“You must never so much think as whether you like it or not, whether it is bearable or not; you must never think of anything except the need, and how to meet it.” — Clara Barton

Nursing students have always been taught to care for individuals of all ages and cultural backgrounds based on the individual’s physical, emotional, psychological, intellectual, social and spiritual needs. Physical science, social science, nursing theory and technology should all be drawn upon by the nursing profession to provide that care. Princeton Healthcare System (PHCS) nurses have always built on this foundation and continued to do so throughout 2013.

There is tremendous power in the professional nursing practice. PHCS nurses have demonstrated their understanding of that power again and again, and have learned how to use it. That distinction has been critical to shaping our nursing practice and impacting our work environment. On a regular basis, our nurses not only identify opportunities for improvement but research best practices, engage their coworkers in their efforts and then implement them.

PHCS nurses’ pride in their work is obvious. Every day the pride of who they are and the excellent care they provide is demonstrated in their interactions with patients, who have placed their trust in them to provide the best possible care. That care is provided with compassion, quality and professionalism, which has resulted in elevating our inpatient satisfaction scores to the 99th percentile.

Questions like, “Why do we have to do that?” and “Why do we need to change?” are rarely — if ever — heard among PHCS nurses. The comments that resound are “How can we do that even better?,” “How can we change it?” or, simply, “Let’s do it!” This can-do attitude has continued to build exponentially over the years, and seems to know no limits. As you read through the following pages, you will see a selection of successful initiatives that demonstrate an amazing level of dedication, intelligence and determination from the PHCS staff. PHCS has considered the “need” and determined how it can be met.
The Department of Nursing **Vision** Statement

The nurses of University Medical Center of Princeton are dedicated to promoting health and caring service by providing our patients with exceptional nursing care in an environment that empowers, educates and nurtures patients and guides them and their families through the healthcare system.

The Department of Nursing **Mission** Statement

Our mission is to provide the highest level of compassionate and patient-centered care through innovative evidence-based practice, education and research.
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IN 2012, the Department of Education, along with senior leadership, recognized the need to better support the schools of nursing, including providing a more comprehensive orientation process. Working in collaboration with representatives from the schools of nursing, a one-day orientation process was developed for the 2013 academic year. To prepare for this change in process, a four-hour informational session was held to disseminate materials to the schools' clinical instructors, who would be overseeing and managing the students during their clinical experiences. During this time, the instructors had the opportunity to gain a clear understanding of their roles and responsibilities in the new orientation process, meet with members of the Department of Education along with unit managers and take a tour of the new hospital setting.

The new orientation process includes students and school instructors meeting with a University Medical Center of Princeton (UMCP) clinical instructor on the first day of a clinical experience. Following the meeting, the group is escorted to a classroom setting, where they receive information on the facility’s policies and procedures, along with computer training. This allows for important information to be disseminated prior to the start of a clinical experience.

Although this information had been provided in the past, connecting the students and instructors with a UMCP clinical instructor in a face-to-face setting allows for a more personalized introduction to the facility, improves communication and enhances the learning experience. This change in process has been met with positive feedback by both the schools of nursing and the staff at UMCP.

Lopa Patel, RN, MSN, ONC, Clinical Instructor and GetWell System Manager

“Being an instructor, I can honestly say that my students definitely benefit from the orientation process here at UMCP.” (Diane Driver, 2013)

“Thank you for the super orientation program at Princeton House!” (Marilyn Drucker, 2013)
ON OCTOBER 3, 2013, the American Nurses Credentialing Center (ANCC) awarded University Medical Center of Princeton’s Partnerships for PIECE the 2013 Magnet® Honors. The award, presented at the National Magnet Conference® in Orlando, Florida, recognizes unique programs where innovative action transforms nursing practice. ANCC cited inter-professional collaboration and reduction in hospital readmissions for patients who enrolled in the Partnerships for PIECE program as key features influencing their decision.
The ANCC, a subsidiary of the American Nurses Association, developed the Magnet Recognition Program® to acknowledge superior patient care, nursing excellence and innovations in professional nursing practice. UMCP is one of 393 organizations—or less than 5 percent of hospitals nationwide—to earn Magnet status and one of the select few newly designated healthcare organizations to be awarded Magnet Honors.

Partnerships for PIECE—Patient-Centered Integrative Elder Care and Empowerment—is a grant-funded program to help elderly patients transition from the hospital to the next level of care, whether that be to their own home or to a skilled nursing facility. The Partnerships for PIECE program takes a unique three-tiered approach to eldercare: (1) training and working closely with skilled nursing facilities across care transitions, (2) navigating patients through the move back into their home and (3) streamlining electronic communications through a new data registry system. With funding from Robert Wood Johnson Foundation’s New Jersey Health Initiatives 2011 Transitions in Care grant program, as well as the Blanche and Irving Laurie Foundation and The Church and Dwight Employee Giving Fund, the program, under the leadership of Kathleen Seneca, MSN, APN, CNL, Program Director, served over 11,000 frail, older, hospitalized patients residing in Mercer, Middlesex and Monmouth counties between December 2011 and August 2013. As a result of the project, UMCP realized a 19 percent decrease in readmissions over the life of the grant period.

The three-tier approach included:

**Patient Coaching/Navigation:** Led by an advanced practice nurse (APN) using a customized version of Eric Coleman’s evidence-based Care Transitions Intervention (CTI) model, the program’s patient coaching/navigation component focused on recently hospitalized patients discharged to their home who were most at risk for post-hospitalization adverse events. One of the significant outputs from the intervention was the development of a personal health record for each patient. The record was used as a communication tool with other providers and family members; identified signs and symptoms of worsening medical conditions and encouraged the patient to address these concerns; provided medication reconciliation and helped patients understand their medications and how to take them; and empowered patients to be active participants in their own care during follow-up visits with doctors. Participants had a 10 percent lower readmission rate
than eligible patients who chose not to participate. Additionally, 79 percent of these patients were seen by their physician or APN primary care provider within 14 days of discharge and 64 percent of participants did not experience medication discrepancies.

**Collaboration with SNFs:** In collaboration with New Jersey Goals of Care and nine skilled nursing facilities (SNFs) (Cranbury Care Center, The Elms at Cranbury, Meadow Lakes, Merwick Care and Rehabilitation Center, Monroe Village, Park Place, Pavilions at Forrestal, Princeton Care Center, and Stonebridge at Montgomery), better-functioning communication systems were created between acute care and rehabilitation settings. This included a series of consulting and performance improvement activities, including the use of the POLST (provider’s orders for life-sustaining treatment) form as a replacement for a do-not-resuscitate form to align goals of care with available therapies and promote patient-centered care. Initially piloted at UMCP and subsequently signed into law in New Jersey in December 2011, over 3,000 forms have been completed at PHCS since its adoption, and the POLST implementation process is now being replicated in another New Jersey healthcare system. The SNF collaboration resulted in lowering 30-day readmission rates for frail, elderly patients from 21.3 percent in the fourth quarter of 2011 to 16.67 percent in the second quarter of 2013.

**Enhanced Electronic Communication:** Princeton HealthCare System's Information Technology department launched Princeton HealthCare Connect, a portal for community providers to provide real-time access to pertinent patient information, such as electronic notification of patient admissions to the emergency room or hospital, as well as records to facilitate discharge care plans, including consultative reports and diagnostic testing. Additionally, partnering skilled nursing facilities have similar access to shared patients records.

Partnerships for PIECE has garnered national attention, including recognition as Jackson Healthcare's 2013 Hospital Charitable Service Award Program of Promise and selection by the California HealthCare Foundation as a featured model in its 2013 publication Leading the Way: Complex Care Management Program Overviews, a national scan of best practices.

Kathleen Seneca, MSN, APN, CNL, Program Director
Acute Rehabilitation Reopens

THE ACUTE REHABILITATION UNIT experienced several changes in 2013, starting with a three-month closure of the unit beginning in July due to a vacancy in the medical director’s position. With the support, guidance and inspiration of nursing leadership, staff utilized the temporary closure as an opportunity to review and revise existing processes, practices, policies and procedures.

Based on this review, staff concluded it was necessary to hire a full-time medical director and make significant changes to the pre-admission screening process to ensure a successful re-opening of the Acute Rehabilitation Unit. One of the major challenges was finding the appropriate medical director who would share the unit’s vision and passion. When the unit reopened in October 2013, the medical director was on board, new procedures were in place and, through transformational leadership, the staff was empowered and motivated with a new approach to care.

The unit is presently working toward achieving Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation in June 2015.

Humility Sumuyang, RN-BC, BSN, Nurse Manager, Medical Neurology/Oncology Unit and Acute Rehabilitation Unit
THE PRINCETON HEALTHCARE SYSTEM (PHCS) Succession Planning Program was created to enrich emerging nurse leaders with skills they will need to serve in leadership roles at the institution. The program pairs a participant with a mentor from nursing leadership, and together they select one or more projects for the participant to complete.

The 2013 Nursing Leadership track succession planning participant was Casey Templin, RN, BSN, PCCN, Assistant Nurse Manager, Telemetry, who was mentored by Karyn Book, RN, MSN, CMSRN, CLSSGB, Professional Practice Administrator and Magnet Program Director. During the year-long program, Casey completed three projects under Karyn’s guidance.

Casey took the lead on compiling and analyzing the results of the RN Survey. She collated the data for each unit, as well as the overall hospital, and compared UMCP’s results to those of other hospitals in New Jersey, other Magnet-designated hospitals and all U.S. hospitals. Casey had the opportunity to refine her presentation and public speaking skills, sharing the results with directors, nurse managers, assistant nurse managers, clinical nurse leaders and other leaders at the Department of Nursing Leadership meeting. Her presentation highlighted complex data in a meaningful and interesting way and she provided analysis of the results to the manager of each unit while overseeing the development and implementation of action plans for each nursing unit.

In the summer, Casey became the interim Nursing Performance Improvement (PI) Coordinator, assuming the responsibilities while Sara Moghadam was on maternity leave. Casey demonstrated her ability to be autonomous in completing tasks, and to work independently. In this role, she was responsible for the collection and analysis of all data related to nursing-sensitive indicators, such as falls and restraint use. She
used her clinical knowledge to investigate trends and events and brainstorm plans to improve safety and patient care. She also collaborated with others to educate staff on patient safety.

