

FALL  
2015

# Magnet

## ATTRACTIONS



# TeleWound Innovations

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A PASSION FOR BETTER MEDICINE

 Lehigh Valley  
Health Network



**Anne Panik, MS, BSN, RN, NEA-BC**  
Senior vice president, patient care services and  
chief nursing officer

# What It Means to Be Innovative

**When it comes to innovation**, the American Nurses Credentialing Center – administrators of the Magnet® program – embrace a definition from noted researcher and primary care professor Trisha Greenhalgh. She wrote in 2004: “Innovation in service delivery and organization (is) a novel set of behaviors, routines and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness or users’ experience and that are implemented by planned and coordinated actions.”

As you read our fall edition of Magnet Attractions, you’ll see these themes of innovation brought to life by our talented nurses and clinicians.

For example, you’ll read about clinicians who work with our Community Care Teams. They look to improve health outcomes by providing highly coordinated care to patients who are most at-risk for chronic disease. By taking planned and coordinated actions, these teams have decreased high-risk patient readmission by 48 percent and high-risk emergency department visits by 23 percent.

You’ll also see how innovation happens when our caregivers both embrace new technology and create better ways to deliver care based upon that technology. For example, wound care nurses at LVH–Cedar Crest and transitional skilled unit (TSU) nurses at LVH–17th Street are now connected virtually through telehealth. By taking a picture of a TSU patient’s wound and sending it securely to LVH–Cedar Crest, wound care nurses now provide a consultation in an instant, allowing TSU nurses to treat wounds earlier.

On the transitional trauma unit (TTU), wireless technology allows clinicians to provide better one-on-one monitoring. In this issue you’ll read how observation monitoring technicians work together in a 12-hour shift, merging technology and compassion to improve patient outcomes and reassure families.

And of course, all of us this year have learned Epic, our new electronic medical records system. In this issue you’ll learn how nurses in our physician practices have customized Epic to meet patient needs in the outpatient setting. Use their insight as inspiration to spearhead similar innovations on the inpatient side.

So whether you’re working on a team that’s implementing a new process, pioneering a one-of-a-kind treatment or using a state-of-the-art technology, embrace your role as an innovator. The changes you make today have the power to benefit our patients for years to come.

“INNOVATION IN SERVICE DELIVERY AND ORGANIZATION (IS) A NOVEL SET OF BEHAVIORS, ROUTINES AND WAYS OF WORKING THAT ARE DIRECTED AT IMPROVING HEALTH OUTCOMES, ADMINISTRATIVE EFFICIENCY, COST EFFECTIVENESS OR USERS’ EXPERIENCE AND THAT ARE IMPLEMENTED BY PLANNED AND COORDINATED ACTIONS.”

–TRISHA GREENHALGH



## OUR MAGNET® STORY

Magnet hospitals are so named because of their ability to attract and retain the best professional nurses. Magnet Attractions profiles our story at Lehigh Valley Health Network and shows how our clinical staff truly magnifies excellence.

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## A DAY IN THE LIFE OF A

# Community Care Team

At LVHN, our vision is to become a population health leader. Community Care Teams (CCTs) help bring our vision to fruition.

CCTs specialize in providing a multi-disciplinary approach in caring for patients with multiple chronic conditions, as well as socio-economic and behavioral health issues, in coordination with primary care and specialty clinicians.

“Our team helps patients at risk manage their chronic diseases and links them with the resources and support they need,” says population health director Kay Werhun, DNP, MBA, RN. “This keeps patients well and allows them to manage their disease process at home while preventing unnecessary hospitalizations or emergency department (ED) visits.”

