such as self-extubation. The results indicate there was no significant change in these measures. Although patient satisfaction cannot be directly measured from this initiative, the nurses report that patients appear to be more comfortable. As more nursing time is being spent at the bedside with the patients, better outcomes could be realized as another potential benefit of restraint reduction.

The goal of 75% restraint use was astoundingly exceeded without negative effects. Nursing survey results also indicate an improvement of nurse satisfaction, and a perceived improvement of patient satisfaction and comfort. It has been long believed and accepted that most patients are unmanageable when they wake up after open-heart surgery, therefore requiring restraints for nurse and patient safety. This project has demonstrated to the nursing staff that, without restraints, most patients awake calmly and cooperatively. The path forward includes maintaining the restraint-free environment, supporting the nursing staff in avoidance of habitual restraint use, and applying the methodology to our medical patients.
Promoting Safe Patient Handling in Labor and Delivery Room

Kavitha Edupuganti, RN, BSN, CEAS
Injury Prevention/PEEPS Educator
Gina Scott, RN, BSN
Donna Norris-Grant, RN, BSN
LDR- Women’s health Services
Christiana Care Health System – Newark, DE

Abstract:

Christiana Care Health System supports the use of mechanical devices to prevent staff injury in inpatient and outpatient settings. PEEPS (Patient Environment Equipment Posture Safety)/ Injury prevention in conjunction with nursing staff worked to reduce staff injury and improve patient safety by using mechanical devices since 2000, with positive results of zero transfer injuries. The increasing population of obstetric bariatric patients adds to the maternity nurse’s physical stress. Occupational Safety and Health Administration (OSHA) recommends that there should be one staff member present for each 35 pounds that needs to be transferred. Staffing limitations makes this difficult to follow this standard and increases the risk for patient or nursing injuries. In Labor and Delivery unit ceiling mounted lifts (CML) were installed in every labor room in 2009, to promote safe patient handling practices. Education was provided by the PEEPS Educator with demonstration of techniques to handle patients safely with various types of slings. In labor and delivery room, patients are immobilized with regional anesthesia requiring nursing to assist with all activities: turning and repositioning, assisting with elimination, and holding extremities during second stage of labor or in medical emergencies, which supported the need for utilizing mechanical devices.

A pilot project was initiated to place the repositioning/bed slings on every bed in the unit to maximize the use of the slings. The repositioning slings are utilized to assist with position changes and for transfers in the operating room. Transfer/chair slings are utilized during the second stage of labor to provide comfort to patients and safety to staff. Limb slings are used to hold lower extremities while patients are pushing, or to hold the pannus with gravid abdomen for fetal monitoring on bariatric patients.

At the end of three months pilot study, the staff expressed that it was convenient to have a sling as part of the bed linen to use it with patients when needed. Patients and nurses expressed feelings of safety with use of slings for transfers and repositioning. Patients expressed increased comfort with the chair sling support during second stage of labor.

Lessons learned were: Ceiling mounted lifts provide safe handling of laboring patients especially when regional anesthesia is used. Patient and staff safety is assured when utilizing ceiling lifts for transferring, turning and repositioning labor patients.
Building a Certification Oasis…
One System, One Unit, One Nurse at a Time

Tamekia L. Thomas, MSN, RN, PCCN
Michelle L. Collins, MSN, RN-BC, ACNS-BC
Carrie Bonnett, Administrative Assistant II
Nursing Development and Education
Christiana Care Health System – Newark, DE

Background:
Specialty nursing certification plays a significant part in a nurse’s professional development. Achieving this honor is another way a nurse can validate his/her knowledge, skills, and competency in a specialized area of nursing. Professional nursing certification is also a requirement for our nursing leadership and advancement on our Clinical Ladder. Our organization has created a virtual oasis that promotes professional nursing certification on every level. A goal was set by our Chief Nursing Officer to increase the number of certified nurses within our system by 10% over a fiscal year. Collaboration with Nursing leaders, Managers, staff nurses, and administrative staff was necessary to meet this system-wide goal.

Intervention(s):
The structural empowerment regarding certification began with the revision of our certification policy to include financial support for preparation, initial testing, and maintenance for certifications. Offering on-site review courses, online prep courses, increasing the access to preparatory materials within the libraries and the units have facilitated preparation for these rigorous examinations. An all-inclusive website was developed as a “one stop” certification information source which includes the Certification Honor Roll, upcoming review courses, and other resources. Having a designated coordinator contributes to the organizational support for certification as the coordinator responds to staff questions and assists with the application process. System wide and unit based recognition contributes to the sense of pride and promotion of nursing excellence.

Results/outcomes:
Financial burden was eliminated as a barrier for our nurses to obtain and maintain their certification. Within one year, over 277 nurses attended a live on-campus review course, 250 nurses utilized the online review courses, and over 400 nurses benefited from the prepayment option for initial exam applications. The number of certified nurses increased from 1183 (Feb 2011) to the current total of 1446, which is a 22% increase in percentage of total system certified nurses. The support from the system, unit level encouragement, and from the individual nurse setting the goal for certification has contributed to this increase.

Conclusion:
We exceeded our goal by having a 22% increase in the total number of certified nurses and the change is now embedded in our nursing culture throughout the system. Lessons learned, we now assess over-all percentage of certified nurses by identifying the total number of certification eligible nurses (nurses with >2 years experience in the specialty). Currently 57% of the nurses eligible to certify hold a professional certification. Results indicate that investment in the
professional development of our nurses will lead to overall employee satisfaction, improved quality of care, and increased competency among our nursing staff. Next steps include imbedding nursing certification in the career advancement process and increased recognition of certification on the unit level.