Casey’s also produced the Nursing Annual Report. She assisted in obtaining photographs of staff featured in the articles and candid shots representing the many faces of professional nursing at UMCP. She also collaborated on stories highlighting the abundant achievements of UMCP nurses, showcasing talented nurses at all levels.

Casey reports that her succession planning journey gave her the opportunity to grow personally and professionally, and has continued to be a positive experience beyond the formal end date of the program. Her relationship with her mentor continues to be productive, and she is looking forward to her future opportunities in nursing.
A RECORD NUMBER OF direct-care nurses — 222 throughout Princeton HealthCare System — participated in the Clinical Advancement and Recognition of Excellence (C.A.R.E.) Program™ in 2013. The C.A.R.E. Program was developed in 2011 by the System-wide Professional Council to recognize and reward direct-care nurses for their commitment and dedication to promoting health and caring service through evidence-based practice, education and research.

Each direct-care nurse participating in the program was required to present his or her accomplishments to the members of the System-wide Professional Council in 2013. They were able to share their commitment to scholarship, service and social change through their council participation, projects, education, research and volunteer work. The nurses and members of the System-wide Professional Council found this experience to be both rewarding and empowering.

Susan Straszynski, MSN, RNC, Direct-care Nurse, LDR
IN 2013, C.A.R.E. PROGRAM participants engaged in numerous projects benefiting patients and their families, including:

A Tracheostomy Care Policy was created by Marissa Rago, RN; Edita Surbliene, RN; Sarah Knowles, RN; Philip Tran, BSN, RN; Alexa Greenstein, BSN, RN; Heather Hollman, RN; and Katherine Woodall, RN. The team evaluated current practice beginning with a literature review. After formulating recommendations, a policy was developed and approved, including best practices for maintaining and caring for tracheostomy patients. The group then began educating all RNs on staff on the policy through the annual Clinical Skills Fair and Skills Fair preparation sessions.

The Perinatal Bereavement Project, headed by Susan Straszyinski, MSN, RN, and including team members Stacy Booher, RN; Bernadette Kelton, RN; and Chaplain Cheryl Regis, began with an evidence-based literature review and fact-finding mission regarding perinatal loss and the statistics surrounding the various types of pregnancy loss. The team’s findings were developed into a five-hour perinatal bereavement seminar for the staff, including instruction on how to care for families experiencing a pregnancy loss and the most appropriate methods of communicating during times of grief. Cultural and spiritual aspects of care were also discussed, to ensure that all members of the PHCS community would have their needs met in a manner that would not be inadvertently offensive. Further education included a review of the policy on pregnancy loss, as well as a review of the support groups to which families could be recommended. The seminar concluded with a segment on self-care for the caregivers, so staff would be able to better support and care for one another.

Sandi Mariani, RN, MSN, Clinical Nurse Leader, ED
The Sands Scholar Program celebrated its 10th anniversary in 2013, a testament to Estelle Sands, who wanted to support nursing at UMCP. Established with gifts from the George H. and Estelle Sands Foundation, the program is a scholarship/work commitment model.

The program is designed to help recruit and retain bachelor’s degree-prepared professional nurses and to assist students at the University of Pennsylvania School of Nursing finance their education. It brought the first senior nurses to UMCP for their clinical rotations in the spring of 2003.

Student eligibility for the Sands Scholar Program is contingent on potential leadership and good academic standing. After successfully completing their senior year and passing their National Council Licensure Examination (NCLEX), each student commits to working two years as a staff nurse at UMCP.

The Sands Scholar Program has a tremendous impact on both the University of Pennsylvania School of Nursing and UMCP. In its first decade, the program has aided 17 nurses.

The following nurses presently on staff at PHCS were Sands Scholar Program students:

Juliet Puorro, MSN, RN, CNL, ONC (2006)  
Kristin Doloff, BSN, RNC, MNN (2007)  
Casey Templin, BSN, RN, PCCN, ANM (2007)  
Meagan Ratwani, BSN, RN, ONC (2011)  
Ahmaad Johnson, BSN, RN (2012)  
Anne Kim, BSN, RN (2012)  
Katherine Woodall, BSN, RN (2012)  
Samantha Anderson, BSN, RN (2013)  
Jillian Hart, BSN, RN (2013)  
Janan McCormick, BSN, RN (2013)  
Amber Stark, BSN, RN (2013)

Not present in the photo: Juliet Puorro, MSN, RN, CNL, ONC; Jillian Hart, BSN, RN; Janan McCormick, BSN, RN; Anne Kim, BSN, RN; and Katherine Woodall, BSN, RN.
A DISCUSSION DURING A TELEMETRY staff meeting resulted in the development of the eight-week Healthcare Enrichment and Role Teaching (H.E.A.R.T.) Program. Launched in 2013, UMCP’s high school enrichment program provides educational opportunities to high school students interested in pursuing a career in nursing. The program allows students to observe
RNs in their daily routine, administering medications, providing patient care, interacting with interdisciplinary team members and coordinating patient care. This allows them to gain an understanding of the knowledge and skills required for a career in nursing.

Committee members Lauren Firman, RN, BSN, MHA, NCML; Alex Wildman, RN, BSN; Mike Wexler, RN, BSN, PCCN; Rachel Pie, RN, BSN, PCCN; and Danielle Carey, RN, BSN, PCCN, with direct-care nurse Sarah McHugh, RN, BSN, serving as chair, first met in May 2013, to establish a general vision and goals for the program. Once the proposal was presented to the Clinical Practice Council and approved for implementation, materials were prepared for the program, including a vision and mission statement, an overview program summary to provide to interested schools, and pre- and post-evaluation forms.

Reaching local students who might be interested in participating in the H.E.A.R.T. Program involved contacting schools with summary information and distributing flyers. During this process, Committee Chair Sarah McHugh, RN, BSN, reached out to Antoinette Fugee, Project Director/State Advisor of the National Health Occupations Students of America organization (HOSA), who provided the committee with contacts at local schools. Committee members also met with her to discuss how to publicize the program to nearby schools.

The application process consisted of interested students submitting a one-page document explaining why they would like to participate in the program. Three out of the five applicants underwent face-to-face interviews with the entire committee. In addition to providing students an opportunity to gain interview experience, the process was designed to provide committee members with a more comprehensive picture of the career goals and expectations of the students.

The three accepted students participated in a two-hour orientation session a week before the program began for a review of the necessary requirements and documents and a detailed synopsis and overview of the H.E.A.R.T. Program. Students also toured the Telemetry floor. The eight-week program was set to begin in January 2014, and included interdisciplinary team member shadowing opportunities so the students can see what departments such as Respiratory, Physical Therapy and Wound Care do in relation to nursing.

Sarah McHugh, RN, BSN, Direct-Care Nurse, Telemetry
AT THE CLOSE OF 2013, UMCP reported being hospital-acquired pressure ulcer-free for 26 straight months. The impressive record is the result of a multidisciplinary approach spearheaded by the Skin Integrity Team (SIT). Since January 2012, the SIT has heightened awareness throughout the hospital, collaborating with all departments to improve patient outcomes. Routine in-services are held to promote prevention, as well as monthly meetings of all departments, which work together to improve patient outcomes and maintain a Hospital Acquired Pressure Ulcer-free environment.

A multidisciplinary group consisting of nursing, medical, ancillary, dietary, physical therapy, information technology and documentation staff meets monthly to continue integrating evidence-based practice, relating skin and wound care to pressure ulcer prevention. A valuable outcome of these meetings has been the Wound Resource Manual, which focuses on best practices, related to wound prevention, improving healing outcomes and, in turn, reducing the overall cost of wound care treatment. The manual is accessible from computers at every nursing station.

Reaching beyond the hospital setting, the SIT participates in the annual Hill-Rom prevalence study to assess all patients for HAPUs, and in the past two years maintained a perfect performance. The SIT also reports quarterly to the National Database of Nursing Quality Indicators (NDNQI®) regarding pressure ulcers, and the team had the opportunity to share UMCP practices with other healthcare organizations during the New Jersey Hospital Association Pressure Ulcer Collaboration Conference and perform poster presentations at several wound care conferences.
The team also encourages unit-based research projects to collect data and establish the best practices for prevention of pressure ulcers. A few of the practices within the facility in 2013 included:

• Soft silicone-backed foam dressings were utilized to boney prominence on patients deemed to be at high risk of breakdown, as well as patients facing extended surgery.

• Nursing assistants utilized moisturizers on patients twice daily to maintain skin integrity, which had an added benefit of ensuring patients’ conditions were frequently scrutinized.

• The Wound Care Manual was developed and made easily accessible to nurses as a resource to provide best practices for skin care. The manual also improved collaboration with physicians.

The SIT team continues to educate nurses, conduct monthly audits and incorporate evidence-based clinical guidelines to provide the best quality care to patients. The team has found that redundancy of education heightens awareness, reducing skin breakdown.

Connie Johnson, BSN, RN, WCC, LLE, OMS, DAPWCA, Wound Care Nurse/Ostomy Management Specialist
University Medical Center of Princeton at Plainsboro successfully launched the Pain Resource Nurse Program in 2012. Following a full-day course, which included both pre- and post-testing, 32 nurses successfully completed the program and now sit on the Pain Committee.

The role of the pain resource nurse (PRN) is to function both as a resource and a change agent in disseminating information and interfacing with nurses, physicians, other healthcare providers, patients and families to facilitate effective pain management. UMCPP's pain resource nurses are advised by Pain Committee Chair, Donna Post, RN-BC, BSN, Clinical Instructor, who, along with the hospital's nursing leadership provides educational opportunities and support for the PRNs.

UMCPP’s pain resource nurses completed their training course in April 2012, and reconvened after the move to the healthcare system’s new facility in June. Their first task was learning about the Pain Dashboard and the significance of the data it provides. The PRNs then began receiving Press Ganey and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey reports for review on a monthly basis, and used the data to work within their units to formulate strategies for improvement. As a result, units such as SCU, Telemetry and LDRP met their overall goal for pain management for the fourth quarter of 2012.