Our CCTs currently support 26 primary care and specialty practices in five counties, and soon will expand to 30 practices. Each team includes:

- **REGISTERED NURSE CARE MANAGER**
  - Educates patients, reviews discharge instructions and medication list, ensures doctor’s appointments are made and identifies barriers to care
- **CLINICAL PHARMACIST** – Ensures appropriateness, effectiveness and safety of all medications, consults and collaborates with providers about disease state management, and educates patients about medications and related disease states
- **BEHAVIORAL HEALTH SPECIALIST**
  - Provides brief therapeutic interventions and referrals to outside mental health treatment providers for ongoing care and psychiatric triage
- **SOCIAL WORKER** – Completes a comprehensive psychosocial assessment used by social services to coordinate a plan to address barriers and provide support



(L-r) Ambulatory care manager Angela Giordano, BSN, RN, clinical pharmacist Barb Dubyk, BS Pharm, RPh, social worker Angela Sirak, MSW, LSW, care manager Sharon Kloiber, BSN, RN, and behavioral health specialist Lauren Dennelly, MSW, LCSW, comprise one of LVHN’s Community Care Teams.

To identify patients at risk and in need of services, CCT members use a combination of clinical and claims data from Epic and Populytics. Patients typically have these characteristics:

- Three or more abnormal clinical indicators
- Five or more chronic conditions
- Seven or more medications
- Two hospitalizations or ED visits within 180 days

Team members call these patients, discuss their medical history and establish a relationship.

Each team member carries a laptop computer, cellphone and iPad, which can be used to access interpreter services and patient education materials. “CCTs have access to videos that teach patients about their chronic conditions, such as diabetes or COPD, in a format that is easy to understand,” says education consultant Victoria Chestnut, BSN, RN.

A CCT is an extension of a primary care practice. Team members have the autonomy to update patients’ medical records so care decisions are based on the newest information. Patients even have team members’ work cellphone numbers so they can call when they have questions or concerns.

Since CCTs began at LVHN in July 2012, we have reduced high-risk patient readmission by 48 percent and high-risk ED visits by 23 percent. Now we’re taking CCTs to the next level by adding another person to the team.

The CCT that supports LVPG Internal Medicine–Muhlenberg includes ambulatory care manager Angela Giordano, BSN, RN. “I help prevent low-risk patients from becoming high-risk,” Giordano says. “I provide education and ensure patients take medications properly, have transportation to their appointments and do everything they’re supposed to.”

### EXEMPLARY PROFESSIONAL PRACTICE

## EP5

Magnet® hospitals involve nurses in interprofessional collaborative practice within the care delivery system to ensure care coordination and continuity of care. Our nurses are actively engaged with other clinicians in Community Care Teams that are reducing readmissions and high-risk ED visits.

## 5E O

Magnet® hospitals involve nurses with the design and implementation of technology to enhance the patient experience and nursing practices. Our nurses embrace TeleWound technology to improve wound care on the transitional skilled unit.

# How Telehealth Improves Wound Care

TECHNOLOGY BRINGS WOUND CARE NURSES TO THE TSU BEDSIDE

**It's hard to treat a wound you can't see.** That had been the challenge for wound care nurses based at LVH–Cedar Crest when advising colleagues at the transitional skilled unit (TSU) at LVH–17th Street. Now an innovative telehealth system called TeleWound specifically designed for wound care is bridging gaps of distance and knowledge, with early results showing it improves patient care.

Treating wounds is an important aspect of patient care on TSU. When patients come to the unit – often after surgery or acute illness – to undergo rehabilitation with physical, occupational or speech therapy, they may have wounds from a variety of causes. These include moisture-related breakdown of skin due to incontinence, wounds from medical devices, and pressure wounds from extended immobility.

“These tend to be preventable wounds, so we focus on them,” says telehealth clinical coordinator Mindy Brosious, RN, BSN. “The goal is to close wounds quickly.” Wounds categorized as stages 1 and 2 often can resolve quickly. “With stage 2, the skin is opened, but it's still early,” Brosious says. Once a wound reaches stage 3, achieving closure and healing takes longer. “That's a big stress on patients and a potential portal for

bacteria to cause an infection,” Brosious says. “You definitely don't want to cross that threshold between stages 2 and 3.”