IN AUGUST 2013, Audrey Amir, RN, MSN, CNL, PCCN, Clinical Nurse Leader, MNO; Alicia Calisto, RN, MSN, CNL, PCCN, Clinical Nurse Leader, Telemetry; and Sue Jafar, RN-BC, MSN, CNL, ONC, Senior Care Coordinator and Clinical Nurse Leader, ACE and Acute Rehab, completed their MSNs for clinical nurse leader. As a culmination of their studies, each chose a topic of interest and completed a capstone project.

Alicia Calisto’s project was entitled Implementation of a Unit-based Preceptor Class. Based on a predicted increase in the nursing workforce, and as a result the need for more highly proficient preceptors to train new nurses, the project focused on implementing an interactive unit-based preceptor class.

Three focus areas—preceptor preparedness, preceptor anxiety related to precepting and knowledge of the orientation manual—were used in drafting the curriculum for the class. Results of the post-class evaluation demonstrated a 42 percent reduction in the level of anxiety toward precepting, an overwhelming 100 percent increase in preceptor-perceived level of preparedness for precepting and a 50 percent increase in familiarity with the telemetry orientation manual. As a result, the project was used to update the organizational preceptor class. The project highlighted how the role of the nursing preceptor is crucial to the continued success of the nursing profession, and that interventions to support and improve this role must be made from an evidence-based foundation that continually assesses what preceptors need to succeed.

Audrey Amir’s project, entitled An Integrated Approach to Improve Nursing Documentation of Patient Diabetes Education in the Inpatient Setting, focused on the gap in nursing documentation related to patient diabetes education. A proposal was made for an integrated approach combining a computer-generated order for patient diabetes education, patient education documentation screens with pre-filled selections specific to diabetes, and nursing education as a means to improve nurses’ documentation. Multifaceted education for nurses focused on American Diabetes Association (ADA) Survival Skills topics and included an informational poster at the Nursing Skills Fair, in-service programs and education via email. Implementation of the educational component successfully increased documentation and improving identification of survival skills topics. Pre-intervention, 10 percent of patients had documented diabetes patient education, identifying only medication management. Post-intervention, documentation
increased to 69 percent, with identification of survival skills topics increasing to 39 percent. In analyzing the data, it was discovered that the effect of education diminished over time, reinforcing the need for an integrated approach to effect change in practice. As a result of the project and applying for Joint Commission inpatient diabetes certification, collaboration with the Diabetes Management Program is underway to implement computer-generated orders for diabetes education, to develop nursing documentation screens specific to patient diabetes education and to create required nursing education.

Sue Jafar’s project was entitled Assessing the Risk of Delirium Postoperatively. As the over-65 population continues to grow, pre-disposing and precipitating factors, as well as orthopaedic surgery, present an increased risk for post-op delirium. This may lead to poor outcomes. Prior to surgery, patients are not screened for their risk of developing delirium so education was implemented on the surgical unit focusing on delirium, its risk factors, warning signs and interventions. A pre-education questionnaire was given to staff (nurses as well as nursing assistants) to assess their knowledge of dementia versus delirium. Screening tools for risk factors and assessing delirium were presented. Post-education screening of patients revealed all orthopaedic patients over the age of 65 were at risk for delirium, with 80 percent posing a high risk and 20 percent a moderate risk. This project raised awareness of delirium and factors that increase the surgical patient’s risk for developing delirium post-operatively, as well as interventions to decrease that risk.

These projects highlight the importance of bridging the gap in knowledge with the goal of improving patient care.
IN 2005, PHCS BECAME the first medical facility in New Jersey to be designated as a Bariatric Surgical Center of Excellence (BSCOE) by the American Society of Metabolic and Bariatric Surgery (ASMBS). The designation ensures the facility maintains the highest quality and safety standards for the care of bariatric surgical patients.

To remain accredited, facilities must undergo an extensive site visit every three years, or when a facility moves to a new location, and complete a comprehensive online reaccreditation application. Since UMCP moved to a new location in 2012, an onsite ASMBS inspection took place in the summer of 2013 to evaluate all equipment and confirm staff members were knowledgeable in bariatric sensitivity, safe transfer of bariatric patients and recognition of the signs and symptoms of complications that may occur with bariatric surgical patients.

In preparation for the onsite inspection, interdisciplinary departments worked together to ensure appropriate equipment was available for bariatric patients, and that all staff caring for patients had completed the required education components.

On July 31, 2013, the surveyor completed a thorough inspection of the operating room, emergency room, imaging department, intensive care unit, and surgical care unit to ensure that PHCS met ongoing requirements for BSCOE designation after a facility move. During the onsite inspection, the surveyor questioned staff members on their knowledge regarding the care of bariatric patients, including equipment weight limits, availability and usage; bariatric sensitivity; safe patient transfers and potential complications. Staff from all units displayed exemplary professionalism and knowledge during the onsite inspection. At the completion of the visit, PHCS was notified the facility had met or exceeded the site requirements in all areas.
To address the second component for reaccreditation, the Metabolic and Bariatric Steering Committee (MBSC), consisting of multidisciplinary members, reviewed the BSCOE standards. A subcommittee of the MBSC revised the clinical pathways for the care of bariatric patients, ensuring a standardized pathway is followed for each surgical procedure completed at PHCS. The MBSC reviewed the necessary documentation requested for each BSCOE requirement, ensuring that PHCS was in compliance with all requirements. In late November 2013, the application was submitted electronically to the ASMB, and shortly thereafter PHCS received full reaccreditation as an ASMB Bariatric Surgical Center of Excellence.

Lisa Stout, RN, Bariatric Coordinator, Center for Bariatric Surgery
THE JIM CRAIGIE CENTER for Total Joint Replacement opened on November 4, 2013, with a group of orthopaedic certified nurses preparing the first patients for surgery. This highly qualified team was established over the course of several years, with the foresight and support of nursing management. The surgical care
nurses earned certification in orthopaedic nursing after completing rigorous training and education, along with several days in AM admissions to prepare for managing care in a wellness environment. Prior to the opening, each nurse also participated in a “day in the life” experience, simulating the patient experience at the Joint Center.

The nursing staff learned new processes, started IVs, drew blood and worked more closely with anesthesia and the operating room staff. They also began actively working in conjunction with the nurse navigator, discharge planner and social worker. In the process, they acquired new skill sets and mastered new situations, which gave them a deeper sense of accomplishment and the confidence to achieve higher levels of success. The nursing staff quickly were reminded of the value of teamwork, each bringing his or her own skills to work for the benefit of the patient and the treatment team. In addition to personal and professional growth, team members have become more versatile and flexible, which ultimately has enriched their careers.

A testament to the nursing staff’s preparedness is that after being open for just four days the Joint Center was surveyed by the Joint Commission and received full certification in both hip and knee joint replacement, earning a Gold Seal of Approval.

Sandra Deming, RN, ONC, Direct-care Nurse, SCU, and Elizabeth Shokoff, RN, MSN, ONC, Direct-care Nurse, Surgical Care Unit
NURSING GRAND ROUNDS (NGRS) were reintroduced at UMCP in January 2013, providing staff with the opportunity to present cases, research and outcomes to fellow staff, administration and students, which enhances the nursing profession.

They are performed on a quarterly basis to strengthen nursing practice, and are live sessions that must be attended in person for participants to receive continuing nursing education (CNE) credit. UMCP is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s (ANCC) Commission on Accreditation. To receive full ANCC-accredited contact hour credit for a CNE activity, licensed nurses must attend the entire program and complete and submit an evaluation after the program.

Nurses are encouraged to propose a specific case, research area or situation that will enhance nursing practice for consideration as a Nursing Grand Rounds topic. Program development takes four to six months to complete and begins with a discussion with a nurse manager, an educator or the CNE coordinator.

The following CNE programs were held in 2013: complications and skin failures related to malnutrition in the bariatric patient; pain, odor and dignity; conquering cancer and patient disposition at discharge.

Connie Johnson, BSN, RN, WCC, LLE, OMS, DAPWCA, Wound Care Nurse/Ostomy Management Specialist
SINCE MOVING INTO THE NEW hospital in May 2012, the Emergency Department (ED) has experienced a noted increase in patient visits. Patient volume increased as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
</tr>
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<td>2013</td>
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</tr>
</tbody>
</table>
The Emergency Department Management Team and staff soon realized a process redesign was necessary in order to treat patients more quickly and manage throughput.

In the first quarter of 2013, a team was assembled consisting of staff nurses, patient care technicians, Emergency Department physicians, a clinical nurse leader, assistant nurse managers, a nurse manager, and Registration, Environmental Services, Laboratory and Radiology staff. Their task was to completely redesign the existing model of patient care and throughput with the following goals:

- Providing safe and efficient patient care
- Decreasing door-to-doctor times
- Improving clinical visibility in the waiting room area
- Maintaining budgetary guidelines

Using the Lean/Six Sigma process improvement guidelines, the team began by evaluating volume and determining the predictability of patient arrivals.
Next, a SWOT (strengths, weaknesses, opportunities and threats) analysis was conducted, as well as a site visit to a neighboring ED that recently implemented a throughput redesign called split flow. Split flow is a method of improving Emergency Department throughput and decreasing patient wait times by directing patient flow into the ED based on acuity; higher acuity patients are assigned a bed in the main ED, while those of lesser acuity receive their bed assignments while in the intake area. A tabletop simulation exercise related to the development of this split flow model was conducted, involving direct-care staff along with the Six Sigma Black Belt Process Improvement Coordinator, and the new model of patient throughput was developed with patient safety and satisfaction in mind.

On May 29, 2013, a six-hour pilot was conducted in the ED employing actual patients and staff members assigned to their new roles in the split flow process. After education was provided to the nursing staff, patient care technicians, float staff, physicians, and physician assistants, the split flow model of care was fully implemented on June 5, 2013.