### The challenge

Prior to TeleWound going live in December 2014, wound care nurses could only view TSU wounds in person. “Travel time was a constraint,” says certified wound, ostomy and continence nurse Christine Whitehead, RN, CWCOCN. “Just dealing with parking might take 10 minutes on each end. Plus, it was a disruption in the flow of our patient care at LVH–Cedar Crest.” As a result, wound care nurses visited TSU only twice a week, on Tuesdays and Fridays. TSU patients might go several days without wounds being addressed by a wound specialist.

TSU nurses did their best to manage wounds on their own. But differences between, say, stage 2 pressure wounds and moisture wounds can be difficult to assess without specialized training. “Between visits, wounds could progress, or patients could develop new wounds,” says TSU nurse Angela Latorre, BSN, RN, CMS-RN. “We needed quicker wound care. The delay was not convenient for patients or ideal for outcomes.”

The TeleWound system addresses multiple issues in a simple way. TSU

nurses take two pictures of wounds on which they order wound care consults using a common digital camera. Pictures and background information upload wirelessly to a secure system where wound nurses can access them and provide professional treatment advice remotely. (Photos are deleted from the camera.) In most cases, wound care and TSU nurses talk directly by phone about what each wound is and how it should be treated.

“We now do consults with TSU five days a week instead of two,” Whitehead says. “They're placing proper wound care orders much faster than before, which prevents wound deterioration and speeds healing.”

### Instant results

Nurses quickly noticed benefits. “In the months since TeleWound launched, no wounds have progressed from stage 2 to 3, and all wounds have received a consult within 24 hours instead of days,” Brosious says.

Other benefits emerged as well. Previously, wound consults had to be ordered through a doctor, so nurses sometimes weighed whether orders were warranted. “The new system is nurse-driven,” Latorre says, so there's less hesitation to consult expert colleagues. “Prior to TeleWound, we had 24 wound consults in three months,” Brosious says. “Post-live, we had 25 in one month. We thought, ‘Wow, this system is working and really making a difference.’”

Increased communication between nurses also has helped TSU staff learn about wounds. “They're the experts, and they've taught me a lot about staging and treatment, like which creams are best for which kinds of pressure ulcer,” Latorre says. “The extra communication and support has been really great.” With technical support from information services, the TeleWound program also is being implemented this fall at LVHN–Tilghman and at the Center for Inpatient Rehabilitation at LVH–Cedar Crest.

“TeleWound is beneficial for everyone,” Whitehead says – “the patients, the TSU nurses and us, because our No. 1 goal is for wounds to get better.”



**Angela Latorre, BSN, RN, CMSRN** left uses a point-and-click camera to photograph wounds on TSU, then **Christine Whitehead, RN, CWCOCN** right reviews the photos and provides consultation.



**Louanne Verba, OMT** serves as the watcher monitoring patient rooms on TTU remotely.

## Video Monitoring Improves Care on TTU

PILOT HELPS TO ENHANCE PATIENT SAFETY, JOB SATISFACTION

**Colleagues on the transitional trauma unit (TTU)** care for up to 30 high-acuity patients a day, many elderly. Patients often have cognitive issues including dementia or ICU delirium, making them confused and sometimes agitated.

Such patients are at high risk for impulsivity, falls, pulled lines and other behaviors, and need to be monitored continuously. Typically, these patients are assigned a “sitter” – a technical partner or patient observation assistant – who stays within arm’s length and can intervene as necessary.

Keeping these patients safe is the focus of an innovative pilot. Since June, the program is testing the viability of video monitoring technology in eight TTU beds as an alternative to one-on-one sitters. Such technology is used successfully by other health systems and is proven to enhance safety and control costs.

### Here’s how it works:

- Two observation monitoring technicians (OMTs) work together on a 12-hour shift. One OMT acts as a “watcher” for three hours, while the other acts as a “runner,” continuously rounding in eight patient rooms. After three hours, the colleagues switch roles.
- The watcher sits in a private command center just off TTU and monitors patients on a split-screen video monitor. When signs of trouble develop, the runner is alerted through an Ascom phone.
- Watchers maintain patient privacy by turning on a “privacy mode” feature that veils the screen in blue each time a bedside curtain is closed for toileting, dressing, bathing and other tasks.

### Improved safety and job satisfaction

To date, the pilot has been successful in catching potential patient injuries, such as falls after getting out of bed, pulled lines or injuries that can occur during a seizure.

“Video monitoring is a proactive approach to providing care,” says TTU director Jody Shigo, MSN, RN. “We’re providing an extra layer of security for our patients and giving our nurses and technical partners one less thing to worry about.”

Family members feel good knowing their loved ones are safe too. And patients find that being on camera is less intrusive than having someone at their bedside 24/7. “Many patients become agitated with a sitter at their bedside; they feel like they’re under a microscope,” says Charlie Reitz, OMT. “We’re still monitoring

them continuously, but they like it better when we're out of the room."

Colleagues who expressed doubts that video monitoring could work as well as one-to-one monitoring now are convinced.

"We've become very good at identifying small signs that a patient is becoming agitated and might try something risky," says Louanne Verba, OMT. "We're actually much more proactive about intervening. We get to patients before a problem escalates."

Besides monitoring safety issues, Reitz and Verba also help reposition, toilet and bathe patients. And since runners round on TTU three hours at a time, they're also available to support nurses and technical partners in other ways, including clearing food trays, getting water and assisting with other tasks.

"There is more job satisfaction in this role because we're taking care of more patients, doing more to help patients and supporting our colleagues on the floor," Reitz says. "There is a lot of information sharing, which helps to integrate us as part of the team."

While the pilot runs through December, Shigo is already seeing signs that it's working. Patients are safe, families feel reassured, and colleagues support the changes. Video monitoring also promises to be a cost saver, because previously sitters could only care for one patient at a time.

"Our patients are sicker and need more care and interventions to keep them safe," Shigo says. "Video monitoring is a great way to keep patients safe while giving nurses the time to concentrate on other tasks and deliver high-quality care."



**Charlie Reitz, OMT** is a runner responding to patient needs as alerted from the watcher via his phone.

## NEW KNOWLEDGE, INNOVATIONS AND IMPROVEMENTS

### EO

Magnet® hospitals support and encourage nursing innovation. Nurses on TTU use video and wireless technology to monitor and respond to patient needs. This has resulted in improved patient safety.

# Our Epic Launch

CLINICIANS HELP OUR NEW EMR COME TO LIFE

**As record-setting cold descended on the Northeast in February**, LVHN launched its Epic electronic medical record (EMR) system – an event accompanied by a few shivers of its own, says Sarah Cruz, BSN, RN, practice director for LVPG Neurology. “We felt anxiety along with fear about something new and unknown.”

Now more than eight months after Wave 1 Go-Live, clinicians at LVPG Neurology, LVPG Internal Medicine–3080 Hamilton Blvd. and the LVPG Children’s Clinic have cleared their initial hurdles and are optimizing Epic. “My staff is no longer asking how to do things, but asking ‘Can?’ or ‘Why?’,” says Pamela Youse, BSN, RN, CPN, clinical coordinator at the LVPG Children’s Clinic. “They are motivated to use this system to its capacity.”

## One patient – one record

The Epic transformation is focused on providing the best patient care. The keystone: one medical record for each person. Previously, sifting through multiple EMRs or paper charts to find patient information was common – and frustrating. “It was a constant challenge to use as many as five different systems to find information,” says internist Jennifer Stephens, DO, with LVPG Internal Medicine. “But since inpatient (Wave 2) went live in August, the single record has shown its worth. Now I can see the progress notes and follow along a patient’s admission.”

At LVPG Neurology, “one patient – one record” means a patient’s medications are no longer a mystery. “We used to call

pharmacies to double-check what a person was prescribed, because not all patients are certain of what they are taking,” Cruz says. “Now the list is in their chart, complete with dosage and prescribing provider information, ensuring safe care for patients.”