This total redesign has been successful in decreasing door-to-doctor times, and increasing patient satisfaction. The level of teamwork in the ED has greatly improved following interdisciplinary collaboration on this project.
The metrics speak for themselves and demonstrate a marked decrease in median times for the following statistics: length of stay for patients being discharged home; door-to-doctor times; and length of stay for patients with an ESI of 4/5, which represents traditional “fast track” patients.

Patient satisfaction has increased since implementation of the new system. In January 2013, overall Emergency Department patient satisfaction reached a mean score of 80.8 for the month. With the implementation of split flow in June 2013, patient satisfaction rose to a mean score of 91.9 by the end of 2013.

This improvement in Emergency Department processes is directly related to the interdisciplinary collaboration and dedication of the nursing team involved in process improvement.

Daphne Berei, RN, BSN, NEA-BC, Nurse Manager, Center for Emergency Care
WHEN ADDRESSING WOUND CARE in the hospital setting pressure ulcers usually come to mind, but there is an ever-growing prevalence of skin tears. A skin tear is defined as “a traumatic injury occurring principally on the extremities of older adults as a result of shearing or friction forces which separate the epidermis from the dermis (partial thickness wound) or which separate both the epidermis and the dermis from underlying structures (full-thickness wound).” (Payne and Martin, 1993, p. 16) Skin tears can be just as painful and costly, and are as easily preventable, as pressure ulcers.

Much like the emphasis on hospital-acquired pressure ulcers (HAPUs), allowing skin tears will no longer be an option. All research points to prevention, which is far more cost-effective than treatment. The pain associated with skin tears will also reflect on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

Late in 2013, after marking two years of being HAPU-free, the skin integrity team at UMCP took on a new challenge. The STAR (skin tear audit research) classification system was introduced to properly document and categorize skin tears. Effective documentation of skin tears at UMCP laid the foundation for future research and for accurately measuring their prevalence. Furthermore, a skin tear risk assessment tool (White et al., 1994) was adopted to identify patients at risk for developing skin tears. Through proper utilization of this tool, nursing care plans and interventions were generated to ensure optimal prevention of skin tears in at-risk patients.
Preliminary feedback from nursing staff revealed an increased awareness of skin tear risk, prevention and treatment.

The current research project at UMCP aims to evaluate skin tear risk criteria in patients admitted to the ACE Unit. The goal is to develop a skin tear risk assessment tool that is both simple and effective in identifying patients at risk for developing skin tears. Through collaboration with the Information Technology department, such an assessment tool would evaluate risk criteria previously documented in the patient’s electronic medical record. With the burden of rising healthcare costs, institutions can no longer be complacent in regard to skin tear prevention. A simple and effective skin tear risk assessment tool translates into decreased skin tear prevalence while increasing compliance and staff satisfaction.

Michael Katzman, RN, BSN, ONC, Float Nurse, WCC
IN JULY 2011, a multidisciplinary committee formed to implement best practices related to care of the hospitalized patient at risk for alcohol withdrawal syndrome. At the time, the care of these patients was based on physician discretion and preference. As a result, the committee was faced with the task of developing a policy and protocol to guide care for these patients.

In 2013, the Management of Alcohol Withdrawal Syndrome Policy was created and the Clinical Institute Withdrawal Assessment (CIWA-ar) protocol was implemented. With the policy in place, educating staff on the new protocol began, and one-on-one as well as Health Stream education was provided to staff hospital-wide.

The CIWA-ar protocol was developed based on the alcohol withdrawal syndrome literature for medically ill adult patients, and is consistent with protocols used nationally. Based on a set of assessments, the nurse obtains a score to rate the severity of a patient’s alcohol withdrawal. Medication management of withdrawal is based on severity of symptoms. By supporting a symptom-triggered approach, the CIWA-ar protocol decreases overall benzodiazepine use, prevents progression to alcohol withdrawal delirium, and is associated with less over-sedation. Like the heparin protocol, it is physician-initiated, nurse-driven, and includes QCPR documentation and orders to support interventions. Two years after its inception in July 2011, the CIWA-ar protocol was fully implemented.

Development of the Alcohol Withdrawal Syndrome Policy and implementation of the CIWA-ar protocol highlights the efforts of a multidisciplinary team in bringing evidence to the bedside.

Audrey Amir, MSN, RN, CNL, PCCN, Clinical Nurse Leader, Medical Neurology Oncology Unit
ON MOST CARE UNITS, noise and frequent interruptions can stress patients during hospitalization. On the 6th floor (Labor and Delivery, Mother-Baby) these stressors can impact both the mother and infant by delaying the healing process, hindering parent/infant bonding and interfering with establishing positive and effective breastfeeding patterns. With these issues in mind, in December 2012, the 6th floor decided to implement a designated quiet time program. By working closely with dietary and environmental services, the nurses were able to set aside the hours of 1 to 2:30 p.m. as a period of undisturbed time on the floor. This allotted time period enables parents to bond with their newborn, breastfeed, or simply relax without interruption. Staff members are able to use this time to chart.

Quiet hours are observed in a number of ways:

• Where possible, lights are dimmed. Simply dimming the lights can encourage staff, patients and visitors to speak more softly.
• Overhead paging is minimized.
• Conversations in nursing stations and other areas are minimized or conducted in a hushed manner.
• Visitors are encouraged to use this time as an opportunity to eat lunch or take a stroll around the UMCP campus.
• Phone conversations are restricted to designated areas, away from patient rooms.
• Clinical interventions (vital signs, blood draws, etc.) are minimized or eliminated during quiet hours.
• Rounds are moved to times outside of the designated quiet hours.

The concept of quiet time is not a new one; however, the concept is new to UMCP, and was brought to the unit by Sveta Elmoudden, BSN, RNC, Mother-Baby Unit.

Diane Driver, MSN, RN, Clinical Instructor, Center for Maternal & Newborn Care
SINCE THE CONGESTIVE HEART FAILURE (CHF) patient population has multiple educational needs and is at high risk for readmissions, the Telemetry Unit was chosen to trial the CHF pathway and Project Re-Engineering Discharge (RED). The unit sought to improve readmission rates, reduce medication discrepancies, and increase discharge patient readiness and satisfaction scores as they relate to the CHF patient. All of these goals were addressed by implementing Project RED, an evidence-based practice to improve patient outcomes related to discharge.

The CHF pathway is a personalized workflow that proactively empowers and engages patients in their healthcare through an interactive system. Project RED is an evidenced-base discharge toolkit developed by Boston University in collaboration with the Agency for Healthcare Research and Quality (AHRQ) that aims to reduce hospital readmissions and increase patient satisfaction in the area of discharge. Throughout 2013, a multimodal approach utilizing both the CHF pathway and Project RED was developed. Clinical staff was educated on how to incorporate the CHF pathway and Project RED initiatives into their daily workflow.

Preliminary results of both initiatives demonstrate an increase in patient satisfaction as it relates to discharge readiness. Following implementation of Project RED and the CHF pathway through the patient interactive system, discharge satisfaction scores on Telemetry rose from the 75 percent (2013) to 90 percent (2014) and Telemetry CHF readmission rates dropped from 20 percent in 2012 to 13.8 percent in 2013. These metrics will continue to be monitored on a daily basis.

Lopa Patel, RN, MSN, Clinical Instructor and GetWell System Manager
IN THE REALM OF PSYCHIATRIC NURSING, the use of physical restraint is a necessary treatment modality utilized to maintain patient and staff safety. Over the past several decades, the field of psychiatric nursing has evolved, resulting in a reduction in the use of physical restraints and patient injury, sometimes associated with restraint. This is due in part to the
development of new and improved medications. However, increased knowledge and skills by mental healthcare providers of de-escalation techniques, coupled with the adoption of a clinical approach encouraging staff to reduce/minimize the usage of restraints by implementing the least restrictive interventions available, has had a more significant impact. At Princeton House, the staff is given intensive training necessary to ensure proper handling of patients who are not in control of their behavior.

Though Princeton House’s rate of restraint was low compared to national benchmarks, staff began a performance improvement project to see if scores could be further improved. Changes were implemented over the year, which resulted in a reduction of incidents of restraint. One of the key components of the plan was staff education. At Princeton House, the nursing staff is required to complete a yearly Handle with Care (HWC) course. The program is designed to teach staff how to identify early warning signs of patients who may become aggressive, how to verbally de-escalate a patient, and how to intervene if a patient becomes violent. Staff is taught how to deal with these difficult situations in a way that preserves the client’s dignity, ensures staff and patient safety, and maintains a perception of physical and psychological safety among other patients. Emphasis is placed on utilizing the least restrictive modes of interventions first, before considering restraint.

HWC classes are taught by nursing staff members who have been specially trained as instructors. As part of the PI project, the number of staff at Princeton House trained at the instructor level was increased. From that point, most codes had an instructor present. Through debriefings led by these instructors after each incident of restraint, continual refinements to the process were made. The debriefing process starts immediately after the restraint episode. The staff involved carefully review the events precipitating the episode and determine what steps may have been utilized to have possibly prevented the event. The interventions during the event are reviewed, as well, to ensure they were applied correctly and identify any opportunities for improvement. A treatment plan is then developed and initiated by the staff involved in the event to help prevent future episodes of restraint.
As part of the PI improvement project, a committee consisting of Handle with Care instructors was formed. The purpose of this committee was to examine ways to improve staff responses, not only during those times when a patient is in crisis but throughout all interactions with a patient during their hospitalization. Trainers met monthly to review all episodes of restraint, psychiatric codes called, whether they resulted in an episode of restraint or not, and documentation for the month to ensure the policy and procedures regarding the use of restraints were followed. It is also an opportunity for instructors to learn from one another.

Recommendations from the committee are then incorporated into future trainings, resulting in a constant flow of improvements. These meetings also helped ensure all the instructors were teaching the same information in the same way, and instructing staff on the most beneficial way of handling agitated and potentially violent patients.

The PI project resulted in positive outcomes. The national benchmark for episodes of restraint is 4.6 (per 1,000 patient days). For the first six months of 2013 the Princeton House rate was 1.3, at which point the PI project was implemented. By the end of 2013, Princeton House’s rate was 1.0.