## Three Epic improvements

Clinicians are shaping patient care with these three Epic innovations:

- 1. MyLVHN:** It offers patients access to their personal medical information, including test results and after-visit summaries, and offers a secure way to contact the provider and care team. “We require our staff to tell people about it,” Cruz says. “Once people started to sign up, calls decreased because patients could ask questions and request medication refills and appointments electronically.”
- 2. Care Everywhere:** Epic users can share and receive pertinent patient information with other organizations as needed. Since Wave 2 Go-Live, more than 90,000 documents have been shared with over 90 Epic-connected organizations. “Care Everywhere is important for care coordination since we work closely with other regional children’s hospitals and providers.” Youse says.
- 3. Personalization:** Epic offers opportunities to customize the user experience. “For example, for our multiple sclerosis patients, an Epic template pulls the test results and patient information we need into one form,” Cruz says.



Sarah Cruz, BSN, RN



Pamela Youse, BSN, RN, CPN

## Epic Optimization Electronic Patient Forms

### Three practices

Neurology, Pediatrics, Endocrinology and Internal Medicine at Muhlenberg are working with members of the Epic team to develop and test electronic patient forms that will let patients fill in their information at home on their personal electronic device or on a tablet handed to them in the practice. The information will then populate into the patient’s chart.

Forms will cover commonly required types of information like:

- Review of systems
- Patient history
- Screening questionnaires
- Disease-specific questionnaires

**Benefit:** More patient-provider quality time instead of time spent entering information from forms into the chart

**Time frame:** Pilot sites will begin using the electronic forms starting in December 2015.

## NEW KNOWLEDGE, INNOVATIONS AND IMPROVEMENTS

### 5E O

Magnet® hospitals involved nurses with the design and implementation of technology to enhance the patient experience and nursing practices. Our nurses have been front-and-center in the Wave 1 and 2 go-live of LVHN’s Epic electronic medical records system.



# How Innovation Keeps Patients Warm

BAIR PAWS™ HELPS PREVENT SURGICAL HYPOTHERMIA

**They're wearing paper-thin gowns,** receiving intravenous fluids and are worried about an impending procedure. It's no wonder patients typically shiver under mounds of blankets while waiting in pre-op. Thanks to the Bair Paws™ gown warming system, those shivers are becoming a thing of the past.

"Our patients love it," says Janice Magliane, RN, with the surgical staging unit at LVH-Cedar Crest.

The system includes a specialized gown and warming unit connected by a tube resembling a vacuum cleaner hose. The unit pumps warm air into the gown, with the temperature adjusted by patients via a handheld remote. "The adjustability is key," says Cheryl Barr, RN, patient care specialist for the LVH-Cedar Crest pre-op staging unit and post-anesthesia care unit (PACU). "We're returning an element of control back to patients, which helps ease their anxiety."

The system is made by 3M,™ which also makes the Bair Hugger,™ a warming

unit used during surgery for nearly two decades. When used in conjunction with fluid warmers, both systems help prevent unintended hypothermia (a body temperature below 96.8 degrees), which can lead to surgical site infections, extended post-anesthesia side effects and excessive post-op shivering, which in turn raises oxygen demands.

"Patient temps typically drop 1-2 degrees following the induction of anesthesia, so if a patient arrives in the OR with his or her temperature already down, it's a concern," Barr says. "By storing added heat, Bair Paws makes hypothermia less likely than with the Bair Hugger alone."

The system's well-documented track record led to endorsement by the American Society of Peri-anesthesia Nurses. Our anesthesia department corroborated that evidence with its own 2014 pilot on 100 adult patients, and Bair Paws units were installed at LVH-Cedar Crest and LVH-Muhlenberg this past spring. The system is offered to specific "vulnerable"

populations including all ERAS (enhanced recovery after surgery) colon-rectal patients as well as those having robotic surgery and abdominal surgery expected to last longer than two hours.

The results so far are encouraging. "Patients are arriving in recovery with body temperatures at or above target," Barr says. In addition, patient blanket use during surgical stays has dropped by about a third, from an average of 15 to around five. That saves money and staff time, but the benefit to patients is even greater. "They're shivering less and smiling more," Magliane says. "Feeling warm and comfortable is essential to a positive surgical experience."

## Get the

learn more about the [Bair Paws](#) system.