Dan Friel, BSN; Karen McLeod, MS, RN, and Andrew O’Rahilly, RN
PRINCETON HOMECARE provides comprehensive in-home nursing and rehabilitation, hospice care and support services. The multidisciplinary services include aspects of therapeutic care, teaching, and counseling. In 2013, Princeton HomeCare admitted 4,228 patients with an average census of 460 patients per day.

In 2013, Princeton HomeCare’s patient outcomes exceeded the state and national benchmarks in the following areas:

- Improvement in ambulation
- Improvement in bathing
- Conducting pain assessments and implementing appropriate interventions (achieved 100 percent of the time)
- Addressing heart failure symptoms
- Assessing pressure ulcer risks and implementing preventative measures
- Completing drug education for all medications
- Conducting fall risk assessments (100 percent of the time)
Also in 2013, Princeton HomeCare successfully reduced hospital readmissions, achieving a 17.3 percent readmission rate—better than the national average and significantly lower than our benchmark of 23 percent.

In addition, Princeton HomeCare focused on improving medication reconciliation in the home. In the 4th quarter of 2013, at least 70 audits and nine site visits were conducted per month to ensure that patients kept a current medication list in the home and that it matched the data in the electronic medical record. Princeton HomeCare achieved its goal of 90 percent or greater compliance.

Princeton HomeCare was actively involved with planning the new Jim Craigie Center for Joint Replacement and has helped to evaluate the center’s care and service since it opened in late 2013. Princeton HomeCare changed its requirements and began providing physical therapy seven days a week to accommodate patients of the Jim Craigie Center. Both the nursing and therapy staff were educated on the new post-operative standards. HomeCare now provides therapy in the home seven days a week for two weeks to help joint center patients transition to an outpatient setting. Feedback has all been positive.

One field clinician, Ann Mathiews, published an article, co-authored by Susan Salmond, in the June 2013 edition of Home Healthcare Nurse. The article was titled Opening the Door to Improve Visiting Nurse Safety: An Initiative to Collect and Analyze Protection Practices and Policies.

The Hospice Program of Princeton HomeCare utilizes a team approach to provide coordinated, multidisciplinary services for patients with a limited life expectancy and their families. The program focuses on improving patients and family members’ quality of life by serving physical, emotional, spiritual, social and economic needs during the final stages of illness and through bereavement. In 2013, 425 patients were admitted to the program with an average census of 64.
The hospice team has been working collaboratively with hospital staff to improve pain and symptom management for the inpatient population. Order sets have been developed, and there are plans to implement them in the 3rd quarter of 2014 for physicians.

The hospice team also made positive strides related to home health aide (HHA) supervisions. In 2013, hospice conducted and documented HHA supervisions within the prescribed time frame 87 percent of the time, a significant improvement from prior years.

Bereavement services, an integral part of the Hospice Program, saw improvement in 2013 as well. Hospice measures bereavement contact—in accordance with regulatory requirements—at death, 12 weeks afterward and again 12 to 13 months afterward.

Satisfaction surveys for bereavement services continued to show positive feedback. Risk assessments conducted for family members of patients entering hospice care also showed improvement, with assessments being conducted at the start of care 90 percent of the time.

Several staff members of Princeton HomeCare and the Hospice Program were honored recently at the Celebration of Gratitude, an annual luncheon that recognizes PHCS team members whose work inspired patients or their families to make donations in their names. The honorees were: Pat Koch, Liz Cohen, Maryann Sheerin, Sandra Toles, Kathy Shanaberger, Chris Reisser, Joan Marks, Maureen Register, Shariffa Torres, Shirley Thomson, Violeta Ilicic, Jenna Freund, and Janethe Yaeggy.
2013 Clinical Advancement and Recognition of Excellence (C.A.R.E.) Nurses

RN 1
Sandra Deming
Peggie Lambertson
Sujana Mallipattu
Katherine B. Posch
Janis L. Richards
Alicia Stevens
Regina Zupanc

RN 2
Rowena Aguirre
Nancy Alpaugh
Jeri Ballew
Deborah Ballard
Patricia Bechamps
Pamela Bloom
Brielle Burd
Christina Caamano Hussein
Lisa Calabrese
Loretta Chipin
Lucky A. Colon
Kathleen Cooney
Lisa D’Angelo
Debra Davies
Melanie Delin
Eileen Devlin
Margaret Deysher
Michelle Diaz
Gina Dinunzio
Kristin Doloff

RN 3
Rebecca Drexel
Donna Ecke
Jamie Ellmer
Kimberly M. Enterline
Christine Faust
Claire Fazio
Mayda Federovitch
Cecilia Ferreira
Charles Gallagher
Lakeisha Gayles
Alexa Greenstein
Liya Gu
Sharon E. Hamilton
Maria Hevery
Christine B. Hicks
Qinghe Jiang
Ahmaad Johnson
Shana Joshua
Sang Jung
Keturah Kallens
Erin Kane
Cynthia Keintz
Mary Kiensicki
Anne Kim
Catherine Knott
Sara Knowles
Laurie K. Kopanyi
Cheryl A. Kotarski
Meghan R. Kwiatkowski
Kelly J. Lacava
Ann Lippin
Mary M. Maguire
Natalie Martin
Kate McClure
Senora McDonald
Brigitte McNamara
Neha Mistry
Stella Molineros
Kristen Montefusco
Tani Nachtman
Tania Nandy
Mollie Nutkiewicz
Chioma Obiukwu
Rachele Olivier
Andrew O’Reilly
Amber Parker
Rachel Pie
Jane M. Platt
Kelly Porreca
Faye Pringle
Marissa Rago
Stephanie A. Reed
Brenda Reyes-Sussman
Neydin Rivera
Ellen Rodriguez
Kim Rogers
Patricia Rogers
Nicole Schaible
Shannon Scott
Grace Shah
Marlene Smith
Elenora Soskind
Jessica Soto
Maryellen Spencer
Donna Starling
Maria Stout
Marcia J. Szochet
Catherine Taaffe
Catherine Toto
Phillip Tran
Eva Treder
Marites Ventus
Kamman A. Viterito
Linda Werner
Michael Wexler
Dianne Willan
Hong Yan
Allison M. Yiacas
Jeong Yoon
Jung S. Yun

RN 4
Susan Anderson
Eileen Aneskewich
Jeannie Arena
Susan Ayres
Devaki Balasingham
Lorna Barron
Alicia Becker
Dolores Blauth
Julia Blum
Stacy Booher
Christina Brescia
Elizabeth Brogan
Jessica Campbell
Gail E. Charette
Ashley Charmello
Patricia Chehanske
Anna Cheung
Jessica Cohen
Kristyn Compitello
Debra Cristelli
Ivon Crucero
Esta Desa
Jill DeStefano
Sandra Dutcher
Amanda Dzwilewski
Ashley C. Edling
Pam Ellet
Svetlma Eloumouden
Carol Fabian
Mary Ellen Finn
Daniel Friel
Vanessa A. Gundersen
Colleen Haraz
Allison Healy
Barbara Heruska
Murielle Jeanty
Sheena Jebu
Jennifer Johansen
Lisa J. Johnson
Fanta Kallon
Judith Kelly
Laura M. Kelly
Coleen Kelly-Toler
Karen L. Kraehenbuehl
Subha Jyothi Kukkula
Fayez Labid
Galit Landau
Lorianne Leonardi
Cori Levesque
Jeannette Levin
Sandra A. Long
Martine Lubin
Monica Lyle
Andrea Lynn
Dawn Mabin
Kim MacAvoy-Sorochen
Natali Macon
Aileen Margiottto
Alice Matey
Andrea McCarty
Denise McGinley
Sarah McHugh
Frances A. McKinley
Molly Meek
Berbeth Meisel
Treeza Menezes
Amy L. Miller
Denise Monahan
Lori O. Mozenter
Sheenamol Nair
Olubukola Osinowo
Pamela Panahon
Joytsna Patole
Tisha Payne
Lee Ann Popovich
Barbara D. Reese
Dawn A. Rittley
Debbie Savastano
Carol Schwab
Amanda B. Sheehan
Eileen Sheppard-Hinkle
Elizabeth Shokoff
Lori Sletta
Sheryl Smolensky
Hina Summers
Edita Surlbiene
Hebe Tangga-An
Casey Templin
Elana Toboul
Sheila Troiano
Kristin Tyrell
Lauren Varvi
Mary Villardi
Janet Viscomi
Teresa Voightsberger
Loretta Voorhees
Deborah Walsh
Josephine M. Waseleski
Karla Weekes
Jennifer Wiley
Jordana Webber

RN 5
Mary E. Aitken
Christina Allen
Elizabeth Beckett
Debra Brian-Taft
Gail Haftel
Susan Jafar
Michael Katzman
Griselda Quia
Nancy Rhodes
Nicole L. Rook
Susan L. Straszynski
Britni Walton
Jordana Zisman
Direct-care Nursing Excellence Winners and Nominees

Overall Direct-care Winner
Dolores Blauth

Center for Critical Care
Kimberly Enterline
Alice Matey
Kristen Peterson (Winner)

Telemetry
Sarah McHugh (Winner)
Dee Balasinghar
Michael Wexler

Medical Neurology/Oncology Unit
Rebecca Drexel
Denise McGinley
Rachele Oliver
Anisha Pittman
Britni Walton (Winner)

Acute Care the Elderly Unit
Ashley Charmello
Cecilia Ferreira
Theresa Hartman
Allison Healy
Cori Levesque
Amy Miller
Sheenamol Nair
Tisha Payne (Winner)

Float Pool
Alicia Becker
Michael Katzman (Winner)

Center for Emergency Care
Christina Allen (Winner)
Jeannine Booth
Lakeisha Gayles
Meghan Kwiatkowski
Sandy Long

Center for Pediatric Care
Judy Kelly
Griselda Quia (Winner)

Mother-Baby
Jill Destefano (Winner)
Sheena Jebu

Labor and Delivery
Lisa D’Angelo
Pam Ellet
Lacey Lisner
Aileen Margiottto (Winner)

Peri-Operative Services
Frances McKinley (Winner)

Nursery
Margy Deysher
Nikki Rook
Susan Straszynski (Winner)