## NEW KNOWLEDGE, INNOVATIONS AND IMPROVEMENTS



Magnet® hospitals encourage nurses to evaluate and use evidence-based findings in their practice. Nurses used evidence communicated by the American Society of Peri-anesthesia Nurses to implement the Bair Paws patient-warming technology.

**Tara Chestnut, RN** (right) shows how the Bair Paws works in patient care.

# Meet Our 2015 Nightingale Award Finalists

THEY CONTINUE OUR TRADITION OF STATEWIDE NURSING EXCELLENCE

For 24 years, the Nightingale Awards of Pennsylvania have recognized exceptional nurses practicing in the commonwealth. LVHN has had Nightingale Award finalists in all 24 years, and 19 nurses have been Nightingale Award recipients. This year three LVHN nursing leaders are finalists for the 2015 awards, which will be presented in late October in Camp Hill.



## **Kristina Holleran, MSN, RN, CMSRN**

**PATIENT CARE SPECIALIST, 4K AND 6K**

**FINALIST – NURSE EDUCATOR – STAFF AWARD**

Holleran focuses on the professional development of each colleague on her units. She was nominated for her enthusiasm in investing in each nurse resident's success, making herself available to mentor through challenging situations. "A good nurse educator has an ability to provide both recognition and feedback that is meaningful to the learner," she says. She also was a key participant in the development of ROADMAP (Review of All Daily Medical Actions and Plans), a daily bedside plan of care shared with patients that has evolved into a standard hospital practice. "I hear regularly from colleagues who have family members or friends as patients and found ROADMAP to be so helpful in keeping them up to date," she says.

## **Nicole Reimer, BSN, RN, OCN**

**DIRECTOR, CLINICAL SERVICES, 7C HEMATOLOGY ONCOLOGY**

**FINALIST – NURSING ADMINISTRATOR – LEADER/MANAGER AWARD**

Reimer's success as a director is evidenced by a 0 percent nurse vacancy rate and consistently high marks in employee satisfaction. "Not a day goes by that I don't ask every employee on our unit if there's something that I can do to make their day better," Reimer says. She's also been involved with numerous nursing organizations and has been a major contributor to the Ideal Patient and Family Experience initiative, advocating family presence. "Families are the voice for their loved ones," Reimer says. "Our staff does whatever it takes to help families cope with cancer." Reimer has authored two articles in the Clinical Journal of Oncology Nursing that highlight strategies to impact exemplary professional practice on her unit.



## **Anne Panik, MS, BSN, RN, NEA-BC**

**SENIOR VICE PRESIDENT AND CHIEF NURSING OFFICER**

**FINALIST – NURSING ADMINISTRATION – EXECUTIVE (CNO LEVEL) AWARD**

Panik clearly communicates personal expectations and publicly recognizes achievements. She practices what she preaches, annually joining colleagues volunteering for our drive-through flu clinics and inside Musikfest's health tents. "Choosing nursing was one of the best decisions of my life," she says. "When you see a life saved, a baby being born, or hold the hand of an elderly dying patient, it validates why you chose the profession." She directed LVHN's winning nomination of the prestigious 2013 Magnet prize for our innovation in telehealth services and also has spearheaded the adoption of the tenets the Institute of Medicine and Robert Wood Johnson Foundation "Future of Nursing" report. "Health care is not easy because it pulls on your mind and heart," she says. "You see such joy and sadness – there is always that duality with which one has to deal."



# TNICU Nurses Release Second Children's Book



**Angela Strausser, RN (left), and Eileen Wasson, RN (right),** are both full-time trauma-neuro intensive care unit nurses. They're also full-time moms of young children. Their lifelong passion for nursing inspires them to introduce the profession to children at a young age. It's why they recently completed their second children's book, "Mommies and Daddies Work in Hospitals." The book, which came out in the spring, introduces children to the various caregivers and procedures they might encounter during a hospital stay. "We love what we do, and we want to share it with kids and maybe inspire them in the process," Wasson says. The book is a sequel to "Mommies and Daddies Are Nurses," which the two nurses wrote in 2011, and it's available through Amazon or through the nurses directly. "We have another book in the works," Strausser says. "We hope to extend the series to five books and maybe more."