Neonatal Intermediate Care Unit
Andrea McCarty (Winner)
Bernadette Rabbitt

Center for Eating Disorders Care
Baljit Dodd
Cynthia Keintz (Winner)
Teresa Voigtsberger

Surgical Care Unit
Sue Anderson
Dolores Blauth (Winner)

Radiology
Christina Brescia (Winner)

Center for Ambulatory Surgery/Endoscopy
Donna Eicke (Winner)

Center for Ambulatory Surgery - Monroe
Karen Cote (Winner)

Princeton HomeCare
Pat Anene (Hospice) (Winner)
Elizabeth Reynolds (Winner)
Krystine Steffen

Acute Rehabilitation
Suzanne Keith
Maryann Protz (Winner)

Bristol-Myers Squibb Community Health Center
MaryEllen Finn (Winner)

2013 DAISY Winners
January
Grace McDonald-Largie
Maternal Fetal Medicine

February
Karla Weekes
Float Pool

March
Jessica Soto
Acute Care of the Elderly Unit

April
Michael Katzman
May
Ann Spedding
Princeton HomeCare

June
Dolores Blauth
Surgical Care Unit

July
Christine Kelly
Mother-Baby Unit

August
Sharon Braconi
Labor and Delivery

September
Mary Ann Sheerin
Princeton HomeCare

October
Rachel Aquino
Neonatal Intermediate Care Unit

November
Imelda Remolada
Princeton HomeCare

December
Eva Kantor
Princeton HomeCare

2013 Nurses Week Nominees and Winners

2013 Leadership Nursing Excellence Winners and Nominees

CNL
Inez Brandon
Alicia Calisto
Sandra Mariani (Winner)

Educators
Rebecca Godofsky
Connie Johnson (Winner)
Lopa Patel
Nancy Rhodes

Nurse Managers/Directors/Administration
Mary Aitken
Karyn Book (Winner)
Toni Marie Brusnahan
Jeff Cliver
Sara Mognodan
Katrina Pfeiffer
Lydia Pitonyak
Humility Sumayang
Mindy Tanpiengo
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<td>January 16</td>
<td>Senior Education Day</td>
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<td>January 17</td>
<td>Hernias, What You Need to Know</td>
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<td>Basic Arrhythmia Course</td>
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<td>Nursing Grand Rounds: The Study of Wounds in Compromised Patients</td>
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<td>April 12</td>
<td>RN Float Team Education Day</td>
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<td>April 16</td>
<td>Verbal De-escalation of an Agitated Patient</td>
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<td>Hello I am Here to Help: Verbal De-escalation of an Agitated Patient</td>
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<td>Legal Aspects of OR Nursing Documentation</td>
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<td>Febrile Neutropenia</td>
<td>1.00</td>
</tr>
<tr>
<td>May 21</td>
<td>Basic Fetal Monitoring</td>
<td>4.00</td>
</tr>
<tr>
<td>May 24</td>
<td>Antepartum Educational Program</td>
<td>5.50</td>
</tr>
<tr>
<td>May 29</td>
<td>Annual Stroke Day</td>
<td>5.25</td>
</tr>
<tr>
<td>May 31</td>
<td>Basic Arrhythmia Course</td>
<td>7.50</td>
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<tr>
<td>June 6</td>
<td>Antepartum Educational Program</td>
<td>5.50</td>
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<tr>
<td>June 10</td>
<td>Neurobiology of Eating Disorders and Comorbidity with Substance Dependence</td>
<td>1.00</td>
</tr>
<tr>
<td>June 12</td>
<td>Nursing Grand Rounds: Conquering Cancer</td>
<td>1.00</td>
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<tr>
<td>June 18</td>
<td>Preceptor Program</td>
<td>3.50</td>
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<tr>
<td>June 19</td>
<td>Nursing Research Mini Series 2013</td>
<td>2.50</td>
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<tr>
<td>June 24</td>
<td>Addiction Treatment and Policy: What Does the Future Hold?</td>
<td>1.00</td>
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<tr>
<td>June 28</td>
<td>Bereavement Program</td>
<td>4.00</td>
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<tr>
<td>July 8</td>
<td>Longevity</td>
<td>1.00</td>
</tr>
<tr>
<td>July 10</td>
<td>Nursing Research Mini Series 2013</td>
<td>2.50</td>
</tr>
<tr>
<td>July 17</td>
<td>Psychotropic Medications</td>
<td>1.00</td>
</tr>
<tr>
<td>July 17</td>
<td>Ultrasound Physics and the Use of Ultrasound for Invasive Monitor Placement</td>
<td>1.00</td>
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<tr>
<td>July 18</td>
<td>Arrhythmia Review</td>
<td>0.50</td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Credit Hours</td>
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<tr>
<td>August 7</td>
<td>Nursing Research Mini Series 2013</td>
<td>2.50</td>
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<tr>
<td>August 12</td>
<td>DSM-5: A Critical Overview</td>
<td>1.00</td>
</tr>
<tr>
<td>August 21</td>
<td>The Screening and Commitment Process</td>
<td>1.00</td>
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<tr>
<td>August 26</td>
<td>Emerging Clinical Issues Facing GLBT Clients in a Time of Cultural Change</td>
<td>1.00</td>
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<tr>
<td>September 9</td>
<td>Management of a Misunderstood Molecule: The Role of Methadone in Addiction Medicine</td>
<td>1.00</td>
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<tr>
<td>September 12</td>
<td>STABLE Program</td>
<td>12.00</td>
</tr>
<tr>
<td>September 23</td>
<td>Disgust: Origins, Evolution and Development</td>
<td>1.00</td>
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<tr>
<td>September 24</td>
<td>Role of Ketamine in Acute Pain Management in the Opiate Tolerant</td>
<td>1.00</td>
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<tr>
<td>September 25</td>
<td>9th Annual Research Day: The Nurse of the Future</td>
<td>5.50</td>
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<tr>
<td>September 27</td>
<td>Grand Rounds: Hypertensive Emergencies in Obstetric Patients</td>
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<tr>
<td>October 2</td>
<td>Oncology Day</td>
<td>6.50</td>
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<tr>
<td>October 8</td>
<td>Ostomy Care</td>
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<tr>
<td>October 11</td>
<td>Geriatric Noon Conference</td>
<td>1.00</td>
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<tr>
<td>October 14</td>
<td>Lyme Disease and Other Tick-borne Infections: Screening Tools for Mental Health Clinicians</td>
<td>1.00</td>
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<tr>
<td>October 15</td>
<td>Charge Nurse Course</td>
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<tr>
<td>October 15</td>
<td>Charge Nurse Course (with OB Enhancement)</td>
<td>4.50</td>
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<tr>
<td>October 17 &amp; 24</td>
<td>Certified Emergency Nurse 2-Day Review Course</td>
<td>7.00/6.50</td>
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<tr>
<td>October 25</td>
<td>Grand Rounds: Art, Evidence and the OB</td>
<td>1.00</td>
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<tr>
<td>October 28</td>
<td>Suicide Interventions: Lessons Learned from First Responders</td>
<td>1.00</td>
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<tr>
<td>October 30</td>
<td>Orthopaedic Day</td>
<td>5.00</td>
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<tr>
<td>November 7</td>
<td>Cardiology Day</td>
<td>6.50</td>
</tr>
<tr>
<td>November 8</td>
<td>Newborn Physical Assessment</td>
<td>2.00</td>
</tr>
<tr>
<td>November 11</td>
<td>Neuromodulation and Depression</td>
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<tr>
<td>November 12</td>
<td>Just the Basics: Left Ventricular Assist Device</td>
<td>1.00</td>
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<tr>
<td>November 12</td>
<td>Wound Assessment/Documentation</td>
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<tr>
<td>November 22</td>
<td>Grand Rounds: Implementation of Cell-free DNA Testing</td>
<td>1.00</td>
</tr>
<tr>
<td>November 25</td>
<td>Compassion Fatigue and Self-care</td>
<td>1.00</td>
</tr>
<tr>
<td>December 2</td>
<td>Anesthesia and the Labor Patient</td>
<td>1.00</td>
</tr>
<tr>
<td>December 5</td>
<td>Engaging Clinical Allies in Philanthropy</td>
<td>1.00</td>
</tr>
<tr>
<td>December 6</td>
<td>STABLE Program</td>
<td>12.00</td>
</tr>
<tr>
<td>December 9</td>
<td>Beyond SSRs: Strategies for Refractory Mood Disorder</td>
<td>5.00</td>
</tr>
<tr>
<td>December 20</td>
<td>Newborn Physical Assessment</td>
<td>2.00</td>
</tr>
<tr>
<td>December 23</td>
<td>Internalized Stigma and Severe Mental Illness: Clinical Considerations</td>
<td>2.00</td>
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</tbody>
</table>

**Total**                                                                 | **201.5**
Degrees Achieved

**Audrey Amir**, RN, MSN, PCCN, CNL, Clinical Nurse Leader, MNO; **Sue Jafar**, RN, MSN, OCN, CNL, Direct-care Nurse, SCU; and **Alicia Calisto**, RN, MSN, PCCN, CNL, Clinical Nurse Leader, Telemetry, graduated from The College of New Jersey with their masters in nursing, with a focus on the Clinical Nurse Leader Program.

**Jeannie Arena**, RN, MSN, Direct-care Nurse, ED, received her MSN in nursing education from University of Phoenix.

**Karen Boland**, RN, Direct-care Nurse, ED, graduated from Drexel University in June with her BSN degree.

**Debbie Brian-Taft**, RN, MSN, CPAN, Direct-care Nurse, PACU, received her MSN in education from Walden University.

**Stephanie Devine**, RN, BSN, Direct-care Nurse, Telemetry, received her BSN from Gannon University in December.

**Nicole Kuczinski**, RN, BSN, Direct-care Nurse, MNO, received her BSN from Gwynedd Mercy College.

**Cori Levesque**, RN, BSN, Direct-care Nurse, ACE Unit, received her BSN from Rowan University in August.

**Dee Vandegrift**, RN, BSN, Direct-care Nurse, Mother Baby Unit, received her BSN from the University of Delaware.

Publications

**Lori McMullen**, RN, MSN, OCN, Senior Oncology Nurse Navigator for the cancer program in the Edward & Marie Matthews Center for Cancer Care, contributed an article titled *Oncology Nurse Navigators and the Continuum of Care* to the journal *Seminars in Oncology Nursing*. In November, the Oncology Nursing Society (ONS) published her article titled *ONS Oncology Nurse Navigator (ONN) Core Competencies*.