## □ □ ational Presence for □ □ □ □ □urses

**Since the late 1990s,** Tina Roma Fisher, MSN, RN, CCRN (left), and Kim Bartman, BSN, RN, CVN (right), have been members of national professional organizations, served on various board committees, championed innovation in nursing, and furthered their professional development. Now both have been elected to serve on the boards of national nursing organizations.

Roma Fisher, the director of clinical services at the Center for Inpatient Rehabilitation, was elected to the national Association of Rehabilitation Nurses (ARN) board last July. "Over the years, professional organization membership has helped me to network, learn best practices and improve my nursing care," Roma Fisher says. "Now it's great to be involved with a national organization at the same time we've started the new Center for Inpatient Rehabilitation here at LVHN."

Bartman, patient care coordinator on 4K medical-surgical, was elected to the National Society of Vascular Nursing board at the end of April after being an active member of the organization for almost 20 years. "The society develops nursing guidelines, institutes education, holds annual conferences, and publishes the quarterly Journal of Vascular Nursing," she says. "I have learned about and shared best vascular practices from around the world and made friendships that will last a lifetime. It's very satisfying to be part of such a great organization."



## PROFESSIONAL MILESTONES

### AWARDS

Association for Professionals in Infection Control and Epidemiology (APIC) 2015 Annual Conference in Nashville in June 2015

[Hero of Infection Prevention Award](#)  
*Terry Burger, MBA, BSN, RN, NE-BC, CIC*

American Association for Respiratory Care (AACR) Awards Ceremony in Tampa, Fla. in November 2015

[Yellow Ribbon Award](#)  
*Kenneth Miller, MEd, RRT-ACCS, NPS, AE-C, FAARC*

### PROFESSIONAL EXCELLENCE

Society of Trauma Nurses Chair

[Geriatric Special Interest Group](#)  
*Kai Bortz, MSN, RN, CMSRN, CNL*

### ORAL PRESENTATION

Transforming from an ambulatory surgery center to a hospital-based ORC at OR Today Live Surgical Conference in Las Vegas in August 2015

*Darlene Hinkle, MSN, RN, CNOR*

### POSTER PRESENTATIONS

Correlation of Endobiliary Brush Cytology to Fine-needle aspiration in suspected Pancreaticobiliary Malignancies using a new large-caliber Endobiliary Brush at Digestive Disease Week 2015 in Washington D.C. in May 2015

[Matthew Sullivan, DO](#)  
*Joan Collette, RN, CGRN*

Embracing a Shared Governance Model to Improve our Practice at the Academy of Medical Surgical Nurses Annual Convention in Las Vegas in September 2015

*Heather Painter, RN*  
*Sharon Pustilnik, BSN, RN, CMSRN*  
*Alyssa Soltis, RN*

"Modified Early Warning Score (MEW) Value in the Intensive Care Unit at the Hospital of the University of Pennsylvania Nursing Research Conference in Philadelphia in September 2015

*Anne Rabert, DHA, RN, CCRN, NE-BC*

Missed Nursing Care Reveals Opportunities to Promote a Healthy Work Environment at the Hospital of the University of Pennsylvania Nursing Research Conference in Philadelphia in September 2015

*Tricia Bernecker, PhD, MSN, RN, ACNS-BC*  
*Mae Ann Pasquale, PhD, MSN, RN*

Innovative Patient Care Community Care Teams to Manage High-Risk Patients at the American Nurses Credentialing Center National Magnet Conference in Atlanta in October 2015

*Cathryn Kelly, RN, LDN*  
*Anne Panik, MS, BSN, RN, NEA-BC*

Creating an Orthopedic Specialty Hospital Focused on Exceptional Patient Experience, High Clinical Quality and Benchmark Level Efficiencies," at OR Manager Conference in Nashville in October 2015

*Louann Newman, BSN, RN, CNOR*

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#### FALL 2015

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