**Lopa Patel**, RN, BSN, Clinical Instructor, had her abstract on succession planning accepted for the 2013 New Jersey League of Nursing Convention.
Audrey Amir, RN, MSN, PCCS, CNL, MNO Unit, and Sue Jafar, RN-BC, MSN, CNL, NICHE Coordinator, received their Clinical Nurse Leaders certification in August.

Linda Bellaus, RN, Direct-care Nurse, Mother-Baby Unit, and Kristin Doloff, RN, Direct-care Nurse, Nursery, both achieved their lactation counselor certification.

Inez Brandon, RN, MSN, Clinical Nurse Leader, MNO, was re-certified in hospice and palliative nursing through December 2016.

Jessica Cohen, RN, BSN, Direct-care Nurse, OR, received her certified nurse operating room certification.

Sandy Dutcher, RN, CPAN, Direct-care Nurse, PACU, and Amy Sheehan, BSN, RN, CPAN, Direct-care Nurse, PACU, received their certified post-anesthesia nurse certification.

Amanda Dzwilewski, RN, BSN, PCCN, Direct-care Nurse, Float Pool, and Kristin Tyrell, RN, BSN, PCCN, Direct-care Nurse, Float Pool, received their PCCN certification.

Ashley Edling, RN, ONC, Direct-care Nurse, SCU; Megan Ratwani, RN, BSN, ONC, Direct-care Nurse, SCU; Maria Stout, RN, ONC, Direct-care Nurse, SCU; and Mary Zegarski, RN, OCN, Direct-care Nurse, OR, received their orthopedic nursing certification.

Sveta Elmoudden, RN, BSN, Direct-care Nurse, Mother-Baby Unit, received pain resource RN certification.

Vanessa Gunderson, RN-BC, BSN, Direct-care Nurse, ACE Unit, passed her geriatric nursing certification.

Connie Johnson, BSN, RN, WCC, LLE, OMS, Wound/Ostomy Nurse, successfully completed certification as an Ostomy Management Specialist through the National Alliance of Wound and Ostomy Care.

Michael Katzman, BSN, RN, ONC, WCC, Float Pool, received his wound care certification in December.

Britni Walton, RN, BSN, Direct-care Nurse, MNO, received oncology certified nurse certification through the American Nursing Credentialing Center (ANCC) and successfully completed her wound care certification through the National Alliance of Wound Care.
**Poster Presentations**

**Hedi Badolato**, RD, Nutrition; **Denise Dacey**, RD, Nutrition; **Kim Stevens**, RN, Direct-care Nurse, CCU; **Jen Fox**, RN, Direct-care Nurse, CCU; **Connie Johnson**, RN, BSN, WCC, LLE, OMS, Wound and Ostomy Nurse; **Dr. Youssef**, and **Dr. Sinner** presented a poster titled *Complications and Skin Failures Related to Malnutrition in the Bariatric Patient*. The poster was accepted to multiple conferences in 2013.


**Alicia Calisto**, BSN, RN, PCCN, Telemetry, had Skin Integrity Team members present her poster titled *Rapid Cycle Test Comfort Becomes Compliance* at the Wild on Wounds Conference in Las Vegas, NV, in September.

**Connie Johnson**, BSN, RN, WCC, LLE, Wound Care Nurse, presented the poster *Side by Side* A Case Series Comparing Cost and Effectiveness of Leptospermum Honey and Collagenase at the Wild on Wounds Conference in Las Vegas, NV, in September. She received the 1st Place Case Study Poster Award for the poster during the 2012 Symposium on Advanced Wound Care Fall Conference in Baltimore, MD. A poster titled *A Cost-Effective Alternative: Investigating Absorbent Gelling Calcium Alginate Dressings with Antimicrobial Silver* was presented on her behalf at Wounds International Global Conference 2013 in Kuala Lumpur, Malaysia, and a poster titled *Benefits of a Novel Medihoney Hydrogel Colloidal Sheet on Complex Wounds* was presented on her behalf at Wounds UK Annual Conference 2013 in London, UK in November.

**Mike Katzman**, BSN, RN, ONC, Float Pool, presented the poster *Heightened Awareness Through Risk Assessment Raises Moving Standards, Successful Prevention From Old House to New House* at the Wild on Wounds Conference in Las Vegas, NV, in September.

**Judy Kelly**, BSN, RN, COCN, CPN, Pediatrics, presented the poster *Skin Integrity Team* at the Wild on Wounds Conference in Las Vegas, NV, on behalf of the Skin Integrity Team of UMCP in September. She also presented posters on behalf of the Skin Integrity Team at the Symposium of Advanced Wound Care Conference, in June in Denver, CO.

**Denise McGinley**, BSN, RN, BC, MNO Unit, presented the poster *Pain, Odor, Dignity, Wounds: Management of a Complex Oncology Patient With Multiple Wounds* at the Wild on Wounds Conference in Las Vegas, NV, in September.

**Sara Moghadam**, BA, RN, PCCN, Nursing Performance Improvement Coordinator, and **Nune Mehrabyan**, MS, BSN, Information Technology, developed a poster that was presented at the Wild on Wounds Conference in Las Vegas, NV, in September, titled *Improving Nursing Quality Indicator Outcomes With the Use of Nursing Informatics*.

**Juliet Puorro**, RN, MSN, CNL, ONC, Clinical Nurse Leader, SCU, presented a poster at the National Alliance of Orthopedic Nurses conference in San Antonio in May. Co-authored by **Sheetal Daru**, PT, the poster was titled *Implementing a Group Physical Therapy Program on an Inpatient Surgical Unit*.

**Britni Walton**, BSN, RN, OCN, Direct-care Nurse, MNO; **Alicia Calisto**, MSN, RN, PCCN, Clinical Nurse Leader, Telemetry; **Sandra Long**, RN-BCED, Direct-care Nurse, ED; and **Connie Johnson**, BSN, RN, WCC, LLE, OMS, Wound/Ostomy Nurse, presented a poster on the rapid cycle test done on Telemetry titled *Comfort Becomes Compliance on behalf of UMCP at the National Pressure Ulcer Advisory Panel Conference in Houston, TX, in February.*

On behalf of the **Skin Integrity Team** the following posters were accepted by the Wild On Wounds 2013 Conference, Las Vegas, NV, in September:

- **Poster # 10 - One Size Does Not Fit All**
- **Poster # 11 - Use of Active Leptospermum Honey to Manage Wounds of the Oral Cavity**
- **Poster # 13 - TCC - It’s That Easy!!**

**Alicia Becker**, RN, BC, Float Nurse; **Judy Kelly**, BSN, RN, COCN, Direct-care Nurse, Pediatrics; **Britni Walton**, BSN, RN, OCN, Direct-care Nurse, MNO; and **Connie Johnson**, BSN, RN, WCC, LLE, OMS, Wound/Ostomy Nurse, published and presented multiple posters at the Wild on Wounds Conference in September in Las Vegas, NV, on behalf of Skin Integrity Team and Medical Neurology Oncology (MNO).
Connie Johnson, BSN, RN, WCC, LLE, OMS, DAPWCA, Wound Care Nurse, received the Outstanding Research in Wound Care Award from the National Alliance of Wound Care and Ostomy in September. The award, the second win for her, recognized her use of nursing research to promote growth in the field, mentoring and inspiring others to do the same, and striving to improve wound care knowledge in the community through research. Her research-based publications and poster presentations have been presented at several national conferences, and her research includes protecting patients’ skin during transportation between facilities (specifically distance ambulance transport), wound care formulary guidelines based on evidence-based research, newborn skin best practices, and eating disorder patients best practices in wound management.

Kelly Lamonica, RN-BC, MSN, Clinical Nurse Leader, Maternal Child Health, was appointed to an adjunct faculty position at The College of New Jersey for Obstetrical Nursing.

Lori McMullen, RN, MSN, OCN, Senior Oncology Nurse Navigator for the cancer program in the Edward & Marie Matthews Center for Cancer Care, was presented with the 2013 Oncology Nursing Society Best Special Interest Group Newsletter Article Award for her article highlighting her experiences as an oncology nurse navigator consultant working with the Romanian National School of Public Health, Health Management and Professional Development and the Romanian Nurses Association to develop an oncology nurse navigator model of care in Romania.

Elana Toboul, RN, Direct-care Nurse, CCU, was elected to the American Association of Critical Care Nurses, Central New Jersey Board, as the Treasurer-Elect.
Acute Care the Elderly Unit (ACE)
Mary E. Aitken, Geriatrics
Vanessa A. Gundersen, Geriatrics
Allison M. Healy, Geriatrics
Denise McGinley, RN BC
Amy L. Miller, Geriatrics, MS
Jessica I. Soto, Geriatrics
Veronica Dizon Tiongko, MS
Kristen Viola, MS

Acute Rehabilitation
Karen Genthner, CRRN
Susan Jafar, ONC
Maryann Protz, CRRN

Center for Ambulatory Surgery-Monroe
Karen A. Cote, CAPA
Jeong H. Yoon, CCRN

Breast Health Center
Mary Kiensicki, CBCN

Edward & Marie Matthews Center for Cancer Care
Lori McMullen, OCN
Deborah Richey, OCN

Cardiac Catheterization Lab
Carollynn Cosico-Ramirez, CCRN
Allison Lyons, RN-C
Maria Torralba, CCRN
Allison M. Yiacas, CCRN

Cardiac Rehab
Nancy Alpaugh, CV-NSG
Sally S. Stout, Cardiac Rehab
Loretta Voorhees, Cardiac Rehabilitation

Bristol-Myers Squibb Community Health Center
Lisa Schade Button, RN-BC

Bristol-Myers Squibb Community Health Center-Medical
Mary I. Bracke, APN
Jeannette Levin, CDE
Maureen McSorley, PNP
Teri Nachtman, RN-C
Sara J. Plehn, PNP

Bristol-Myers Squibb Community Health Center-Pediatric
Karen O’Brien, PNP
Maryellen Spencer, IBCLC
Catherine Taaffe, IBCLC

Bristol-Myers Squibb Community Health Center-Specialty
Ann Marie, Maldarelli, RN-C
Lee Ann Popovich, RN-C

Corporate Health-Medical
Adrien Appello, FNP
Mary Hays, COHN-S
Mary Jane Vinch, APN-C

Department of Education
Debra Birkenstamm, CCE
Jeanette Cowen, CNOR
Robyn D’Oria, CCE
Diane Driver, Nursing Education
Charlotte Feeney, CCE
Connie L. Johnson, WCC, LLE, OMS, DAPWCA
Bernadette Flynn Kelton, CCE
Wendy J. Luca, OCN
Eileen Mansfield, CCE
Anna Orlando, CCE
Lopa Patel, ONC
Donna L. Post, RN-BC (Pain Management)

Diabetes Management Program
Deborah A. Brown-Kuhn, CDE
Sheila Hanchel, CDE
Nancy L. Rhodes, CDE

Center for Emergency Care
Christina Allen, CEN
Kristen Baien, CEN
Kristin A. Baroska, CEN
Daphne Berei, NE-BC, RN-C, Geriatrics
Kari Crane, CEN
Randi S. Killian, CMSRN
Amy G. Lazzari, CEN
Kari Crane, CEN
Sandra A. Long, RN-BC
Kim Macavoy-Sorochn, CEN
Sandra J. Marijan, RN-BC
Maureen Mcateer, CEN
Rachel E. Rogalski, CEN

Employee Health
Barbara Koprowski, COHN-S
Colleen G. Rossi, PNP

Center for Ambulatory Surgery/Endoscopy
Donna Eicke, SGNA
Lynne Forester, SGNA
Colleen Haraz, SGNA
Sau Jung, SGNA
Berrith V. Meisel, SGNA
Eleanor Soskind, SGNA

Float-Nursing
Alicia Becker, CMSRN
Debra Davies, CMRSN
Rebecca Doherty, CMSRN
Amanda L. Dzwilewski, PCCN
Sandra Evanko, CLSSGB
Luchy A. Fernandez, Gerontology
Sheri Gillingham, CLSSGB
Nancy Hassanein, CMSRN

Kimberly Rogers, CEN
Toni M. Seibert, CEN
Lori Sletta, CEN
Cherie Timbang, CEN
Maria T. Valades, CEN
Michael L. Volpe, CEN
Kimberly Wainwright, CHPN
Christine A. Wiggins, CEN
Regina C. Zupanc, CEN

Certifications

Barbara Koprowski, COHN-S
Colleen G. Rossi, PNP

Donna Eicke, SGNA
Lynne Forester, SGNA
Colleen Haraz, SGNA
Sau Jung, SGNA
Berrith V. Meisel, SGNA
Eleanor Soskind, SGNA

Alicia Becker, CMSRN
Debra Davies, CMRSN
Rebecca Doherty, CMSRN
Amanda L. Dzwilewski, PCCN
Sandra Evanko, CLSSGB
Luchy A. Fernandez, Gerontology
Sheri Gillingham, CLSSGB
Nancy Hassanein, CMSRN

Maria Hevery, CCRN
Michael Katzman, OCN
Melissa Lagrotta, CMSRN
Senora McDonald, Gerontology
Nicolette Melendez, Gerontology
Olubukola Osinowo, CMSRN
Helen A. Schnarr, SMSRN
Carol C. Schwab, CMSRN
Kristin E. Tyrell, PCCN
Hong Yan, Gerontology

Llura & Gordon Gund Center for Critical Care
Margaret C. Ajac-Ayodele, CCRN
Lorna Barron, CCRN
Liberty Caballar-Calusin, CCRN
Donna Covin, CNL
Kimberly M. Enterline, CCRN
Mayda Federovitch, CCRN
Charles J. Gallagher, CCRN
Claudius Henry, CCRN
Galit Landau, CCRN
Jennifer L. Mac, CCRN
Alice Matey, WCC
Babita V. Nair, CCRN
Tania Nandy, CCRN
Wen Ou, CCRN
Kristen M. Peterson, CCRN
Marlene C. Smith, CCRN
Kimberly Stevens, CCRN
Marcia J. Szochet, CCRN
Mindaline G. Tanpiengco, CCRN
Jolly V. Thomas, CCRN
Elana J. Toboul, CCRN
Mary Vilardi, CCRN
Cecilia Villaruz, CCRN
Janet Viscomi, CCRN
Kaitlyn Zupanc, CCRN

Infection Control
Kathleen Hill, CIC

Integrated Case Management
Zoe U. Kirtom, CCM

Information Technology
Nune Mehrebyan, Nursing Informatics
Sue Sunyak, CEN

Labor and Delivery
Stacy Booher, RNC, OB
Ronni Brennan, RNC, OB
Elizabeth Brogan, RNC, OB
Nancy A. Carrozza, RNC, OB
Elizabeth Contarino, RNC, OB
Esta Desa, RNC, OB
Pamela Ellet, RNC, OB
Carol Fabian, RNC, OB
Claire Fazio, RNC, OB
Janet P. Hesler, RNC, OB
Beth A. Post, RNC, OB
Dawn A. Rittley, RNC, OB
Neydin Rivera, RNC, OB
Shannon Scott, RNC, OB
Jaynemarie Tricarico, RNC, OB
Ellen Winkle, RNC, OB
Jung S. Yun, RNC, OB

Center for Eating Disorders Care
Lydia Pitonyak, CPN, RB-BC (mental health)

Center for Maternal & Newborn Care
Barbara L. Ketterer, RNC, OB
Grace M. McDonald-Largie, CCE
Joan Saccenti, RNC, OB
Richelle White, RNC, Inpatient OB

Medical Neurology/Oncology Unit
Caroll Adams, RN, BC
Jennifer L. Allen, RN, BC
Veronica Amegavluie, OCN
Audrey Amir, PCCN
Michelle Basione, RN, BC
Eileen M. Catinello, RN, BC
Stella Chang, OCN
Melanie Delin, MS
Katherine Gliddon, RN, BC
Jenieve H. Green, OCN
Liya Gu, RN, BC
Murielle Jeanry, RN, BC
Qinghe Jiang, RN, BC
Jennifer Johansen, OCN
Adena A. Romeo Ratliff, OCN
Humility Sumayang, Medical Surgical
Eva J. Tredler, Gerontology
Binh Tran, OCN

Brian Verdi, RN, BC
Britni L. Walton, OCN
Jennifer Woodruff, OCN

Neonatal Intermediate Care Unit
Rachel M. Aquino, RNC
Kerry A. Finnerty, RNC
Barbara M. Goldfluss, MNN
Maria Gould, NCCN
Barbara Heruska, LRNN
Karen L. Kraehenbuehl, LRNN
Margarita Lim, LRNN
Stacie B. Perry, CCRN
Katherine B. Posch, LRNN
Grace E. Shah, LRNN
Bella Edessa Somera, NCCN
Marilyn St. Rose, RN, NP, BC

Nursery
Margaret Deysner, RNC, MNN
Andrea McCarty, RNC
Mary F. Novell, RNC, NIC
Jenny A. Peterson, IBCLC
Sharon D. Petty, RNC, OB
Nicole L. Rook, RNC, OB
Susan L. Straszyński, RNC
Certifications

Nursing Administration
Karyn Book, CMSRN, CLSSGB
Tonimarie Brusnahan, CCRN, CNOR
Barbara Christiano, NEA-BC
Paula Davis, NE-BC
Jennifer Hollander, CMSRN, CLSSGB
Sara Moghadam, PCCN
Kathleen F. Ryan, NEA-BC
Denise Romeo, OCN
Carolyn Schlesier, NE-BC

Outpatient Infusion
Elizabeth Beckett, OCN
Maria V. Cristobal, OCN
Mirian Kim, OCN
Lorianne Leonardi, OCN
Barbara L. Pevahouse, OCN
Linda C. Powel, OCN
Debbie Richey, OCN
Jordana Webber, OCN

Patient Pre-Admissions
Barbara A. Byrnes, CPAN
Frances A. McKinley, CPAN
Sara Philip, PCCN

Center for Pediatric Care
Kristyn Compitello, RNC
Nicole S. Heinz, CPN
Judith Kelly, CPN
Andrea Lynn, CPN
Jyotsna G. Patole, CPN
Griselda Quia, CPN
Karen E. Papanier, RNC
Katrina Pfeiffer, CPN

Performance Improvement
Theresa Faircloth, CPHQ
Beverly Revesz, CPHQ
Lisa Stout, CCE

Post Partum
Lara Ann Mitchell Bauducco, Women’s Health
Barbara A. Demetrician, RNC, OB
Jill Destefano, Mother-Baby
Kristin Doloff, Mother-Baby
Sveta Elmooudden, RNC, OB
Noella A. Folkes, IBCLC
Jennifer A. Hollander, CMSRN, CLSSGB
Sheena Jebu, RNC, OB
Kelly Lamonica, Inpatient Obstetrics
Miriam Lecureux, RNC, OB
Jennifer A. Lee, RNC, Maternal Child
Treeza Menezes, RNC, OB
Donna L. Savarese, RNC, MNN
Deborah Walsh, RNC, MNN

Preop/PACU
Christine D. Faust, Gerontology
Christine B. Hicks, CAPA
Laurie K. Kopanyi, CPAN
Cheryl A. Kotarski, CAPA
Kathryn M. Nyce, NBCC
Jane M. Platt, CAPA

Radiation Oncology
Cindy E. Asta, OCN
Jennifer A. Neumann, OCN
Sheryl Smolensky, OCN

Radiology-Interventional
Danielle A. Kane, CCRN
Amber Parker, CEN

Radiology-Nursing
Christina Brescia, TNCC
Robert W. Brown, CEN
May M. Durano, CEN
Kate M. McClure, CCRN

Recovery Room
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